Contents

This policy is all about your health and wellbeing

Health treatment

We help you get better by covering the costs and being with you every step of the way to recovery.

Healthy lifestyle

We motivate you to make healthier choices every day and reward you for sticking with them.

The 5-minute summary of wyn Health

Hits the bull's eye on health coverage

wyn Fit • Earn rewards for staying active • Redeem them through the mobile application • Get a discount of up to 30% on your renewal premium	**Out-patient expenses** • Doctor consultations virtual or physical • Order prescribed medicines and diagnostic tests • Get a second opinion from specialists • Cashless services only
Hospitalisation • In-patient expenses • All day care procedures • 30 days pre & 60 days post hospitalisation costs • Medical transportation	**Homecare** • In-patient treatment at home via empanelled service providers • Cashless services only • Covers medicines and tests included in the treatment

Be spoilt for choices with our optionals

Super No-Claim Bonus 2x coverage in 2 renewals with 50% bonus sum insured for every claim-free year	**Mom-To-Be** Maternity expenses for normal and C-section deliveries
My Deductible Choose a deductible amount as per your employer provided coverage	**New Born Baby** 24 hours hospitalisation expenses covered for new born baby
LWP Daily Cash Daily cash for leaves without pay during hospitalisation	**Assisted Procreation** Medical expenses covered for infertility and assisted reproduction
All-Payable Claims Consumables / non payables covered at any hospital even beyond our A List hospitals (You read it right!)	**Coverage++** Sum insured that grows in tandem with the inflation at 5% (up to 100%)
Critical Illness Fixed pay-out on diagnosis of 33 major critical illnesses	**Cut The Wait** Get early coverage for pre-existing diseases after a reduced waiting period of just 1 year

The wyn Edge

New Beginnings Mid-term coverage for spouse or child in the first year of inclusion in family	**Renewal Discount** Discount for staying active	**Parental Cover** Unlocked after a year
Wait-Free Daily Cash Cash for hospitalisation in waiting period	**The A-List Hospitals** Non-payables covered at select network hospitals called the A-list hospitals	**Easy Pay** Option to pay the premium in instalments

What we don't cover (Full list on part IV of policy wordings)

	Cosmetic treatments and routine care • Supplements and personal care • Routine check-ups and vaccinations • Hospitalisation for diagnostic purposes only		**Injuries due to** • Self-harm • Drug/alcohol abuse • Criminal activities
	Prosthetics and external aids • External organ support • Spectacles • Hearing aids		**Hazardous or adventure sports** • Mountaineering • Scuba diving • Sky diving

How long before you can avail a benefit (aka waiting period)

Hospitalisation due to accident	0 days
Hospitalisation due to illness	30 days
OPD	30 days
Specified diseases & procedures	2 years
Pre-existing diseases*	2 years; can be reduced to 1 year by opting for Cut The Wait

*You can still avail the wait-free daily cash during the waiting period for declared & accepted pre-existing diseases and specified diseases & procedures.

How to claim			
	Mobile App	Website	Network hospital

The claim cat is out of the bag! (Secrets to get the most out of your claim)

1. Before a planned hospitalisation, always reach out to us at least 7 days in advance.
   i. We arrange for a second medical opinion if you are up for it, so that you can be 100% sure.
   ii. We give you hospital recommendations suitable for your treatment and budget.
2. Opt for a hospital that's on our A-List.
   i. We have negotiated the rates for standard procedures with our A-List hospitals so that nobody can take you for a ride when it comes to medical costs.
   ii. Non-payables at A-List hospitals are covered, and the mandatory reducing deductible is waived off. See section VII C.4 for a full list of non-payable items.
3. In case of emergency hospitalisation, claim within 24 hours of getting admitted.

Save up to 30% on renewal premium

1. Activate fitness data tracking and keep it on at all times.
2. Participate in fitness activities regularly and accumulate maximum fitness points.
3. Avail free medical check-up & get rewarded.

Last, but not the least

Reset your SI once in a year	Lifelong renewability

Now, the detailed version.

I. Preamble

This Policy is proof of the contract between you and us. The declarations, disclosures and consents given by you in the Proposal is also a part of this contract. This Policy testifies that we will insure your interests under the Sections specified as operative in the Policy certificate based on the premium paid by you to us. It confirms that we will indemnify you for the events occurring during the Period of Insurance in the manner and to the extent specified in the Policy. For this, it is vital that you meet, do and comply with anything related to the terms, conditions and exceptions of this Policy.

The bits you shouldn't miss:

Insurance benefit will be null and void at the option of the Insurer, in case of any untrue or incorrect statement, misrepresentation, non-description of any material particular in the proposal form/ personal statement, declaration and connected documents, or any material information has been withheld by you or anyone acting on your behalf to obtain insurance benefit. Refer to policy wordings for the terms and conditions. All disputes are subject to the jurisdiction of Indian Court only. For claims, please reach out to us on the mobile application, website or e-mail to us at ask@hellowyn.com or write to us 16th floor, Peninsula Business Park, G.K Marg, Near Mathuradas Mills, Lower Parel (West), Mumbai – 400013.

This policy has been issued based on the details given by you. Please review the details given in the policy certificate and confirm that same are in order. In case of any discrepancy/ variation, you are requested to reach us immediately on the mobile application, website or write to us at ask@hellowyn.com. In the absence of any communication from you within the period of 15 days of receipt of this document, the policy would be deemed to be in order and issued as per your proposal. All refunds and claim payment will be done through NEFT, UPI or IMPS. This policy certificate is to be read with the policy wordings, as one contract or any word or expression to which a specific meaning has been attached in any part of this policy shall bear the same meaning wherever it may appear.

II. Definitions

Term	Definition
Accident*	A sudden, unforeseen and an involuntary event caused by external, visible and violent means.
Admission	Getting admitted to a hospital as an in-patient for the purpose of necessary medical treatment of an injury and/or illness.
Adventure Activities	Any out-of-the-ordinary activity that can lead to physical injury: ○ adventure racing ○ base jumping ○ biathlon ○ big game hunting ○ black water rafting ○ bmx stunt/ obstacle riding ○ bobsleighing/ using skeletons ○ bouldering ○ boxing ○ canyoning ○ caving/ pot holing ○ cave tubing ○ climbing/ trekking/ walking over 4,000 meters ○ cycle racing ○ cyclo cross ○ drag racing ○ endurance testing ○ hang gliding ○ harness racing ○ hell skiing ○ high diving (above 5 meters) ○ hunting ○ ice hockey ○ ice speedway ○ jousting ○ judo ○ karate ○ kendo ○ luging ○ manual labour ○ marathon running ○ martial arts ○ micro – lighting ○ modern pentathlon ○ motor cycle racing ○ motor rallying ○ mountaineering/ rock climbing ○ parachuting paragliding/ parapenting piloting aircraft ○ polo ○ powerlifting ○ power boat racing ○ quad biking ○ river boarding ○ river bugging ○ rodeo ○ roller hockey ○ rugby ○ ski acrobatics ○ ski doo/ ski jumping ○ ski racing ○ sky diving ○ small bore target shooting ○ speed trials/ time trials ○ triathlon ○ water ski jumping ○ weight lifting ○ wrestling and activities of similar nature
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.
AYUSH Treatment	Medical and/ or hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy Systems.
AYUSH Hospital*	An AYUSH Hospital is 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 recognized 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 at least 5 in-patient beds; ii. Having qualified AYUSH Medical Practitioner in charge round the clock; iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out; iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
Break in Policy	The gap in policy when the renewal premium is not paid on/ before/ within 30 days from the policy expiry date.

Cashless facility*	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.
Condition Precedent*	A policy term or condition upon which the Insurer's liability under the policy is conditional upon.
Congenital Anomaly*	A condition which is present since birth, and which is abnormal with reference to form, structure or position. i. Internal Congenital Anomaly: Congenital anomaly which is not in the visible and accessible parts of the body. ii. External Congenital Anomaly: Congenital anomaly which is in the visible and accessible parts of the body.
Contribution	If a person gets health insurance from different providers, then the insurer can ask the other insurers to share the claim amount proportional to the sum insured. This applies only to indemnity claims and not fixed benefit ones.
Co-Payment*	A cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.
Day Care Centre*	Any institution established for day care treatment of illness and/ or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner and must comply with all minimum criterion as under: i. has qualified nursing staff under its employment; ii. has qualified medical practitioner/s in charge; iii. has fully equipped operation theatre of its own where surgical procedures are carried out; iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
Day Care Treatment*	Medical treatment, and/or surgical procedure which is: i. undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs. because of technological advancement, and ii. which would have otherwise required hospitalization of more than 24 hours. iii. Treatment normally taken on an out-patient basis is not included in the scope of this definition.
Deductible*	Deductible means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the sum insured.
Dental Treatment*	Treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
Dependent Child	A child (up to 20 years of age) who is financially dependent on the insured.
Dependent parent	Parents (Father and mother) aged 46 years and above who are financially dependent on the Insured.
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.
Domiciliary Hospitalization*	Medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances: i. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or ii. the patient takes treatment at home on account of non-availability of room in a hospital.

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.
Emergency inpatient hospitalisation	Means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate inpatient care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.
Grace Period*	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.
Hospital*	Any institution established for in- patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act 2010 or under 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 15 in-patient 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.
Hospitalization*	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.
Illness*	A sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment. • Acute condition - 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. • Chronic condition - A 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
Injury*	Accidental physical bodily harm occurring during the Policy Period, excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a medical practitioner.
In-patient Care*	Treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.
Insured/Insured Person(s)	The individual(s) whose name(s) is/ are specifically appearing as such in the Policy Schedule and is/ are hereinafter referred as "You"/"Your"/"Yours"/"Yourself".
Intensive Care Unit*	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.

ICU Charges*	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.
Life Threatening	A medical condition suffered by you which has the following characteristics: i. Markedly unstable vital parameters (blood pressure, pulse, temperature and respiratory rate). ii. Acute impairment of one or more vital organ systems (involving brain, heart, lungs, Liver, Kidneys and pancreas) iii. Critical care being provided, which involves high complexity decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ failure(s) and requires interpretation of multiple physiological parameters and application of advanced technology. iv. Critical care being provided in critical care area such as coronary care unit, intensive care unit, respiratory care unit, or the emergency department.
Maternity expenses*	Includes: i. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization); ii. expenses towards lawful medical termination of pregnancy during the policy period.
Medical Advice*	Any consultation or advice from a medical practitioner including the issuance of any prescription or follow-up prescription.
Medical Expenses*	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.
Medical Necessary Treatment*	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.
Medical Practitioner/ Doctor*	A person who holds a valid registration from 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 the scope and jurisdiction of his license.
Migration*	means the right accorded to health insurance policyholders/proposers (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.
Network Provider*	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.
Newborn Baby*	A baby born during the policy period and aged up to 90 days.
Non-Network Provider*	Any hospital, day care centre or other provider that is not part of the network.
Nominee	The insured can choose a nominee for the policy to receive the benefits in case of an unfortunate demise of the insured. If he/she is a minor, then the legal guardian can appoint the nominee.
Notification of Claim*	The process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

OPD Treatment*	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.
Policy	Policy wordings, policy schedule, and any endorsement or extensions, if applicable. The policy lays down what is covered, what is not covered and the terms & conditions under which the policy is issued to the insured.
Policy Period	The period from the policy start date to end date as mentioned in policy schedule.
Policy Schedule	It is a part of the policy consisting information on coverage, waiting period, etc.
Policy Year	Period of 12 months from the policy start date or the anniversary of policy start date in the following years.
Portability*	If an insured wants to switch insurer or switch plan under the same insurer, he/she can get the credits gained for pre-existing diseases and other time-bound exclusions transferred to the new policy. This will work only if there's no gap in the previous policy.
Post Hospitalisation Medical Cost*	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 hospitalization was required, and ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.
Pre-Existing Disease*	Pre-existing disease means any condition, ailment, injury or disease: i. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or ii. 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 or its reinstatement
Pre Hospitalization Medical Cost*	Medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that: i. Such medical expenses are incurred for the same condition for which the insured person's hospitalization was required, and ii. The in-patient hospitalization claim for such hospitalization is admissible by the insurance company.
Proposer	means the person(s) or the entity named in the Policy Schedule who executed the Policy Schedule and is (are) responsible for payment of premium(s).
Qualified Nurse*	A person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
Reasonable and Customary Charges*	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.
Renewal*	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.
Room Rent*	Amount charged by a hospital towards room and boarding expenses and shall include the associated medical expense.
Senior citizen	means any person who has completed sixty or more years of age as on the date of commencement or renewal of a health insurance policy.
Service Provider	We have partnered with several hospitals and healthcare providers either in individual capacity or through aggregation, to deliver the benefits to you under this policy. The list of our service providers is available on our website (www.hellowyn.com) and can change time to time.
Sub-limit	A cost sharing requirement where we would only pay up to the pre-defined limit.

Sum Insured	The total maximum amount that an insurer will pay to the insured against claims in a policy year. For benefit based covers, it is the fixed amount that gets paid for a claim. The sum insured is mentioned against each cover in the policy schedule.
Surgery or Surgical Procedure*	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.
The A-List Hospitals	Select hospitals or preferred health care providers from our cashless network. The A List hospitals are a subset of our network hospitals.
Unproven/Experimental treatment*	The treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.
Waiting period	Period of time from the first policy start date which must elapse before your coverage can begin. However this will not be applicable on renewal. In case of enhancement of sum insured the waiting period shall apply afresh to the extent of sum insured increase.
We/Ours/Us	ICICI Lombard General Insurance Company Limited
You/Your/ Yours/ Yourself	The insured i.e. the person named in the Policy Certificate as the insured.

*Standard definitions as per IRDAI Standardisation guidelines.

Before you dig into what this policy has to offer,

Just remember, you can avail these only if,

1. Your **waiting period** is over (there are very few anyway ;)). Check the 5-minutes summary for details.
2. Your balance sum insured and deductions in line with sub limits, co-pays and mandatory deductible allow for the claim to be paid.
3. The injury, illness or hospitalisation occurs **during the policy period**.
4. The terms and conditions as defined in the policy are met.
5. The incident doesn't fall under any exclusion of the policy.

III. Benefits covered under the policy

A. It pays to stay active with us, literally!

A.1 wyn Fit

Setting fitness goals is easy, but sticking to them can be tough. We've all been there, done that. So we are sweetening the deal for you by splurging you with exciting rewards when you participate in fitness activities. These include walking, working out at the gym, yoga, zumba, undergoing a health check-up, completing a health quiz, etc. We will track every initiative, and this will help you earn 'fitness points/wyn coins'. You can redeem these points against available health and fitness services at our service providers.

i. Tricks of the game!

How to earn fitness points?

Activities	Walking	Burning it at the gym, yoga & Zumba	Undergoing the health check-up	Completing a health quiz	Fitness challenges
Max points you can earn	100/day >10,000 steps	100/day >= 500 kcal/session	700	50	50/challenge for participation 120/challenge for milestone achievement 300 for top performance
Bonus tip!	Walk 5,000 steps for 21 days & earn extra 40 points	Burn 300 kcals/ session for 21 days & earn extra 40 points	Earn 5% extra discount with good reports		
Fun Fact	**The super wynner in you can burn it and earn up to 36,500 points in a year!**				

ii. Get set, redeem!

What can the fitness points get you?

Rewards that can amount up to 25% of your premium. You can redeem the rewards at our service providers to avail:

Gym subscription	Health supplements	Fitness tracking device	Diet program subscription	Dietician consultation
Fitness training subscription	Health coach	Entry to sports/fitness events	Health check-up	Physiotherapy sessions

iii. The best part? Discounts, period.

Get heavy discounts on renewal premium for staying active!

Discount	**1%**	**2%**	**3%**	**5%**	**10%**	**25%**
Points earned annually	12000	15000	16000	18000	25000	36000

Bonus tip: Earn 5% extra discount for good reports with health check-up

No questions unanswered (FAQs)

1. **How will you track my activity?**
   You can either choose an activity on our mobile application or a service provider's application. You'll need to allow us to access the data if you opt for an activity on the service provider app. We can then track your progress and reward you with fitness points accordingly.

2. **How do I redeem my rewards?**
   Our wyn Fit program is filled with exciting rewards. As you earn fitness points, you unlock rewards. So let's say you have 36,000 fitness points in your kitty, you'll be eligible for rewards worth 25% of your premium. What are these rewards, you ask? Take your pick - gym subscription, diet consultation, health coach, fitness training, and more, all available with our empanelled service providers just by utilising your fitness points. The rewards are subject to availability with our service providers.

3. **Will my fitness points get carried forward at renewal?**
   We'll apply the discount you've earned basis your accumulated fitness points to your renewal premium and reset your points to 0 for next year.

4. **What happens if I become inactive for a while?**
   If you are inactive for over 3 weeks at a stretch, you'll lose 200 fitness points. This will continue for every 3 weeks of continued inactivity until you reach 0.

5. **How can I avoid this penalty for inactivity?**
   You can block some period as 'out of action' in your calendar to avoid the penalty. You can do so twice a year and only for a duration of 3 weeks each time.

6. **What happens to my fitness points if my policy expires?**
   If your policy expires and you miss renewing it during the grace period, you end up losing all your fitness points.

   For more details on wyn Fit, refer part VII C.2 of policy wordings.

Do not skip this part!

I. wyn Fit is intended to help you improve your well-being and habits and obtain a healthy lifestyle. But, this is not a substitute for a consultation with an independent doctor.
II. You need to provide our service providers with your necessary details before you can avail the health risk assessment services on call or through online/digital mode. Rest assured your information will be used only for wyn Fit and kept confidential with our service providers and us at all times.
III. You need to inform us and submit the relevant documents, reports, receipts within 60 days of undertaking such activity.
IV. You will have to bear any cost incurred on additional tests for preventive screening recommended by a dietician or physical trainer.
V. The service can only be arranged if the service provider is available at the requested location.
VI. The services provided under wyn Fit should not be used to diagnose or identify treatment for a medical or mental health condition.
VII. In case of a floater that covers 2 adults and 1 child, both adults will need to participate in wyn Fit to earn rewards and renewal discount. Both adults will need to download the wyn pp and allow us to track activity for rewards. Children will not be eligible to participate in the wyn Fit program.

Illustration 1: If Adult 1 earns 10% renewal discount and Adult 2 earns 5% renewal discount, then 5% renewal discount will be applied on the policy at renewal. Rewards, however, can be redeemed as per individual performance and fitness points.

Illustration 2: If Adult 1 earns 10% renewal discount and Adult 2 earns 0% renewal discount, then no discount will be applied on the policy at renewal. Rewards, however, can be redeemed as per individual performance and fitness points.

B. When you're feeling under the weather and in need for some OPD care

B.1 OPD

We've all been there – a bad cold, agonising headache or a stubborn cough that just won't go away! We feel you and that is why we have partnered with reputed service providers where you can consult a doctor or avail any outpatient treatments prescribed by the doctor as cashless services after the initial 30 day waiting period. You can claim for:

i. Physical consultation with a doctor
ii. Doctor consultations via audio and video
iii. Chat with a doctor
iv. AYUSH treatments, psychiatric ailments or mental health issues
v. Diagnostic tests prescribed by a doctor
vi. Medicines prescribed by a doctor

Availability of certain services may be subject to our then existing partnership with service providers

No questions unanswered (FAQs)

1. **How do I avail cashless OPD services?**
   You just need to order the medicines on the mobile application and we'll have them delivered to your doorstep. Similarly, you can book an appointment with a doctor or schedule a diagnostic test by choosing from the options available on the mobile application.

2. **Can I get reimbursement for these services?**
   You can get reimbursement only in case of doctor consultations for major illnesses and surgeries and when the preferred specialist is not available on our empanelled network. Acceptance of a reimbursement claim for specialist consultations is subject to our discretion and prior approval.

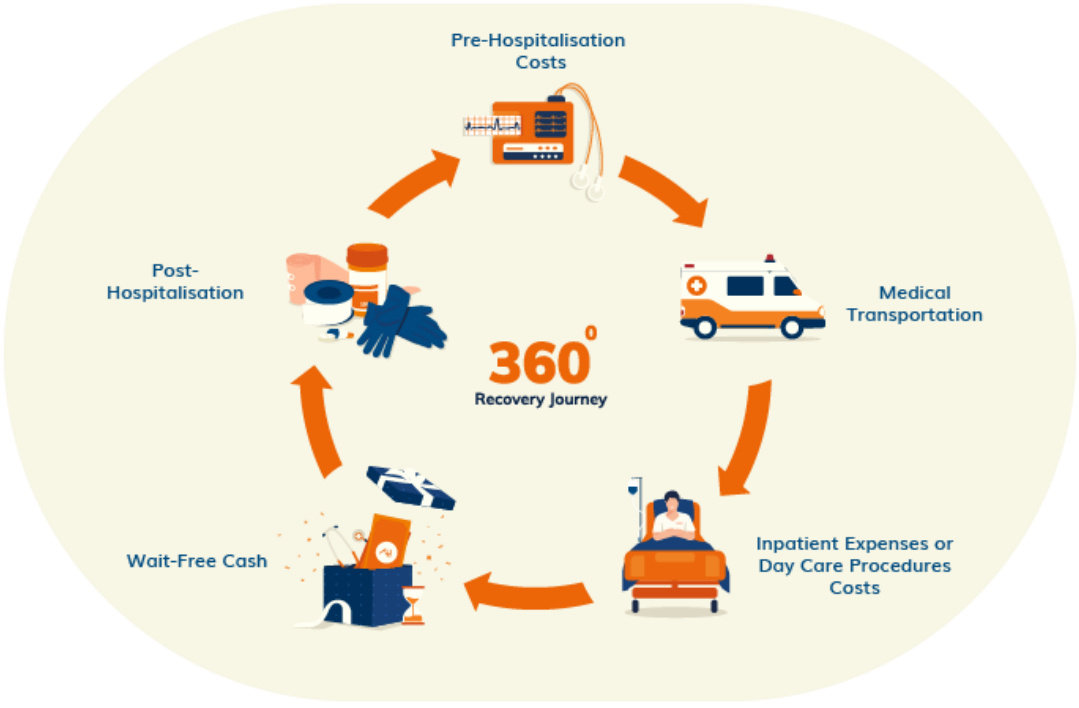
Do not skip this part!

This will exclude expenses for:

I. Preventive screening of any nature
II. OTC drugs unless prescribed as a part of an active treatment
III. Conditions that have a waiting period
IV. Vaccinations of any nature
V. External medical aids
VI. Expenses related to spectacles and contact lenses
VII. Dental treatment
VIII. Physiotherapy sessions
IX. Health supplements, nutraceuticals, foods for special dietary use, foods for special medical purpose, foods with added probiotics and/or foods with added prebiotics, vitamins, tonics or other related products
X. Cosmetic treatments unless associated with allergic reactions or injuries and recommended by treating physician

C. When hospitalisation is the only resort ☹

Getting hospitalised is a real downer. Our 360 degree coverage has got your back throughout the recovery process – before, during, and after hospitalisation:



C.1 Before the hospitalisation ordeal begins

Pre-Hospitalisation

If your in-patient claim has been approved, we cover your:

i. **Pre-hospitalisation expenses** for up to 30 days prior to the in-patient hospitalisation and related to the in-patient hospitalisation claim.
ii. **Medical transportation** for in-patient hospitalisation via road, water or air to the nearest hospital which is fully equipped for the needed treatment.
   a. This will be applicable for emergency transportation to nearest hospital only which is adequately equipped for treating the patient.
   b. Transfer to a different hospital will be covered only if the current hospital is not adequately equipped to treat the patient and treating doctor recommends the transfer.
   c. Transportation to the nearest diagnostic centre from the hospital is covered if the hospital is not equipped for the diagnostic test.

Any transportation after discharge will not be covered.

C.2 Living through hospitalisation, rather, homesickness

In-Patient Hospitalisation

When we accept your in-patient claim, we cover your in-patient expenses for room rent, nursing charges, consultant and treating doctor/ specialist/ surgeon fees, diagnostic charges, medicine charges and surgery charges. Under this, AYUSH in-patient treatments at Government recognised AYUSH hospitals are also covered.

C.3 For the short procedures

Day Care Treatment

Recommended day care procedures and treatments will be covered. These are procedures that require less than 24 hours admission as an in-patient in a hospital.

Do not skip this part!

I. Mandatory Reducing Deductible: A mandatory deductible of an amount specified in your policy schedule will be applicable to your in-patient and day care treatment claims. Your mandatory deductible will be reduced by 20% each year up to 5 years at no additional cost and irrespective of claims made in the past year. At the end of 5 years, the mandatory reducing deductible will be nil.
II. If you've opted for My Deductible, it will be applied over and above Mandatory Reducing Deductible.
III. If you have bought the policy from Zone II and are hospitalised in Zone I, a 25% co-pay will be applicable to your in-patient and day care treatment claims. It will be applied after Mandatory Reducing Deductible and My Deductible have been applied to the payable amount.

C.4 After the worst (read - hospitalisation) is over

Post-Hospitalisation

When we agree to cover your in-patient expenses, we also cover your post-hospitalisation medical expenses related to the in-patient hospitalisation incurred up to 60 days post discharge. These include medicines, diagnostics tests and physiotherapy sessions that are prescribed by the treating doctor and are related to the in-patient hospitalisation claim.

C.5 Flipping the worst case scenario i.e. hospitalisation during waiting period

Wait-Free Daily Cash

You can't claim for in-patient expenses due to pre-existing diseases that are specified in your policy schedule for the first 2 or 1 year as opted by you. In addition, you can't claim for the specified diseases

and procedures for the first 2 years (For full list of specific exclusions please refer Section V). Here's your wyn moment—you will get a fixed daily cash allowance of ₹1,000 for each completed day of in-patient hospitalisation due to conditions that have a waiting period, like the ones we just mentioned. This benefit can be availed up to a maximum of 15 days once in a policy year. However, any conditions that are permanently excluded will not be covered under this benefit.

No questions unanswered (FAQs)

1. Can I claim this for pre-existing diseases during the waiting period?
A big yes! We created this cover so that you don't feel the burden weighing down on you if a pre-existing condition triggers in-patient hospitalisation. Although your pre-existing diseases as specified in your policy schedule will not be covered under in-patient hospitalisation cover until the waiting period is over, you can still claim under Wait-Free Daily Cash and get some relief.

2. Can I avail this benefit even after renewal?
You can avail it till you complete your waiting period for pre-existing diseases and specified diseases and procedures as specified in your policy schedule. After that, this cover will become inactive.

3. Will you consider my claim for OPD to avail this benefit?
You can only claim for any in-patient expenses if you are hospitalised due to a specified disease or procedure or pre-existing disease during the applicable waiting period. OPD expenses cannot be reimbursed with Wait-Free Daily Cash.

Do not skip this part!

I. You can claim only for pre-existing diseases (which is declared and accepted by us) and for specified exclusions mentioned under Section V (Specified disease/procedure waiting period Code- Excl02).
II. Your claim will be covered only if your in-patient hospitalisation happens after the initial 30 days waiting period.
III. You cannot claim if your sum insured has been exhausted by previous claims.
IV. This benefit will not be applicable for permanent exclusions that are defined under Section V, optional covers specified in Section IV F and non-payable items as per IRDAI list.
V. This benefit will become inactive once you are done serving all the waiting periods.

C.6 When it hasn't been your year and your sum insured needs a reset

Reset Benefit

After a claim is paid, if your balance sum insured is insufficient for your next in-patient hospitalisation claim, we will reset your sum insured up to 100% without any extra premium. This way you won't be hung out to dry when you need us the most.

No questions unanswered (FAQs)

1. Can I avail this benefit for my first claim?
No, reset benefit will not trigger for first claim. You can only use this in subsequent claims in case your balance sum insured including Super No claim Bonus or Coverage++ if opted by you is insufficient to pay the claim.

2. Can I avail this benefit if I claim for the same illness again?
No, you cannot claim for the same illness again in the same policy year. However, in case of floater Reset Benefit will trigger for same illness if insured person is different.

3. If I don't end up using the reset sum insured, will you carry forward it?
Any balance sum insured will lapse at the end of your policy year.

Do not skip this part!

I. Sum insured doesn't get reset for the first claim of the policy year.
II. Reset will not be available if the next claim in the same policy year is related to an illness, disease or injury for which a claim has been paid for the same person.

III. For a single claim during a policy year the maximum amount payable won't be more than the aggregate sum of the sum insured and Super No Claim Bonus or Coverage++ if applicable.
IV. The reset feature will not be applicable for any medical relapses or readmission for the same illness within 45 days of discharge.
V. Any unutilised reset balance will not be carried forward to the next policy year.

C.7 When you need the hospital care to come home

Homecare

We make it happen! Thanks to our bunch of empanelled service providers, who specialise in rendering home healthcare services. These are cashless services that you can avail once your initial 30 days waiting period has ended. If the doctor advises you in-patient hospitalisation and if you choose to undergo in-patient treatment at home, we'll cover:

i. Doctor visits
ii. Nursing charges
iii. Prescribed medicines
iv. Prescribed diagnostics

Do not skip this part!

I. You can avail Homecare only if the treating doctor approves it. Else you will need to go to a hospital.
II. You can avail of the cashless services only when a network provider/ service provider is available.
III. If our network provider is unavailable, you would need us to approve availing them from a non-network service provider beforehand.
IV. Pre-existing diseases and time-bound excluded disease/treatment will be covered only after you complete the waiting period for them.
V. Only a continuous and active line of treatment prescribed by treating doctor will be covered.
VI. The treatment that can be availed under outpatient will not be covered.
VII. This cover will exclude AYUSH treatment.

D. The perks that make wyn Health, a win for you.

Bonus features that make this policy a no-brainer!

D.1 The A-List Hospitals

The perks of choosing cashless services from the A-List Hospitals on our network for in-patient hospitalisation and day care procedures is nothing short of a red carpet treatment. How, you ask?

a. We cover your expenses—for the non-payable items (as listed under Section VII C.4) incurred towards such hospitalisation.
b. Plus, we also waive off the Mandatory Reducing Deductible.

To view and locate the nearest A-List Hospitals, please visit: www.hellowyn.com
For knowing the availability of beds and specialists, please use our Health buddy services.

D.2 New Beginnings

When you welcome someone in your life, we celebrate too. We cover your newly-wed spouse or new born baby or legally adopted child aged up to 18 years, mid-term for the rest of the policy year, for in-patient hospitalisation expenses only, even in case you forget to include them in the policy. We extend this for you only for the year that the event occurred (i.e. marriage or child birth, or child adoption). You can avail this benefit by adding your spouse or child to your policy, mid-term in the year of the event as applicable, if

a. You get married 90 days after the policy start date
b. Your child is born 90 days after the policy start date (coverage for new born child will begin after 91 days from the date of birth)

c. You have legally adopted a child/ children (coverage for adopted child will begin 91 days since its birth or adoption, whichever is later)
d. the proposed new life:
   i. Is under 45 years of age
   ii. Is not on any medication, daily or of any other frequency
   iii. Does not have any hospitalisation history nor has consulted a doctor for any current or past medical history in the last 4 years
   iv. Is not diagnosed with diabetes, hypertension or cardiac conditions or any other pre-existing condition
   v. Has never been diagnosed with nor had any history of nor consulted a doctor for any chronic diseases or recurring illness or injury which require ongoing medical attention or limit activities of daily living or both such as disorders of any organ or system

No questions unanswered (FAQs)

1. **What benefit will be available to my newly wedded spouse or new born child under this cover?**
   We'll cover them for in-patient hospitalisation expenses for illness or injuries that are not pre-existing or chronic in nature. Any internal congenital abnormalities in the new born child will be covered after 2 continuous renewals after inclusion of the child in the policy by paying the applicable premium.

2. **What documents do I need to submit to avail this benefit?**
   We will need marriage certificate/ marriage registration confirmation to add your spouse, child's birth certificate to add your child and legal adoption papers to add your adopted child.

3. **What if mid-term coverage is refused to them due to their medical history? Can I add them at renewal?**
   Yes, you will have the option of adding the new life at renewal. However, acceptance of proposal to add the new life will be subject to our underwriting guidelines.

4. **Will you cover my spouse and baby even after renewal?**
   At the time of renewal, your plan will be revised to include the new life added under new beginnings in the previous year, provided you pay the applicable premium. When you do so, they will be covered for all the benefits of the policy.

Do not skip this part!

I. We will cover only the in-patient hospitalisation of your newly wedded spouse or child under this cover for the remaining duration of the policy.
II. Any pre-existing diseases or chronic illnesses will not be covered under this benefit.

E. wyn Unlock

Depending on how long you stay insured with us, we will unlock the Parental Cover as a loyalty benefit irrespective of your claims history.

E.1 Parental Cover

It can be difficult and expensive to get a fresh policy for ageing parents. At renewal, we unlock the parental cover, which you can use to secure your dependent parents. You can avail this at the time of policy renewal at an incremental premium based on the age of the parent(s) to be included. You can choose the sum insured option available under the cover. The coverage will also vary as per their age, and you can include them in either of our 2 plans:

Coverage	Plan A	Plan B
Age	46 to 55 years	56 years and above
Pre-Hospitalisation	Up to 30 days	Up to 15 days

Post-Hospitalisation	Up to 60 days	Up to 15 days
In-Patient Hospitalisation	Yes	Yes
Day Care Treatment	Yes	Yes
Medical Transportation	Yes	Yes
24x7 Tele Consultation with a doctor	Yes	Yes
**Arranging emergency ambulance based on patient condition	Yes	Yes
**Finding service providers for second opinion	Yes	Yes
**Finding service providers for home healthcare	Yes	Yes
Lifelong Renewability*	Yes	Yes
Mandatory Reducing Deductible	Yes, applicable as per base plan	-
Mandatory co-pay of 20%	-	Yes
Sub-limits:		
#Eye surgeries	-	₹1,00,000
#ENT	-	₹1,00,000
#Joint replacement surgeries	-	₹1,00,000
#Vertebra related surgeries	-	₹1,00,000

*Subject to the base policy being active.
#Procedures capped at the amount specified against them, including pre and post hospitalisation expenses.
** We shall only facilitate the services, expenses incurred on these will need to be borne by you.

Waiting periods for Parental Cover shall commence from the day you opt for it.

Hospitalisation due to accident	**0 days**
Hospitalisation due to illness	30 days
Specified diseases & surgical procedures	2 years
Pre-existing diseases* (PEDs)	2 years; PEDs that are disclosed at the time of proposal and accepted by us and specified in the policy schedule will be covered after 2 continuous renewals

Do not skip this part!

I. The coverage and benefits under this cover will be restricted to those specified under each variant.
II. Your parents will have to undergo a medical screening. Their proposal will be accepted as per the underwriting guidelines that prevail then.
III. Conditional underwriting and premium loading will trigger basis medical history declared at the time of screening.
IV. Pre-existing diseases specified in the policy schedule will be covered after 2 years of continuous coverage from the date when the Parental Cover was declared and accepted.
V. The eligible claim amount for one or more claims for one or both insured parent as the case may be will not be greater than the sum insured specified against the Parental Cover in the policy schedule.
VI. You can include a maximum of 2 insured under the Parental Cover.

F. There's more if you want to spruce up your coverage with some optional add-ons

F.1 Super No-Claim Bonus

We will increase your sum insured by a whopping 50% for every claim-free year. This gets accumulated for back-to-back claim-free years up to a maximum of 200%. When you do claim, you go down a slab on the Super No-Claim Bonus, i.e., by 50%. However, this in no way affects your base sum insured.

No questions unanswered (FAQs)

1. What will be my Super No-Claim Bonus if I increase my sum insured at renewal?

After a claim-free year, if you go for a higher sum insured, the Super No-Claim Bonus will be applicable on your last completed year's sum insured. On the other hand, if you choose to reduce your sum insured at renewal, the Super No-Claim Bonus will apply to your newly opted sum insured.

Here's an illustration of how much Super No-Claim Bonus you can earn depending on the sum insured opted at renewal.

Scenario 1: SI upgrade at renewal

Policy Years	Sum Insured Opted	Policy Type	Super No Claim Bonus Earned
Year 1	₹10 lakh	Fresh	NA
Year 2	₹15 lakh	Renewal	₹5 lakh

Scenario 2: SI downgrade at renewal

Policy Years	Sum Insured Opted	Policy Type	Super No Claim Bonus Earned
Year 1	₹10 lakh	Fresh	NA
Year 2	₹5 lakh	Renewal	₹2.5 lakh

Do not skip this part!

I. For floater policies, the accrued Super No-Claim Bonus will be on a floater basis. It will only be available to those who were insured in the previous policy year(s) after renewal.
II. The accrued Super No-Claim Bonus will not be added if the policy is not renewed with us by the end of the grace period.
III. Merging individual policies to floater policy: If you merge two or more individual policies into a floater policy during renewal with us, you can still get the bonus. The bonus carried forward in the floater policy will be the lowest amongst the individual policies accrued over the years.
IV. Splitting a floater policy: At renewal, if a floater policy is split into multiple floater or individual policies, the bonus will be proportionate to the sum insured of the renewed policies.
V. If you go for a higher sum insured at renewal, the bonus shall be calculated on the sum insured of the last completed policy year. Table F.1.1 illustrates this for you.
VI. If you choose to reduce your sum insured at renewal, the Super No-Claim Bonus shall apply to the newly opted sum insured as illustrated in table F.1.2.
VII. If you make a claim for the previous policy year after renewal, any bonus added for the policy will be rolled back.
VIII. At the time of renewal if you opt out of this optional cover, then the Super no claim bonus accrued up until the expiring policy year will be forfeited

F.2 My Deductible

You can make this policy work for you as a booster plan for your employer provided health policy by opting for a high deductible and lowering your premium even further. You can choose a deductible amount basis your corporate cover or employer provided coverage. In the future, if you were to lose your

corporate cover due to job loss, you can switch this policy to a base plan by paying an incremental premium at the time of renewal.

No questions unanswered (FAQs)

1. **What if I lose my employer provided health policy?**
   You can bring your deductible down to zero by paying an additional premium and sharing the necessary documents. This way, you'll stay adequately covered no matter what. This can be done only at the time of renewal.

2. **Can I reduce my deductible if my employer provided policy's sum insured is reduced?**
   You will have the option to convert your policy to a base plan. However, it cannot be reduced in any other proportion.

3. **If I opt for this cover, will you also apply Mandatory Reducing Deductible?**
   Yes, My Deductible is applicable over and above Mandatory Reducing Deductible. So, it is recommended that you choose your My Deductible accordingly.

Do not skip this part!

I. My deductible will be applicable only on in-patient expenses and not on OPD or any optional add-ons, e.g. Mom-to-be, Parental Cover etc.
II. You can switch to the base policy only at upcoming renewal after you lose your employer provided health policy.
III. You'll have to share supporting documents for the loss of employer provided health policy.
IV. Approval of such proposal is subject to our discretion and then prevailing underwriting guidelines.
V. There's no extra waiting period on converting to base plan.

F.3 LWP Daily Cash

We will pay a fixed daily cash allowance of ₹2,000/day for each day of hospitalisation (maximum up to 7 days) if you have to avail leave without pay in your employment for in-patient hospitalisation. You need to be a salaried employee to avail this benefit. This benefit can be availed once a year, only for claims accepted under Section IV C.2 (In-Patient Hospitalisation) for illness and accident. The daily cash will be reimbursed after you submit the HRD (Human Resource Department) letter from your employer confirming about your unpaid leave.

F.4 All-Payable Claims

We will cover expenses incurred by you on your hospital bill against non-payable items listed in Section VII C.4 up to your base sum insured, even if it is at a hospital outside of our A-List Hospitals network.

F.5 Mom-To-Be

We will cover the medical expenses incurred on delivery of a child either through normal delivery or caesarean up to the limit as specified below. We will also cover any pregnancy related complication including medically necessary termination requiring minimum 48 hours of in-patient hospitalisation. You can also claim for prenatal and postnatal outpatient expenses along with the pre and post hospitalisation expenses within the maternity limit defined against child delivery. You will be eligible for this cover after the mandatory waiting periods as specified below are completed from the date you opted for this cover.

Do not skip this part!

i. We will increase your sum insured if you are blessed with more than one baby during delivery in the manner as stated below:

Mom-To-Be covers	Sublimit	
Base	**For SI up to ₹20 lakh**	**For SI ₹25 lakh and above**

Delivery (Normal or C-section)	₹50,000	₹100,000
Twin birth	₹75,000	₹125,000
3 children delivered	₹100,000	₹150,000
4 or more children delivered	₹125,000	₹175,000
Pregnancy related complication requiring minimum 48 hours hospitalisation	Covered up to sum insured	Covered up to sum insured

ii. You can extend this cover to both individual and floater policies. Your waiting period, in that case, would be:

Plan details	Waiting period
Floater with self and spouse with or without kids	24 months
Individual female	24 months
Individual male	24 months
Spouse added after 24 months	More 12 months

The applicable waiting period for this cover will start from the day you opt for this add-on.

iii. Medical expenses related to ectopic pregnancy proved by diagnostic means, certified to be life threatening by a doctor will be covered as in-patient hospitalisation up to the base sum insured. Coverage for ectopic pregnancy will not fall under Mom-To-Be.
iv. You can claim under this cover twice in the lifetime, i.e. for 2 pregnancies.
v. We will not cover expenses incurred for harvesting and storage of stem cells when carried out as a preventive measure against possible future illnesses.

F.6 New Born Baby

New born baby related medical expenses incurred only on in-patient hospitalisation for a continuous duration of 24 hours will be covered up to the base sum insured if we have accepted the claim for maternity benefit under Mom-To-Be cover after completion of mandatory waiting period. Pre and post hospitalisation expenses, vaccination and related expenses will not be covered under this cover.

F.7 Assisted Procreation

We will cover medical expenses related to infertility and assisted reproduction, including outpatient treatment up to an amount as specified in your policy schedule once in your lifetime. If we have accepted a claim under this benefit, the same shall not be available in subsequent renewals. The benefit will be payable for:

i. In vitro fertilisation (IVF)
ii. Intracellular sperm injections (ICSI)
iii. Intrauterine insemination (IUI)
iv. Gamete intrafallopian transfer
v. Zygote intrafallopian transfer

Do not skip this part!

I. Any expenses with respect to the use of a third party surrogate or gestational carrier in pregnancy will not be covered.

II. Any expenses for consultation, diagnostic tests or procedure or any such other expenses for diagnosis of infertility will not be covered.
III. You will unlock the benefits of this cover after renewing your policy with us for 4 years continuously.
IV. We will need all relevant documents establishing infertility and treatment papers along with bills and receipts of payment made at the time of claim.

F.8 Coverage++

Your sum insured will keep up with inflation. Your coverage can be enhanced by 5% every year up to a maximum of 100% irrespective of any health claim in the expiring policy. At the time of renewal if you opt out of this optional cover, then the accrued sum insured under Coverage++ up until the expiring policy year will be forfeited.

F.9 Cut The Wait

This is your cheat code to cut short your waiting period for pre-existing diseases from 2 years to 1 year, subject to underwriting approval.

F.10 Critical Illness

This cover gives a lump sum amount if the insured is diagnosed with any of the critical illnesses listed below for the first time during the policy period. The payout will be as per the policy schedule given the signs or symptoms of the critical illness first appear after 90 days from the coverage start date. You can avail this cover for adults under the base policy. It cannot be availed for parents under parental cover. This is a once-in-a-lifetime cover. Hence, the cover will end after the claim is paid and won't be available for renewal.

Sr. No	Body system
Heart and Vascular Conditions	
1.	Myocardial infarction
2.	Refractory heart failure
3.	Cardiomyopathy
Lung conditions	
4.	End stage lung failure
5.	Primary(idiopathic) pulmonary hypertension
Liver conditions	
6.	End stage liver failure
Neuro/ spinal disease	
7.	Multiple sclerosis with persisting symptoms
8.	Motor neuron disease with permanent symptoms
9.	Permanent paralysis of limbs
10.	Stroke resulting in permanent symptoms
11.	Coma of specified severity
12.	Alzheimer's disease
13.	Parkinson's disease
14.	Apallic syndrome

15.	Benign brain tumour
16.	Creutzfeldt-Jakob disease (cjd)
17.	Major head trauma
Renal diseases	
18.	Kidney failure requiring regular dialysis
19.	Medullary cystic disease
Musculoskeletal diseases	
20.	Muscular dystrophy
21.	Poliomyelitis
Bleeding disorders	
22.	Aplastic anemia
Auto immune diseases	
23.	Systemic lupus erythematosus with renal involvement
24.	Myasthenia gravis
25.	Scleroderma
26.	Good pastures syndrome with lung or renal involvement
Others	
27.	Blindness
28.	Deafness
29.	Cancer of specified severity
30.	Third degree burns
31.	Loss of speech
32.	Loss of limbs
33.	Loss of independent existence

For details on these critical illnesses, their meaning and the related exclusions, please read Section VII C.1 (named “Critical illnesses”) of Appendix.

IV. Exclusions

A. What’s not covered (loud and clear!)

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 24 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 24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

2. Specified disease/procedure waiting period Code- Excl02

a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 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. If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f. List of specific diseases/procedure:
    i. Cataract
    ii. Benign Prostatic Hypertrophy
    iii. Myomectomy, Hysterectomy unless because of malignancy
    iv. All types of Hernia, Hydrocele
    v. Fissures &/or Fistula in anus, haemorrhoids/piles
    vi. Arthritis, gout, rheumatism and spinal disorders
    vii. Joint replacements unless due to accident
    viii. Sinusitis and related disorders
    ix. Stones in the urinary and biliary systems
    x. Dilatation and curettage , Endometriosis
    xi. All types of Skin and internal tumours/ cysts/nodules/ polyps of any kind including breast lumps unless malignant
    xii. Dialysis required for chronic renal failure
    xiii. Surgery on tonsils, adenoids and sinuses
    xiv. Gastric and Duodenal erosions & ulcers
    xv. Deviated Nasal Septum
    xvi. Varicose Veins/ Varicose Ulcers
    xvii. All types of internal congenital anomalies/ illness/defects

In case the above Illnesses are Pre-existing condition(s) at the commencement of this Policy, then these Illnesses shall be covered after the applicable waiting period as defined under your policy schedule has elapsed, since Period of Insurance Start Date.

3. 30-day waiting period Code- Excl03

a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

4. Investigation and evaluation Code-Excl04

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

5. Rest cure, rehabilitation and respite care Code- 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.

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 comorbidities following failure of less invasive methods of weight loss:
         i. Obesity-related cardiomyopathy
         ii. Coronary heart disease
         iii. Severe Sleep Apnea
         iv. Uncontrolled Type2 Diabetes

7. **Change of gender treatments Code- Excl07**

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

8. **Cosmetic or plastic surgery Code- Excl08**

   Expenses for cosmetic or plastic surgery or any treatment to change appearance unless needed because of an accident, burn(s) or cancer or as part of the medically necessary treatment to remove a direct and immediate health risk to the insured. To count as a valid claim, the attending doctor must certify this to be a medical necessity.

9. **Hazardous or adventure sports Code- Excl09**

   Expenses related to any treatment required 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.

10. **Breach of law - Code- Excl10**

    Expenses for treatment directly arising from or being a consequence of the Insured person committing or attempting to commit a breach of law with criminal intent.

11. **Excluded providers Code- Excl11**

    Expenses incurred towards treatment in any hospital or by any doctor or any other provider specifically excluded by us and disclosed on our website / notified to you are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilisation are payable but not the complete claim.

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

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

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 doctor as part of hospitalisation claim or day care procedure. Code- Excl14

15. **Refractive error Code- Excl15**

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

16. **Unproven treatments Code- Excl16**

    Expenses related to any unproven treatment, services and supplies for any treatment.

17. **Sterility and infertility Code- Excl17**

    Expenses related to birth control, sterility and infertility. This includes:

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

18. **Maternity code- Excl18**

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

B. Other exclusions:

1. Expenses related to the treatment of the below mentioned illness within 90 days from the first policy commencement date shall be excluded unless they are pre-existing and disclosed at the time of underwriting

   a. Hypertension
   b. Diabetes
   c. Cardiac Conditions

   This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months.

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

2. Any physical or medical treatment or service that is specifically excluded in the Policy Schedule under Special Conditions will not be covered.
3. Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, crutches, instruments used in treatment of sleep apnoea syndrome or cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively will not be covered.
4. Expenses incurred on all dental treatment unless necessitated due to an Accident which requires 24 hours hospitalisation will not be covered.
5. Personal comfort, cosmetics, convenience and hygiene related items and services will not be covered.
6. Acupressure, acupuncture, magnetic and other therapies will not be covered.
7. Circumcision unless necessary for treatment of an Illness or necessitated due to an Accident will not be covered.
8. Expenses for venereal disease or any sexually transmitted disease other than HIV/AIDS will not be covered.
9. Treatment relating to birth defects and external congenital Illnesses or defects or anomalies will not be covered. Internal congenital anomalies will be covered after two (2) years of continuous coverage.
10. Treatment taken outside the country will not be covered.
11. Intentional self-injury (whether arising from an attempt to commit suicide or otherwise) will not be covered.
12. Any expenses arising out of domiciliary hospitalisation will not be covered.
13. Expenses related to donor screening, treatment, including surgery to remove organs from a donor in the case of transplant surgery will not be covered.
14. Any injury or illness caused by or arising from or attributed to war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority.

15. Any Illness or Injury caused by or contributed to by nuclear weapons/materials or arising from or contributed to by ionising radiation or contamination by radioactivity by any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel.

V. All about claims

Before you claim,

1. You must follow the guidance and advice of the doctor and take all necessary care for your recovery.
2. Insurance is extended in good faith. So, stay true to your obligations and help us or any of our representatives review the case.
3. Extend your support with proper and timely intimation and submission of information/ documents.
4. Pay your premium in full and without delay.
5. All claims will be paid based on the zone, and mandatory or My Deductible opted for at the time of purchase.

A. How to claim?

A.1 If you choose a hospital from our network for cashless facility, (Recommended)

i. Inform us about your hospitalisation on the mobile application
   a. At least 48 hours before admission for planned surgery
   b. 24 hours after admission for emergency
ii. Show your health card and ID proof at our network hospital.
iii. We'll come back with a pre-authorisation letter with-
   a. Approval on sanction amount and sub-limits/deductibles/co-pay if any
   b. Rejection in case the treatment is not covered under the policy
iv. At the time of discharge, you may have to pay your share of the bill, if any.
v. We settle the bills directly with the hospital.

A.2 If you choose a hospital outside of our network and make a reimbursement claim,

i. Claim with us
   a. At least 48 hours before admission for planned surgery
   b. 24 hours after admission for emergency
ii. Submit the necessary documents within 30 days of discharge. See the full list of mandatory documents below.
iii. Additionally, we may also try and help you out by collecting the documents on best effort basis.

Which documents are needed for reimbursement claims?

We will need:

i. Claim form A and B.
ii. Original bills including hospitalisation, pharmacy, implants against your name.
iii. Indoor case papers/ Operation theatre notes, original investigation test reports with prescriptions and doctor's referral letter and discharge certificate.
iv. All pre and post-investigation, treatment, and follow up (consultation) records about the present and past ailments since their first diagnoses.
v. Treating doctor's certificate regarding missing information in case of histories, e.g. Circumstance of Injury and Alcohol or drug influence at the time of Accident.
vi. For accident related claims
   a. Treating doctor's letter stating:
      1. Details of Accident/trauma
      2. Whether patient was under the influence of alcohol or any intoxicating substance during incident / Accident

3. Pre & post- operative imaging reports

b. Copy of MLC (Medico legal case) records and FIR (First information report)

vii. Legal heir certificate (if applicable).

viii. We may ask for some more documents if needed.

ix. To get claim amount in your account:
NEFT details (to enable direct credit of claim amount in the bank account), KYC (recent ID/ Aadhaar card/Address proof and photograph), and PAN card.

You need to courier us the necessary claim documents on:

16th floor,
Peninsula Business Park,
G.K Marg,
Near Mathuradas Mills,
Lower Parel (West),
Mumbai – 400013.

A.3 If you need to avail OPD services,

i. Visit the OPD section on the mobile application and raise a claim.

ii. You can book any of the following services available with our partner via the mobile application
a. Appointment with a doctor
b. Order prescribed medicine
c. Appointment for a diagnostic test

iii. We will approve the claim basis policy terms, conditions and available sum insured.

iv. You may have to make the payment if you want to avail a service that is not covered under this policy or in case your OPD balance falls short.

v. We will settle the claim directly with the service provider at the time of order.

A.4 If you need to avail homecare,

i. Choose an empanelled service provider on the mobile application 48 hours before you wish to avail the cashless services.

ii. We'll come back with a pre-authorisation letter with-
a. Approval on sanction amount and sub-limits/deductibles/co-pay if any
b. Rejection in case the treatment is not covered under the policy

iii. At the end of your homecare treatment, you may have to pay your share of the bill, if any.

iv. We settle the bills directly with the service provider.

If we are unable to provide a cashless service, we'll let you avail homecare through a service provider of your choice, subject to prior approval from us.

A.5 If you have any health related queries and want to use Health Buddy,

Reach out to us in the help section on our app, and we will help you navigate with our Health Buddy services. You can avail the following services on the mobile application and website:

i. Finding a specialist or super specialist doctor for medical 2nd opinion and scheduling an appointment

ii. Hospital recommendations for cashless facility and specialised surgeries or procedures

iii. Guidance on availing post-hospitalisation care services such as physiotherapy and nursing at home

iv. Facilitating ground medical transportation services, where available

With this effort, we intend to help you be on the right path to recovery. But, this is not a substitute for a consultation with an independent doctor. If you decide to consult a doctor on our recommendation, the same will be covered under OPD subject to OPD terms, conditions and available sum inured.

A.6 If you need to claim under New Beginnings,

i. Add a new life to the policy as soon as possible to cover them for the rest of the policy year

ii. In case you forget to add them,
a. Ensure they are added at least 7 days in advance so you can avail cashless facility

b. Follow the reimbursement claim process mentioned under Section VI A.2 for emergency hospitalisation.

To know the scenarios where you may not be able to add a new life, please refer to Section IV D.2.d.

Do not skip this part!

I. It is up to you whether or not you want to avail this service. We arrange these services so that you are confident about the treatment. But you will have to bear the extra cost unless we have confirmed about cashless servicing.
II. During an emergency, please rush to the nearest hospital without waiting for anything.
III. If the appointment is cancelled or delayed, you can go to the nearest hospital of your choice.
IV. The service can only be arranged if the service provider is available at the requested location.
V. By availing this service, you agree to have no objection against us storing your health records for internal uses only.
VI. If you make a reimbursement claim, you need to inform us within 30 days after discharge.

B. Claim service guarantee

We provide you with the following claim service guarantee:

B.1 For cashless facility claims

i. We will check your coverage as per the eligibility and respond to the hospital within 4 hours of the actual receipt of pre-authorisation request and required documentation, with:
   a. Approval through an authorisation letter, or
   b. Rejection, or
   c. Query seeking further information
ii. In case of a request to enhance the authorisation limit, we will evaluate and respond to such request within 1 hour of receiving the enhancement request.
iii. In case of delay in response by us beyond the period stated above for cashless claims, we will be liable to pay ₹1,000 to you.
   a. However, we will not be liable to make any payments under this clause if such delay is caused due to any force majeure, natural event or manmade disturbance which impedes our inability to make a decision or to communicate such decisions to you.
   b. The clause shall also not be applicable for any cases delayed due to reasonable apprehension of fraud or fraudulent claims or cases referred to/ by any adjudicative forum for necessary disposal.
   c. Our maximum liability under claim service guarantee in respect of a single hospitalisation shall, at no time, exceed ₹1,000.

B.2 For reimbursement/fixed benefit claims

i. We shall make the payment of the admissible claim (as per terms & conditions of policy) or communicate the rejection within 14 days after submission of the last necessary document.
ii. In case we fail to make the payment of admissible claims or to communicate non-admissibility of claim within the time period, we shall pay 1% interest over and above the interest rate mandated as per IRDAI (Protection of Policyholders' Interests) Regulations 2017 and amendments made to that from time to time.
iii. Any amount paid towards interest under 'claim service guarantee' will not affect the sum insured specified in the policy schedule.
iv. You may lodge a claim separately under Section IV C.2 (In-Patient Hospitalisation), Section IV C.1 (Pre-Hospitalisation), Section IV C.3 (Post-Hospitalisation), and Optional Covers under Section IV F. In such scenario, if a delay happens beyond the time period as specified above, the interest amount calculated will be on the net sanctioned amount of respective transaction and not the total amount paid for the entire claim.

C. Special considerations for claims pay-out

i. Wherever possible, we will settle the claim on a cashless basis, i.e., directly with the hospital or the service provider after final discharge.

ii. For reimbursement claims, we will transfer the amount to your account. In the event of your demise, we will make payment to your nominee (as named in the policy schedule) and in case of no nominee, to the legal heir who holds a succession certificate or Indemnity Bond to that effect, whichever is available. Receipt of payment by the insured person/nominee/legal heir as the case may be, shall be considered as a complete discharge of our liability against any claim under this policy.

No questions unanswered (FAQs)

1. **I have 2 health policies. How can I submit original bills?**
   If your bill amount is more than the amount already covered by the first insurer then you can claim for the remaining amount from the second insurer. You can do so by providing photocopies of necessary documents as mentioned under Section VI A.2 along with a settlement letter from the first insurer.

2. **What happens if I get hospitalised again due to the same reason?**
   It will be counted as a part of the same claim if you claim within 45 days of your previous one. Any sub-limits for a specific illness will be applied as if they are under a single claim. If you claim after 45 days due to the same reason, we will process it as per the documents you submit.

3. **What if my hospitalisation is across 2 policy years?**
   We will consider the balance sum insured in the previous and current policy after applying the deductibles for each policy period to process the claim. But before we pay your claim, the pending premium will be deducted while renewing your policy or on its due date.

VI. General terms and conditions

A. Standard terms of the policy

1. Disclosure to information norm

The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of mis-representation or non-disclosure of material facts by the Policy holder.

(Explanation: "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)

2. 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- ln 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.

(Explanation: "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)

3. Moratorium period

After completion of eight continuous years under this policy no look back would 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 sum 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 as per the policy contract.

4. 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. Material change

The Insured person shall notify Us 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.

6. Records to be maintained

The Insured person shall keep an accurate record containing all relevant medical records and shall allow Us to inspect such records. The Insured person shall exercise all necessary co-operation in obtaining the medical records from the Hospital, and furnish them, as We may require in relation to the claim within reasonable time limit and within the time limit specified in the Policy.

7. Complete discharge

Any payment to the policyholder, 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.

8. Notice and communication

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

9. Territorial limit

All medical treatment for the purpose of this insurance will have to be taken in India.

10. Multiple policies

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
ii. Insured Person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies, even if the sum insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and conditions of this policy.
iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurers from whom he/she wants to claim the balance amount.
iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

11. Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited. Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s) , who has made that particular claim,, who shall be jointly and severally liable for such repayment to the insurer For the purpose of this clause, the expression

"fraud" means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance Policy:—

i. the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
ii. the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
iii. any other act fitted to deceive; and
iv. 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.

12. Cancellation

i. The Policy holder may cancel this Policy by giving Us 15 days written notice for the cancellation of the Policy and then We shall refund premium for the unexpired Policy Period as per the rates detailed below,

Cancellation Period	Refund % for 1 year tenure policy if premium paid upfront for 1 year
0-1 month	80%
2-3 months	65%
4-6 months	45%
6-9 months	20%
9-12 months	0%

Cancellation Period	Refund % for 1 year tenure policy if premium paid half yearly
0-3 months	45%
4-6 months	0%

No refund will be provided if the premium is paid in monthly or quarterly instalments.

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

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

13. Automatic termination of policy

The coverage for the Insured person shall automatically terminate:
In the case of Insured Person's demise.

i. 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 Insured Person is minor, the Policy shall be renewed only through any one of his/her natural guardian or guardian appointed by Court. All relevant particulars in respect of such person (including his/her relationship with the Insured person) must be given to Us along with the application. Provided

no claim has been made and termination takes place on account of death of the Insured Person for the balance period of the Policy will be effective.

ii. Upon exhaustion of Sum insured and additional sum insured of the Policy, for the Policy year. However, the Policy is subject to renewal on the due date as per the applicable terms and conditions.

14. 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.

15. Arbitration

i. 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).

ii. 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, iii. 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.

16. 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 the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

17. 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. lf 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.
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

18. Renewal

The policy shall ordinarily be renewable except on misrepresentation by the insured person.

i. The Company shall endeavour 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 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.

19. Withdrawal

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.

20. Policy alignment

Policy Alignment option will be available in cases wherein insured(s) with two separate health indemnity policies with Us, having different policy end dates but want to align the policy start dates. We can align the policies by extending the coverage of one policy till the end date of the other policy. Such policies will be charged with premium on pro rata basis though the sum insured under the policy shall remain constant.

21. Premium payment in instalments

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

i. As long as you hold your part of the deal (your obligations) and agree to pay the applicable premium and taxes, charges, cess, etc. as specified in the policy schedule, we will be happy to accept the premium in instalments.
ii. The grace period for different modes of instalments post the premium due date will be:

Instalments	Grace Period
Monthly	15 days
Quarterly	15 days
Half-yearly	15 days
Yearly	30 days

iii. 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.
iv. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace period.
v. No interest will be charged if the instalment premium is not paid on due date.
vi. In case of instalment premium due not received within the grace period, the policy will get cancelled.
vii. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
viii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.
ix. We will deduct any balance premium from the claim amount if we haven't received it in advance.
x. We are not bound to send any notices for payment of premium instalment.

22. 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.

23. Free look period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy The insured person shall be allowed free look period of 15 (fifteen days) from date of receipt of the Policy documents 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;

24. Endorsements (Changes in policy)

i. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the Company. Any change made by the Company shall be evidenced by a written endorsement signed and stamped.
ii. The proposer may be changed only at the time of renewal. The new proposer must be the legal heir/immediate family member. 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.
iii. The proposer may be changed during the Policy Period only in case of his/her demise or him/her moving out of India.
iv. Mid- term endorsement of addition of member in the policy shall only be allowed for newly wedded spouse by marriage and new born baby with relevant documentation.

25. Change of sum insured

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

26. 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. ln 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.

27. Redressal of grievances

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

Website: www.hellowyn.com

E-Mail: ask@hellowyn.com

Courier: ICICI Lombard General Insurance Limited,16th floor, Peninsula Business Park,G.K Marg,Near Mathuradas Mills, Lower Parel (West), Mumbai – 400013.

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

If you are not satisfied with the redressal of grievance through one of the above methods, you may contact the grievance officer at Manager- Service Quality, Corporate Manager- Service Quality, National Manager- Operations & finally Director-services and Business development at the following address:

ICICI Lombard General Insurance Company Limited,
ICICI Lombard House, 414, Veer Savarkar Marg,
Near Siddhi Vinayak Temple,
Prabhadevi, Mumbai 400025

For updated details of grievance officer, kindly refer the link. https://www.icicilombard.com/grievance-redressal

If you are not satisfied with the redressal of grievance through above methods, you may also approach the office of Insurance Ombudsman of the respective area/region for redressal of

grievance as per Insurance Ombudsman Rules 2017. Grievance may also be lodged at IRDAI Integrated Grievance Management System.

https://igms.irda.gov.in/

The details of Insurance Ombudsman are available below:

Office Details	Jurisdiction of Office Union Territory, District
AHMEDABAD - Shri Kuldip Singh 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@cioins.co.in	**Gujarat,** **Dadra & Nagar Haveli,** **Daman and Diu.**
BENGALURU - Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	**Karnataka**
BHOPAL - Office of the Insurance Ombudsman, 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@cioins.co.in	**Madhya Pradesh** **Chattisgarh**
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	**Orissa**
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@cioins.co.in	**Punjab,** **Haryana(excluding Gurugram, Faridabad, Sonepat and Bahadurgarh)** **Himachal Pradesh, Union Territories of Jammu & Kashmir,** **Ladakh & Chandigarh.**
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@cioins.co.in	**Tamil Nadu,** **Tamil Nadu** **PuducherryTown and** **Karaikal (which are part of Puducherry).**
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman,	**Delhi &** **Following Districts of Haryana -**

2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI - Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	**Assam,** **Meghalaya,** **Manipur,** **Mizoram,** **Arunachal Pradesh,** **Nagaland and Tripura.**
HYDERABAD - Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	**Andhra Pradesh,** **Telangana,** **Yanam and** **part of Union Territory of Puducherry.**
JAIPUR - Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	**Rajasthan**
ERNAKULAM - Ms. Poonam Bodra 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@cioins.co.in	**Kerala,** **Lakshadweep,** **Mahe-a part of Union Territory of Puducherry.**
KOLKATA - Shri P. K. Rath 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@cioins.co.in	**West Bengal,** **Sikkim,** **Andaman & Nicobar Islands.**
LUCKNOW -Shri Justice Anil Kumar Srivastava 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@cioins.co.in	**Districts of Uttar Pradesh** Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.

MUMBAI - Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	**Goa**, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	**State of Uttaranchal and the following Districts of Uttar Pradesh:** Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	**Bihar**, **Jharkhand**
PUNE - Shri Vinay Sah 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.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	**Maharashtra**, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

The updated details of Insurance Ombudsman are also available on IRDA website: www.irdaindia.org, on the website of General Insurance Council www.generalinsurancecouncil.org.in website of the company www.icicilombard.com or from any of the offices of Our Company.

B. Special conditions applicable to the policy

1. Renewal

The policy shall ordinarily be renewable except on misrepresentation by the insured person.

i. The Company shall endeavour 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 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period. Any illness/ condition contracted during the grace period will not be covered and will be treated as a pre-existing disease.
v. No loading shall apply on renewals based on individual claims experience.
vi. Premium amount on renewal may change due to:
    a. Your age
    b. Addition of any optional covers

c. Change in any policy conditions such as – floater/ individual, any deductible opted, policy tenure, etc.
d. Increase/ decrease in the sum insured opted for
e. Change in any tax laws by the Government
f. Change in your location
g. wyn Fit's outcome

To retain and earn higher discounts on your renewal premium, kindly refer wyn Fit under Section VII C.2.

vii. In case this policy is revised/modified/withdrawn in future, we will inform you about it at least 3 months before the policy expiry. In case the policy is withdrawn, you will have the option to migrate to the nearest substitute policy as available with us at the time of renewal. In this case, you will be able to avail all the continuity benefits, provided you have been covered under the policy without a break as per the applicable insurance regulatory framework.
viii. When you add a family member to the policy at the time of renewal, the waiting periods regarding any pre-existing disease or exclusions will be applicable for the new member starting from the day he/she has been added to the policy.
ix. If you split your floater policy sum insured into two or more policies at the time of renewal or if your policy is split because of a child attaining the age of 21 years, the Super No Claim Bonus and Coverage++ of the expiring policy will be added to the new policies in the proportion of their respective sum insured.

2. Sum insured enhancement

You can request for an increased sum insured at the time of renewal. The insured person can apply for enhancement of sum insured under the policy at the time of renewal. However, acceptance of such request is subject to underwriters' approval and receipt of appropriate premium.

i. While renewing your policy, you can request for increased sum insured on the website or the mobile application.
ii. We may ask for information or documents and review them before renewing the policy. The policy terms may be altered based on your health condition and claims history.
iii. Waiting periods wherever applicable shall be applied afresh for respective duration for enhanced sum insured. This will be applicable for 30 days, standard exclusions, maternity and all base covers with related sum insured such as OPD.
iv. You may have to undergo a medical checkup at our designated network provider/ service provider depending on your age and enhancement of the sum insured opted. We will bear 100% of the expenses incurred if your proposal is accepted. In case it's not, the premium shall be refunded after deducting the expenses incurred for the medical tests. The medical reports are valid for a period of 90 days only from the date of the check- up.

3. Pre policy medical check-up (PPMC)

You may have to undergo pre policy medical check-up at our designated network provider/service provider depending on your age and sum insured opted for. If we accept your request and issue the policy, we will bear 100% of the costs for the check-up. If not, we will refund the balance premium to you after deducting the cost for the check-up.

In case you have already undergone medical tests as per our defined package*, the same may be considered for proposal provided the medical reports are from an NABL accredited laboratory and not older than 60 days from the date of proposal.

*Please visit our website for the updated list of medical tests.

4. Endorsement

You can request for a change/modification in the policy through an endorsement. Any request for endorsement must be made by the insured person through the website.

Any endorsement would be effective from the date of your request, or the date of receipt of premium, whichever is later.

The following endorsements during the term of the policy.

(i) Non-Financial Endorsements - which do not affect the premium

1) Minor rectification/correction in name of the proposer / insured person (and not the complete name change)
2) Rectification in gender of the proposer/ insured person
3) Rectification in relationship of the insured person with the proposer
4) Rectification of date of birth of the insured person (if this does not impact the premium)
5) Change in the correspondence address of the proposer (used for purposes of communication only)
6) Change/update in the contact details viz., phone No. and e-mail id
7) Change in nominee details

(ii) Financial Endorsements - which result in alteration in premium

1) Deletion of Insured person on death/ separation/ insured person leaving India
2) Change in age/date of birth
3) Addition of optional add-on covers

We may asses the endorsement request and if needed, ask for additional information/ documents.

5. Geography

This policy only covers medical treatment taken in defined cities within India. All payments under this policy will only be made in Indian Rupees within India.

The construction, interpretation and meaning of the provisions of this policy shall be determined in accordance with Indian law.

The premium for policy issuance will be computed based on your city of residence mentioned in the proposal form. The premium that will be applicable zone wise and the cities defined in each zone are:

Zone I- NCR, Mumbai Metropolitan Region, Ahmedabad, Kolkata, Hyderabad, Ludhiana

Zone II- Bangalore, Chennai, Pune, Lucknow, Jaipur

Co-payment would be levied on each and every claim in case medically necessary treatment has been taken in a zone higher (Zone I being the highest followed by Zone II) than the zone for which premium has been paid on issuance of the policy.

Zone opted for	Co-pay for each and every claim in Zone I	Co-pay for each and every claim in Zone II
Zone I	Nil	Nil
Zone II	25%	Nil

If you wish to avail the treatment from any part of the country without a co-pay, then you can do so by choosing to pay the Zone I premium at the time of policy purchase.

In case you undergo medically necessary treatment requiring inpatient hospitalisation in any city other than those mentioned in Zone I & II, during the policy year, we may consider the same on case to case basis, provided you intimate the same to us within 24 hours of such hospitalisation. However, the same would be on reimbursement basis and only for emergency inpatient hospitalisation.

Additionally, in case you have paid the premium for Zone II, a co-pay as specified below shall be applicable for claims made in regions that are not covered under the policy.

Region	Co-pay applicable
Rest of Gujarat	25%
Rest of West	Nil
Rest of Central	Nil
Rest of North	Nil
Rest of East	Nil

Rest of South	Nil

Change of Zone at renewal will be subject to underwriting approval and discretion.

6. Risk based loading

We may apply a risk based loading on the premium payable based upon the declarations made in the proposal form and the health status of the persons proposed for insurance. These loadings are applied from policy period start date including subsequent renewal(s) with us or on the receipt of the request of increase in sum insured (for the enhanced sum insured).

We will inform you about the applicable risk loading or exclusion or both as the case may be at the time of proposal. We will issue policy only after getting your consent and additional premium (if any).

The application of loading does not mean that the related illness/ condition, would be covered from the policy start date. For all such illnesses/conditions accepted by us at the time of proposal, the waiting period for pre-existing diseases will be applicable.

Each of the proposals which need to be written individually, shall be reviewed based on pre-existing ailment(s) declaration and the medical test reports. The maximum risk loading applicable for an individual shall not exceed 100% per diagnosis / medical condition and an overall risk loading of over 200% per person.

C. APPENDIX

C.1 Critical Illnesses

For the purpose of this policy, the critical illnesses covered under this policy would have the meaning and exclusions, as specified below:

1. **Myocardial infarction (First heart attack of specific severity)**

   I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area.
   The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
   1. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
   2. New characteristic electrocardiogram changes
   3. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

   II. The following are excluded:
   1. Other acute Coronary Syndromes
   2. Any type of angina pectoris
   3. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

2. **Refractory heart failure**

   Refractory heart failure is defined as a systolic dysfunction that does not respond to optimal medical therapy (“triple therapy”) and results in permanent physical impairment to the degree of New York Heart Association Classification Class IV, or its equivalent, for at least six months. The diagnosis of refractory heart failure has to be supported by echocardiographic findings of compromised ventricular performance. The diagnosis must be made by a cardiology specialist.

   The following is excluded:
   1. Reversible causes of heart failure such as hypocalcemia, alcohol abuse, thyroid, anaemia.

3. **Cardiomyopathy**

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

Class IV - Inability to carry out any activity without discomfort. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity discomfort will be experienced. The diagnosis of Cardiomyopathy has to be supported by Echographic findings of compromised ventricular performance.

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

4. **End stage lung failure**

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

1. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
2. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
3. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55mmHg$); and
4. Dyspnoea at rest.

5. **Primary (idiopathic) pulmonary hypertension**

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

II. The NYHA Classification of Cardiac Impairment are as follows:
   1. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
   2. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

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

6. **End stage liver failure**

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:
   1. Permanent jaundice; and
   2. Ascites; and
   3. Hepatic encephalopathy.

II. Liver failure secondary to drug or alcohol abuse is excluded.

7. **Multiple sclerosis with persisting symptoms**

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
   1. Investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
   2. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Other causes of neurological damage due to SLE is excluded.

8. **Motor neuron disease with permanent symptoms**

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

9. Permanent paralysis of limbs

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

10. Stroke resulting in permanent symptoms

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

II. The following are excluded:
1. Transient ischemic attacks (TIA)
2. Traumatic injury of the brain
3. Vascular disease affecting only the eye or optic nerve or vestibular functions.

11. Coma of specified severity

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
1. No response to external stimuli continuously for at least 96 hours;
2. Life support measures are necessary to sustain life; and
3. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

12. Alzeimer's disease

Progressive and permanent deterioration of memory and intellectual capacity as evidenced by accepted standardized questionnaires and cerebral imaging.
The diagnosis of Alzheimer's Disease must be confirmed by an appropriate consultant and supported by a Medical Practitioner appointed by Us. There must be significant reduction in mental and social functioning requiring the continuous supervision of the Insured Person. There must also be an inability of the Insured Person to perform (whether aided or unaided) at least three of the Activities of Daily Living, for a continuous period of at least 3 months:
For the purpose of this clause, Activities of Daily Living are defined as:
1. Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
2. Dressing – the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring – the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Toileting – the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
5. Feeding - the ability to feed oneself once food has been prepared and made available. Mobility - the ability to move from room to room without requiring any physical assistance. The following are excluded:
   - First Diagnosis occurring after the age of 50 years
   - Any other type of irreversible organic disorder/dementia
   - Alcohol-related brain damage.

13. Parkinson's disease

I. The occurrence of Parkinson's Disease where there is an associated Neurological Deficit that results in permanent inability to perform independently at least three of the Activities of Daily Living, for a continuous period of at least 3 months:
For the purpose of this clause, Activities of Daily Living are defined as:
1. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means
2. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Mobility: the ability to move indoors from room to room on level surfaces;

5. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
6. Feeding: the ability to feed oneself once food has been prepared and made available.

II. The following is excluded:
i. First Diagnosis occurring after the age of 50 years
ii. Parkinson's Disease accompanied with drug and/or alcohol abuse.

14. Apallic syndrome

Universal non-functioning of the brain cortex, with the brain stem intact. Diagnosis of Apallic Syndrome must be definitely confirmed by a registered Medical Practitioner who is also a neurologist and substantiated by clinical and investigation findings. This condition must be documented for a continuous period of at least one month.

15. Benign brain tumor

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

II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.
1. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
2. Undergone surgical resection or radiation therapy to treat the brain tumor.

III. The following conditions are excluded: Cysts, Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord

16. Creutzfeldt-jakob disease (CJD)

A diagnosis of Creutzfeldt Jakob Disease must be made by a specialist Medical Practitioner who is a neurologist and the diagnosis must be substantiated by CSF examination, EEG, CT Brain and MRI of the brain. There must be permanent clinical loss of the ability in mental, physical and social functioning for a minimum period of 30 days to the extent that permanent supervision or assistance by a third party is required

17. Major head trauma

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

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

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

IV. The following are excluded:
i. Spinal cord injury;

18. Kidney failure requiring regular dialysis

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

19. Medullary cystic disease

I. Medullary Cystic Disease where the following criteria are met:
- **i.** The presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis;
- **ii.** Clinical manifestations of anaemia, polyuria, and progressive deterioration in kidney function; and
- **iii.** The diagnosis of Medullary Cystic Disease is confirmed by renal biopsy along with specialist Medical Practitioner opinion.

II. The following are excluded
- **i.** Isolated or benign kidney cysts are specifically excluded from this Benefit
- **ii.** Any condition is which cysts are absent

20. Muscular dystrophy

Diagnosis of muscular dystrophy by a registered Medical Practitioner who is a neurologist based on the presence of following conditions:
1. Clinical presentation including weakness and loss of muscle mass, absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;
2. Characteristic electromyogram
3. Clinical suspicion confirmed by muscle biopsy.

The condition must result in the inability of the Insured Person to perform (whether aided or unaided) at least three of the Activities of Daily Living, for a continuous period of at least 6 months.
1. For the purpose of this clause, Activities of Daily Living are defined as:
2. Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
3. Dressing – the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
4. Transferring – the ability to move from a bed to an upright chair or wheelchair and vice versa;
5. Toileting – the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
6. Feeding – the ability to feed oneself once food has been prepared and made available.
7. Mobility - the ability to move from room to room without requiring any physical assistance

21. Poliomyelitis

The occurrence of Poliomyelitis, where the following conditions are met:
- **I.** Poliovirus is identified as the cause through laboratory investigation
- **II.** Paralysis of the limb muscles or respiratory muscles must be present and persist for at least 3 months.

The diagnosis of Poliomyelitis must be confirmed by a registered Medical Practitioner who is a neurologist.

22. Aplastic anemia

Irreversible persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least two (2) of the following:
1. Blood product transfusion;
2. Marrow stimulating agents;
3. Immunosuppressive agents; or
4. Bone marrow transplantation.

The diagnosis of Aplastic anaemia must be confirmed by a bone marrow biopsy. Atleast two of the following values should be present:
1. Absolute Neutrophil count of 500 per cubic millimetre or less;
2. Absolute Reticulocyte count of 20,000 per cubic millimetre or less; and
3. Platelet count of 20,000 per cubic millimetre or less.

23. Systemic lupus erythematosus (SLE) with renal involvement

I. Multi-system, autoimmune disorder characterized by the development of auto-antibodies, directed against various self-antigens. For purposes of the definition of "SLE" under this policy is restricted to only those forms of systemic lupus erythematosus, which involve the kidneys and are characterized as Class III, Class IV, Class V or Class VI lupus nephritis under the Abbreviated International Society of Nephrology/Renal Pathology Society (ISN/RPS) classification of lupus nephritis (2003) below based on renal biopsy.

II. Diagnosis by a nephrologist, supported by renal biopsy report is mandatory. There must be positive antinuclear antibody test

The following are excluded

i. Other forms such as discoid lupus, and those forms with only hematological and joint involvement are specifically excluded.

ii. Class I - Minimal mesangial lupus nephritis

iii. Class II - Mesangial proliferative lupus nephritis

24. Myasthenia gravis

I. An acquired autoimmune disorder of neuromuscular transmission leading to fluctuating muscle weakness and fatigability, where all of the following criteria are met:

1. Presence of permanent muscle weakness categorized as Class IV or V according to the Myasthenia Gravis Foundation of America Clinical Classification below; and

2. The diagnosis of Myasthenia Gravis and categorization are confirmed by a registered Medical Practitioner who is a neurologist.

II. Myasthenia Gravis Foundation of America Clinical Classification is as follows:

Class I: Any eye muscle weakness, possible ptosis, no other evidence of muscle weakness elsewhere.

Class II: Eye muscle weakness of any severity, mild weakness of other muscles.

Class III: Eye muscle weakness of any severity, moderate weakness of other muscles.

Class IV: Eye muscle weakness of any severity, severe weakness of other muscles.

Class V: Intubation needed to maintain airway.

III. The following are excluded:

i. Congenital myasthenic syndrome

ii. Transient neonatal or juvenile myasthenia gravis

25. Scleroderma

A systemic collagen-vascular Illness causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. This diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.

The following conditions are excluded:

1. Localised scleroderma (linear scleroderma or morphea);

2. Eosinophilic fascitis; and

3. CREST syndrome.

26. Good pastures syndrome with lung or renal involvement

Goodpastures Syndrome is an autoimmune disease in which antibodies attack the lungs and kidneys, leading to permanent lung and kidney damage. The permanent damage should be for continuous period of at least 30 days. The diagnosis must be proven by kidney biopsy and confirmed by a specialist Medical Practitioner who is a rheumatologist.

27. Blindness

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

II. The Blindness is evidenced by:

1. Corrected visual acuity being 3/60 or less in both eyes or ;

2. The field of vision being less than 10 degrees in both eyes.

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

28. Deafness

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

29. Cancer of specified severity

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

II. The following are excluded –

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

30. Third degree burns

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

31. Loss of speech

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

32. Loss of limbs

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

33. Loss of independent existence

Confirmation by a Consultant Physician of the loss of independent existence due to illness or trauma, lasting for a minimum period of 6 months and resulting in a permanent inability to perform at least three of the Activities of Daily Living, with no hope of recovery

For the purpose of this clause, Activities of Daily Living are defined as:

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

ii. Dressing – the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

iii. Transferring – the ability to move from a bed to an upright chair or wheelchair and vice versa;

iv. Toileting – the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

v. Feeding – the ability to feed oneself once food has been prepared and made available.

vi. Mobility - the ability to move from room to room without requiring any physical assistance.

C.2 wyn Fit rewards and discount

You can earn a maximum of 36,500 fitness points in a year. Your fitness score tells us where you currently are on the health risk scale. Your fitness points decide your fitness rewards.

i. Fitness rewards include:
   1. Gym subscription
   2. Health supplements
   3. Fitness tracking device
   4. Fitness training subscription

5. Physiotherapy sessions
6. Entry to sports/fitness events
7. Dietician consultation
8. Diet program subscription
9. Counsellor/therapist consultation
10. Health coach
11. Health check-up

Fitness points needed to unlock rewards	Rewards as % of yearly premium
9000	1%
10000	2%
12000	3%
15000	4%
16000	5%
18000	10%
25000	15%
36000	25%

Illustration: You have earned 15000 fitness points in Month 4 which makes you eligible to unlock rewards worth 4% of your base premium. In month 6 you earn more 3000 points, bringing your total to 18000 points which makes you eligible for additional rewards worth 6% of your annual premium.

ii. In addition to the fitness rewards, you are also entitled for an annual discount that you can earn on renewal premium by accumulating fitness points. Here is a detailed description of how much discount you can get:

Fitness points accumulated/year	Renewal discount
12000	1%
15000	2%
16000	3%
18000	5%
25000	10%
36000	25%

iii. How to earn fitness points?

You can earn fitness points through various activities and initiatives as defined below.

1. Category 1: Burn it, earn it!
You can earn up to 100 fitness points by letting us track your step count every day. Another method of earning fitness points is through your achievements on other fitness applications. You'll also have to allow us to access the data so we can reward you with the fitness points earned on other platforms through physical activities like gym, yoga, zumba and any other physical exercise method that you may be using.

To know the list of service providers, please visit www.hellowyn.com.

If you cannot find the fitness application used by you listed on the wyn app, please reach out to us at ask@hellowyn.com, and we will try our best to help you out.

a. Fitness points you can earn by engaging yourselves in physical activities:

Regular fitness related activities			
Activity	Measure	How often is it measured?	Fitness points earned
Steps count	3000-4000 steps	Daily	25
	4001-5000	Daily	30
	5001-6000	Daily	35
	6001-7000	Daily	40
	7001-8000	Daily	45
	8001-9000	Daily	50
	9001-10000	Daily	75
	>10000	Daily	100
	No activity	Daily	0
Calories burnt	>= 150 kcal/session	Daily	25
	>= 200 kcal/session	Daily	30
	>= 250 kcal/session	Daily	35
	>= 300 kcal/session	Daily	40
	>= 350 kcal/session	Daily	45
	>= 400 kcal/session	Daily	50
	>= 450 kcal/session	Daily	75
	>= 500 kcal/session	Daily	100
	No activity	Daily	0
	3 weeks of no activity	Measured every 3 weeks	-200

You can choose to earn fitness points either basis your step count or calories burnt at the time of joining wyn Fit.

b. Bonus points you can earn by doing the activities recommended by us on a daily basis:

Streaks	Streak duration	Fitness points earned
Activity More than 5000 steps / 300 kcals/session	5 days	5
	7 days	10
	14 days	25

	21 days	40

Illustration: If you continue to complete more than 5000 steps every day for 5 continuous days, you'll earn bonus 5 points by the end of the 5th day. This will be over and above the points earned through regular fitness tracking. If you continue the streak for up to 14 days, you'll earn more 20 points over and above the regular fitness tracking.

2. Category 2: Health check-up

We will provide a health check-up coupon to you for every policy year. You'll get 2 coupons per year in case of a floater policy. These can be redeemed to avail complimentary health check-up at our designated centres.

After you avail the complimentary health check-up, we will evaluate your reports and based on the outcome you can earn up to 5% good health discount on your renewal premium. In case the reports show any risk or abnormal values, you will not be eligible for the discount.

a. Based on your health status declared at the start of your policy, you will be classified as:

Onboarding	Green	Amber	Red
Medical history	No	Yes	Chronic condition
Access to data	Yes	Yes	Yes
Agree to participate in wyn Fit	Yes	Yes	Yes

b. Fitness points and discount you can earn by getting a health check-up done:

Activity	Fitness points earned	Classification	Discount earned
Undergoing the check-up	700	Green	5%
		Amber	0%
		Red	0%

c. The test list for complimentary health check-up has been shared below. The parameter ranges have also been shared basis which you will be classified into green, amber or red.

Healthy customers with no PED				
Category	Test Name	Green	Amber	Red
Obesity	BMI	18.5 to 25	<18.5 or 26 to 30	>30
	WHR	Women: 0.81 to 0.85; Men: 0.96 to 1	Women: >0.85 to 0.9; Men 1 to 1.25	Women: >0.91; Men: >1.25
Thyroid profile	TSH	0.5 to 5ml/U/L	5 to 5.5ml/U/L;	>5.5ml/U/L;
	T3	100 to 200 ng/dl	200 to 250 ng/dl	>250 ng/dl
	T4	5 to 12 microgram/dl	12 to 13 microgram/dl	>13 microgram/dl
Cardiac markers	BP	Systolic: up to 120 mmhg; Diastolic: Up to 80 mmhg	Systolic: 121 to 139 mmhg; Diastolic: 81 to 89 mmhg	Systolic: 140 mmhg or higher; Diastolic:90 mmhg or higher
Lipid Profile	Sr. cholesterol	<200 mg/dl;	201 to 250 mg/dl	>250 mg/dl

	LDL	<100 mg/dl;	101 to 150 mg/dl	>150 mg/dl
	Triglycerides	<150 mg/dl;	151 to 200 mg/dl	>200 mg/dl
	HDL	60 mg/dl or above	50 to 60 mg/dl	<50 mg/dl
Blood sugar	HbA1C	4% to 5.6%	5.7% to 6.4%	>6.4%
Discount eligibility		Yes	Nil	Nil

Customers with PEDs				
Category	Test Name	Green	Amber	Red
Obesity	BMI	<30	30.1 to 32	>32
Thyroid profile	TSH	0.5 to 5ml/U/L	5 to 5.5ml/U/L;	>5.5ml/U/L;
	T3	100 to 200 ng/dl	200 to 250 ng/dl	>250 ng/dl
	T4	5 to 12 microgram/dl	12 to 13 microgram/dl	>13 microgram/dl
Cardiac markers	BP	Systolic: up to 120 mmhg; Diastolic: Up to 80 mmhg	Systolic: 120 to 139 mmhg; Diastolic: 80 to 89 mmhg	Systolic: 140 mmhg or higher; Diastolic:90 mmhg or higher
Lipid Profile	Sr. cholesterol	<200 mg/dl;	201 to 250 mg/dl	>250 mg/dl
	LDL	<100 mg/dl;	101 to 150 mg/dl	>150 mg/dl
	Triglycerides	<150 mg/dl;	151 to 200 mg/dl	>200 mg/dl
	HDL	60 mg/dl or above	50 to 60 mg/dl	<50 mg/dl
Blood sugar	HbA1C	<5.9%	6% to 6.4%	>6.4%
Discount eligibility		Yes	Nil	Nil

3. **Category 3: Health quiz**
   We will run health related quiz to help understand your current and past medical, lifestyle and family history. This will help you understand how prone you could be to lifestyle conditions in the future. You can thus change your lifestyle accordingly to keep these conditions at bay. On successful completion of each quiz, you will be eligible for an additional 50 points.

4. **Category 4: Fit challenge**
   i. We will organise fitness challenges and events throughout the year.
   ii. These challenges may include step count, running, cycling, burpee, push up, plank, etc.
   iii. Winners can win rewards mentioned under Section VII C.2.i depending on their fitness level or performance.
   iv. Apart from the winners (top positions/ranks), there may be provision for tie-breakers to select the top performer and rewards for participation depending on the fit challenge.

Do not skip this part!

I. It is up to you whether to avail the services or not. Our service provider or we do not warrant the validity, accuracy, completeness, safety, quality, or applicability of the content or anything said or written or any suggestions provided in rendering the fitness services.
II. We, our group entities, or affiliates, their respective directors, officers, employees, agents, vendors, shall not be responsible or liable for any actions, claims, demands, losses, damages, costs, charges and expenses which you may claim to have suffered, sustained or incurred, as a result of any advice or information obtained under wyn Fit or any actions chosen by you based on such advice or information.
III. wyn Fit is subject to revisions based on the insurance regulatory framework from time to time.

C.3 Claims procedure

a. <u>For cashless claims:</u>

i. You can either show your health card along with a photo ID proof (Aadhar card/ Voter ID card / Driving License / Passport / PAN Card / any other identity proof as approved by us) or seek pre-authorisation. You will need to share your policy number along with a photo ID proof at our network hospital when you seek pre-authorisation.
ii. The hospital shall e-mail the pre-authorisation form with yours and the treating doctor's contact and other relevant details to the 24 hour authorisation/cashless department.
iii. We will consider the request after we receive accurate and complete information about the illness or injury.
iv. We shall mention the details of the sanctioned amount, any sub-limits, co-payment or deductible applicable to the claim, and non-payable items, if applicable, in the authorisation letter. This letter shall be valid only for 15 days from the date of its issuance.
v. At the time of discharge:
    1. The hospital may forward a final request for authorisation of any residual amount to us along with the discharge summary and the bill.
    2. Once we provide the final authorisation letter, the hospital may discharge you.
    3. You must pay the, co-payments, deductibles (if applicable) to the hospital before discharge.
vi. Pre-authorisation shall be valid only if all the details of the authorised treatment, including dates, hospital and locations, match with the details of the treatment received.
vii. Pre-authorisation does not guarantee that all costs and expenses will be covered. We reserve the right to review each claim for medical expenses. If there's a change in treatment during hospitalisation or in the admission date, the network hospital shall obtain a fresh authorisation letter from us.
viii. If the hospitalisation cost exceeds the authorised limit, the hospital shall request us to enhance the limit. They must specify the circumstances that led to it. We will review such requests, and their admissibility will be determined as per the terms and conditions of this policy.
ix. In case of an emergency hospitalisation, we may continue to discuss your condition with the treating doctor until our recommendations on your coverage eligibility are finalised.
    1. Meanwhile, the network hospital may consider treating you either by taking a deposit amount or as per their norms in the event of any lifesaving, limb saving, sight saving, emergency medical attention requiring situation.
    2. Once the pre-authorisation is issued, the hospital shall refund such deposit amount to you, barring a token amount to take care of non-covered expenses.
x. If the procedure above is followed, you will not be required to directly pay the bill amount to the hospital that we are liable for, and shall leave the original bills and evidence of treatment in respect of the same with the hospital.
xi. If the surgery/treatment is not covered under the policy, there is insufficient sum insured, or insufficient information provided to us to determine the admissibility of the claim, a rejection letter would be sent to the network hospital. The rejection of a pre-authorisation request for a cashless facility is in no way construed as a rejection of coverage or treatment. You can still go ahead with the treatment, settle the hospital bills and submit the claim for possible reimbursement within the prescribed timelines.
xii. Cashless facility is only available at specific network hospitals. The updated list of network hospitals is available on the website and mobile application. We reserve the right to modify, add or restrict any network hospital for a cashless facility.

b. <u>For reimbursement/fixed benefit claims:</u>

i. You need to notify us on the mobile application or the website by submitting a duly completed 'Claim Form' and the necessary claim documents if:
    1. We deny pre-authorisation for cashless facility
    2. You take the treatment at a non-network hospital
    3. The claim is for a fixed benefit under the policy

4. You don't wish to avail cashless facility

ii. After you notify us about your claim, all supporting documents required under Section VI A.2 are to be provided to us as soon as possible, but in any event within 30 days from the date of discharge from the hospital.

iii. For post-hospitalisation medical expenses (Section IV C.3), documents may be provided within 30 days from the completion of the post-hospitalisation period.

iv. If you fail to submit the documents within 30 days, we will have the right to treat the claim as inadmissible. We may condone the delay provided you give us a valid reason justifying the delay in writing.

v. If there is any deficiency in the documents/ information submitted to us, we will send a letter noting such deficiencies within 7 days of receipt of the claim documents. The pending documents/information should be provided to us within 15 days of our letter noting such deficiencies.

vi. If we disagree with the whole treatment and find some part of it admissible, we may decide to deduct the claim amount and settle the claim.

vii. If requested by us, you must submit to a medical examination by our doctor as often as we consider reasonable and necessary at our cost. We/our representatives must be permitted to inspect the medical and hospitalisation records to obtain an independent opinion to process any claim.

viii. You must take reasonable steps or measures to minimise the quantum of any claim that may be covered under the policy.

ix. If we receive a claim for reimbursement when a pre-authorisation letter has been issued, before we approve, we will check with the hospital if the pre-authorisation has been utilised. We will also verify if you've settled all the dues with them. Once the hospital sends us the declaration confirming that the pre-authorisation was not used and that you settled all the dues, we will process your claim.

x. After approving the claim, we shall make the claim payment within 14 calendar days from submission of the last necessary documents (including any additional information required by us to settle the claim).

xi. Any rejections, if done, would be provided with proper reasons, and communicated within 14 days after submission of the last necessary document.

xii. In case of suspected frauds, the last "necessary" document shall mean the receipt of a verification/investigation report to determine the validity of the claim.

xiii. In case of a rejected claim, you may ask us to reconsider the admissibility of your claim within 15 days of the decision.

C.4 Non-payables

Below are the non-payable items applicable in the policy. The list may be updated as per the direction of Authority, for updated list please visit our website or app.

List of non-payable items as per IRDAI	
S. No.	**Items**
1	Baby food
2	Baby utilities 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	Telephone charges

14	Guest services
15	Crepe bandage
16	Diaper of any type
17	Slings
18	Weight control programs/ supplies/ services
19	Blood grouping and cross matching of donors samples
20	Service charges where nursing charge also charged
21	Television and air conditioner charges
22	Surcharges
23	Attendant charges
24	Extra diet of patient (other than that which forms part of bed charge)
25	Birth certificate
26	Certificate charges
27	Courier charges
28	Conveyance charges
29	Medical certificate
30	Medical records
31	Photocopies charges
32	Mortuary charges
33	Walking aids charges
34	Oxygen cylinder (for usage outside the hospital)
35	Pulse oxymeter charges
36	Spacer
37	Spirometer
38	Nebulizer kit
39	Steam inhaler
40	Arm sling
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	Digestion gels
56	Ecg electrodes
57	Gloves sterilized gloves
58	Nebulisation kit
59	Recovery kit, etc. Any kit with no details mentioned [delivery kit, orthokit, overy kit, etc.]
60	Kidney tray
61	Mask
62	Ounce glass
63	Pelvic traction belt
64	Pan can
65	Trolley cover
66	Urometer, urine jug
67	Ambulance
68	Vasofix safety