Terms and Conditions

Wellness Benefits for Premium Salary Customers

1. The offers are applicable to the Axis Bank Salary Accounts customers from Burgundy, Priority and Prestige segments whose accounts are opened after 1st June, 2026.
2. At least one transaction from debit card (POS/ ATM) or UPI transaction & at least one salary credit within 120 days of account opening is required to be eligible for the program except few categories which are: Insurance/ FI/ Foreign Currency, Charities, Govt. Services, Jewellery, Education, Cash Withdrawal, Fuel, Transport, Wallet, Visa, Rent and Utility
3. The eligible customers shall receive Email/ SMS with voucher code once both the requirements are fulfilled, whichever is later.
4. Customers must use the voucher codes to avail the offers by clicking on the offer page link sent to them over Email/SMS.
5. In case microsite link or mentioned third party page in the offer-based link fails to function, Axis Bank will not be held responsible.
6. Queries will be entertained up to 90 days from the offer communication date via Email/ SMS
7. Customers should use only their registered mobile number and Email ID along with the voucher code to redeem the applicable offer
8. If any other mobile number other than registered mobile number is used along with voucher code to redeem the offers, access to the offers will be denied.
9. Once a voucher code has been redeemed, it cannot be re-issued.
10. Once a specific offer has been utilized, it cannot be re-used.
11. Voucher code validity will be valid for only 60 days from the date of offer communication. Upon redemption, the offers will be valid for a period of 1 year from the date of redemption
12. Once the date of validity of the voucher code expires, the voucher cannot be utilised.
13. The terms & conditions basis existing corporate salary relationship shall be applicable to all the eligible customers as well.

Complete offer list:

Details	Complete Description
Health checkup	Customised Annual Health Check up- 1 Parameters: Hba1c (1) FBS / RBS (1) Thyroid Profile (3) Lipid (9) Urine R/M (24) RFT (10) LFT (11) Iron Profile (3) CBC (24)

General Physician Teleconsultation	Doctor on call/ GP teleconsultation- Unlimited
Health Check-up	Multi-purpose cashless/ reimbursement benefits- Rs.500
OPD health benefits	Specialist and GP consultation cashless/ reimbursement benefit- up to Rs.500 Medicine reimbursement benefit- up to Rs.500 Lab, imaging and scan cashless/ reimbursement benefit- up to Rs.500
OPD health benefits sub-limit	Coach based nutritionist (virtual health coach)- 4
Discount features	Diagnostic test discount- up to 20% Lab discount- up to 50% GP consultation- up to 30% Speciality consultation- up to 20% Pharmacy discount- up to 20%

ANNEXURE: General Terms and Conditions applicable to claims against all type of OPD Services

1. All claims will need to be supported by appropriate documentation that prove:
    a. The existence of an underlying disease condition as permitted within the package.
    b. Validity of payment made to the respective service provider for availing the said service.
2. The reimbursement claims processing time for uncontested cases, free of any queries, is stipulated at 7 days from the date of submission of claim. This turnaround time is applicable under the condition that the submitted cases do not require additional clarifications or corrections. Any deviations from this stipulation may result in delays in the claim processing timeline.
3. The cashless claim processing time for uncontested cases, free of any queries, is stipulated at 3 hours from the date and time of submission of claim. This turnaround time is applicable under the condition that the submitted cases do not require additional clarifications or corrections. Any deviations from this stipulation may result in delays in the claim processing timeline.
4. Depending on the specific inclusions within your package, claims can be raised either for a cashless mode of availment of service or for reimbursement of service where the service has been provided by a service provider other than Livlong 365.
5. Where both reimbursement as well as cashless claim benefits are included in the package, Livlong 365 will attempt to first provide fulfilment of claim in a cashless mode within its network. Only if Livlong 365 is unable to fulfil the claim through its network of service providers, can the customer avail the service in a reimbursement mode.
6. Unless otherwise specified in the policy benefit details, the date of service mentioned in any of the documents tagged within the claim, needs to be after the package purchase date. This applies to all prescriptions, reports, bills and any other documents submitted as part of the claim.
7. Unless otherwise specified, a mandatory waiting period of seven (7) days will apply from the date of purchase of the package before a claim can be raised.
8. All supporting physician prescription and clinical notes should contain:
    a. The prescribing doctor's name, medical registration number, contact information and address;
    b. The patient's full name

c. Diagnosis for the visit;
d. Date of consultation;
e. Prescribed medication names, dosage, the frequency, and duration that the medicines need to be taken;
f. Any laboratory or diagnostic investigations that need to be undertaken for the patient wherever clinically required;
g. Prescribing Physician's signature.

9. Customers expecting a reimbursement should ensure submission of KYC documents for Bank account verification. For KYC verification, customers and their family members will need to submit their PAN card details, proof of address as well as a cancelled cheque in the name of the Primary subscriber.
10. Reimbursement against claims will be credited only to KYC approved bank accounts of the Primary subscriber of the package. Reimbursement of claims raised against family members will also be credited to the Primary subscriber's account.
11. Customers should update bank account details if there is a change in KYC or account details prior to submission of claims.
12. Readable scans of only original documents will be accepted as supporting documents. Claims with photocopies shared as supporting documents will be rejected.
13. Prescription, clinical notes, and the bills submitted as evidence against a claim should mention the same patient's name.
14. Claims initiated in the name of family members will only be acceptable where the purchased package allows for more than one member coverage. For claims made on behalf of a family member, the prescription, clinical notes and the bills should be in the name of the family member against whom the claim is made.
15. If a claim is found to be fraudulent, Livlong 365 reserves the right to blacklist the subscriber. A blacklisted subscriber will not be allowed to raise further claims against their purchased package.
16. A subscriber could be blacklisted for reasons including but not limited to, editing, tampering, modifying, forging, digitally manipulating, or overwriting a bill, clinical note or prescription.
17. Livlong 365 maintains a list of blacklisted providers. Any services availed from blacklisted providers as indicated by the claim documents, will be rejected.
18. Family members of subscribers can be tagged against a package only once in a policy period. Once tagged, members cannot be changed or removed from the package until the package expires. Claims can be raised only against family members tagged within the package.
19. If additional evidence is needed against a claim, Livlong 365 may request for more documentation from the subscriber.
20. Livlong 365 reserves the right to reject a claim at its sole discretion for reasons including, not limited to:
    a. Claims related to non-healthcare expenses.
    b. Claims that are clinical but unrelated to the underlying disease condition mentioned in the prescription or clinical note.
    c. Claims not supported by valid documentation.
    d. Claims incurred before the effective start date of the purchased package.
    e. Prescription or clinical note being outdated i.e. older than 15 days of the bill date for acute ailments and older than 90 days of the bill date for chronic ailments.
    f. Date of service mentioned in the Prescription, clinical note or bill being prior to the package purchase date.

g. Member names mentioned on any or all the documents being different from the subscriber's name or tagged family member's name.
h. Incomplete documents tagged to a claim.
i. Amount claimed being different from the amount mentioned in the bill.
j. Amount available in the package or the specific sub-limit against which the claim is raised has been exhausted.
k. Claim crosses the available threshold of frequency as defined within the package.
l. Missing clinical or other details in the documentation as defined under each claim category.
m. Unless indicated in your specific policy, if a Prescription or clinical note is generated by a non-allopathic doctor, it will be rejected. Claims raised by doctors other than the following degrees (MBBS, MD, MS, McH, DM, DNB, Post MBSS diplomas, Post MBBS CPS certifications) will be considered as non-allopathic.

21. Ailment/Illness – Ailment/Illness means a sickness, or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
22. 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.
23. Chronic Condition - A chronic condition is defined as a disease, illness or injury that has one or more of the following characteristics.
    a. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests.
    b. It needs ongoing or long-term control or relief of symptoms.
    c. It requires rehabilitation of the patient or for the patient to be specially trained to cope with it.
    d. It continues indefinitely.
    e. It recurs or is likely to recur.
24. If a subscriber would like to dispute a rejected claim, they can raise a claim review by sending the necessary documentation explaining the dispute along with the claim details to the email ID - support@livlong.com.
25. The amount defined under the package benefit is non-transferable and non-refundable. In the event that a particular amount of benefit lies unclaimed at the time of expiry of the package, such an amount cannot be transferred even if an additional package is purchased. The benefit amount defined under the package cannot be converted in monetary format or withdrawn.
26. Some packages may apply a co-pay or a co-deductible amount as part of the claim process. Respective amount will be deducted against the claimed amount before processing the claims.
27. Livlong 365 reserves the right to reinvestigate a historically approved case if it is suspected to be fraudulent subsequently. Subscribers are liable to repay the claimed amount if such approved claims have been subsequently proven to be fraudulent or wrongly approved. Livlong 365 can also adjust these amounts against any subsequent claims raised by the subscriber.
28. Livlong 365 reserves the right to modify or update these terms and conditions at any time during the policy period. Livlong 365 reserves the right to terminate or suspend the OPD benefits against a specific package at its sole discretion. Customers will be notified of any changes.
29. Outpatient benefits will not cover any services associated with IPD or inpatient treatment, procedures, or follow-ups.
30. If included within your purchased plan, only those consultations conducted by BAMS, BHMS physicians registered with MCI/NMC registries will be eligible for Ayush-related claims.

31. Unless otherwise specified, costs related to cosmetic body modifications, treatments necessitated due to criminal acts by the insured, and travel or transportation expenses are not covered.
32. A specific listing of documentation guidelines applicable for different categories of claims is indicated below. These are applicable over and over the general terms and conditions listed above. For any category of service other than those listed below, the general terms and conditions listed above will be applicable.

i. Medicine Claims Requirements

a. Both, the bill as well as the doctor prescription needs to be uploaded against any medicine claim.
b. Bills must include the GSTIN number and drug licence number of the pharmacy.
c. Bills should clearly display the invoice number, date of service, and patient's name.
d. Prescribed medicines must be clearly visible on the bill.
e. Bills must state the total bill amount.
f. Unless otherwise specified, claims should be submitted within 30 days from the date of prescription.
g. For acute ailments, the date of prescription should be within 7 days of the date of purchase of medicines.

ii. Consultation Claims Requirements

a. Along with a prescription note a bill or receipt of the amount received by the attending physician should be attached.
b. The attending doctor's name on the prescription and the consultation bill should match.
c. Only prescriptions from allopathic doctors are permissible.
d. Unless otherwise specified, claims should be submitted within 30 days from the date of prescription.

iii. Lab and Diagnostics Claims Requirements

a. Lab and diagnostics reports must bear an authorised signature of the attending physician.
b. The lab report must indicate the National Accreditation Board for Testing and Calibration Laboratories (NABL) number.
c. The lab and diagnostics bill must include the name, address, contact details and GSTIN number of the facility.
d. Prescribed tests should be clearly indicated on the bill.
e. Unless otherwise specified, claims should be submitted within 30 days from the date of prescription.

iv. Vision Claims Requirements

a. Vision claims cover expenses related to eye examinations, vision correction procedures, and ophthalmological treatments prescribed by qualified ophthalmologists.
b. All claims made under the Vision services category must be supported by appropriate medical documentation and bills which include legible bills and receipts, prescriptions and clinical procedure details from qualified eyecare professionals.
c. Unless otherwise specified, vision claims do not cover cosmetic procedures, lenses, frames, sunglasses, goggles or associated equipment.
d. Unless otherwise specified, claims should be submitted within 30 days from the date of prescription

v. Dental Claims Requirements

a. Dental claims wherever applicable cover only routine check-ups, cleanings, preventive treatments, fillings, extractions, root canals, and dental crowns associated with a root canal or a clinically mandated procedure.
b. Any cosmetic dental procedures are not covered under the packages unless otherwise specified. These include but are not limited to teeth whitening, bridges, crowns, and alignment corrections.
c. Unless otherwise specified, claims should be submitted within 30 days from the date of prescription.

vi. Home Care Claims Requirements

a. Home care claims cover expenses related to home-based healthcare services, including attendants, nurses, and physiotherapists.
b. For any home healthcare claims, an attending physician's prescription of the relevant clinical specialty mandating requirement of home service is needed.
c. All claims require proper documentation, including invoices, receipts, and service reports from qualified home healthcare providers.
d. Home Care claims will not cover any services associated with inpatient treatment.
e. Unless otherwise specified, claims should be submitted within 30 days from the date of prescription.

vii. Vaccine Claims Requirements

a. Vaccine claims exclusively cover preventive vaccines and immunisation-related expenses and do not cover non-vaccination healthcare costs.
b. For any vaccine related claims, an attending physician's prescription of the relevant clinical specialty mandating requirement vaccine is needed.
c. Only vaccines endorsed by the Ministry of Health and Family Welfare of the Government of India, through the Universal Immunization Program, will be permitted for reimbursement.
d. Unless otherwise specified, claims should be submitted within 30 days from the date of prescription.

viii. Ambulance Claims Requirements

a. Unless otherwise specified in your package, Ambulance claims are available only in a cashless mode of fulfilment.
b. Our ambulance service is available in specific pin codes only and covers a radius of 20 kms from the specified pin code.
c. Ambulance services are available only in cases of emergency and include transportation from the place of residence to the nearest Hospital suited to the medical emergency.
d. Before availing any further service, it is mandated to share clinical documents with respect to the previous ambulance usage proving the emergency nature of the situation. Livlong 365 is liable to turn down an ambulance request if a previous request's documentation has not been submitted.
e. The turnaround time for our ambulance service is up to 60 minutes from the time of request.
f. Ambulance requests can be rejected if Livlong 365 deems a situation to not be of an emergency nature.
g. Patients with pre-existing disabilities rendering them immobile, prior to the purchase date of policy will not be eligible for availing ambulance services.

ix. Infertility Claim Requirements

a. When covered within your policy, infertility claims will be restricted to consultations, diagnostics and medications focused on infertility related treatments.
b. Unless otherwise specified, claims should be submitted within 30 days from the date of prescription.

x. Imaging/Scans

a. When covered within your policy, for imaging/scans claims, it is mandatory to provide a doctor's prescription, along with the images of scans, X-rays, diagnostic films and reports with the corresponding bills to process the claim.
b. Unless otherwise specified, claims should be submitted within 30 days from the date of prescription.

Please note: The wellness offers are solely curated and administered by *Livlong Protection and Wellness Solutions Ltd.* Axis Bank neither endorses nor assumes any responsibility or liability for the products, services, or claims associated with these offers. All disputes or queries must be directed to the respective service provider. In case of any query, you may connect with your Relationship Manager, or you can call us on 18604195555