



BUSINESS PLAN · INDIA

At-Home Wellness-Testing Brand

*Direct-to-consumer wellness testing with a clinician at both ends - PPV published,
unactionable panels refused*

DIAGNOSTIC LABS & IMAGING

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August 2026

This document is confidential and prepared for planning purposes. All financial figures are illustrative model assumptions for an Indian MSME context and must be validated against live quotes, local rates and professional advice before any investment or borrowing decision.

1. Executive Summary

This plan sets out an **At-Home Wellness-Testing Brand** in India — direct-to-consumer test panels and self-collection kits sold online, covering full venous panels collected at home, subscription retesting programmes, fingerprick and saliva kits, corporate and insurer wellness programmes, speciality hormone and metabolic panels, and white-label testing for partner brands, serving roughly 168,000 customers across 268,000 orders by Year 3.

This plan inherits the diagnostics vertical's rules and takes one of them to its limit. **The preventive-checkup plan established that a well person's positive result is usually false. This plan sells to a well person who has no clinician at either end of the transaction — nobody decided the test was indicated, and nobody is waiting to read it.**

□ **A DIRECT-TO-CONSUMER WELLNESS TEST HAS NO CLINICIAN AT EITHER END. Nobody assessed whether the test was indicated, nobody will interpret the result, and nobody is responsible for what the customer does next — so the entire apparatus of clinical justification, pre-test probability and follow-up that the rest of this vertical depends on IS SIMPLY ABSENT. A well person buying a panel on the internet therefore has THE LOWEST PRE-TEST PROBABILITY OF ANY CUSTOMER IN THIS VERTICAL AND THE LEAST SUPPORT WHEN SOMETHING COMES BACK ABNORMAL. And the category's marketing runs on language that is UNFALSIFIABLE RATHER THAN FALSE — "optimise", "biological age", "hormone balance" — claims no measurement could ever contradict. So this business PUBLISHES PPV PER TEST IN ITS OWN D2C POPULATION, REFUSES PANELS WITH NO ACTIONABLE PATHWAY, INCLUDES A REAL CLINICIAN CONSULTATION IN THE PRICE FOR EVERY ABNORMAL RESULT RATHER THAN UPSELLING ONE, and MAKES NO CLAIM THAT CANNOT BE STATED AS A MEASURED QUANTITY. WHERE NO CLINICIAN ORDERED THE TEST AND NONE WILL READ IT, THE SELLER MUST SUPPLY BOTH ENDS OR NOT SELL THE TEST.**

□ **AND A SAMPLE COLLECTED BY AN UNTRAINED PERSON AT A KITCHEN TABLE IS THE PRE-ANALYTICAL PROBLEM WITH NO PHLEBOTOMIST AT ALL. So SELF-COLLECTION REJECTION RATE IS PUBLISHED at 6.8%, ANALYTE-SPECIFIC VALIDITY FOR SELF-COLLECTION IS PUBLISHED for every analyte offered, and 22 ANALYTES HAVE BEEN WITHDRAWN because self-collection cannot support them.**

□ **AND A WELLNESS SCORE IS A COMPOSITE NUMBER WITH NO REFERENCE STANDARD. So every score and every "biological age" is PUBLISHED WITH ITS FORMULA AND INPUT WEIGHTS or it is not published at all, and RETEST INTERVALS ARE SET BY BIOLOGICAL VARIATION RATHER THAN BY THE BILLING CYCLE — a median of 11.2 months against a category that retests quarterly.**

This plan models an operator requiring **₹16.00 crore** (₹7.20 crore investor + ₹4.40 crore term loan + ₹2.60 crore promoter + ₹1.80 crore working capital), moving from **₹9.00 crore revenue and a ₹3.33 crore loss** to **₹48.00 crore revenue and ₹3.84 crore profit** by Year 3 — *an 8.0% net margin and 29.8% return on capital. (Wellness testing — figures illustrative.)*

2. Business Description, Vision & Legal Structure

Concept: A wellness-testing brand that supplies the clinician the internet took out of the transaction.

Vision: To sell no test whose value cannot be stated as a measured quantity in the population we actually serve.

Mission: Measure and publish the predictive value of every test we sell to well people; refuse the panels that cannot clear it; put a salaried clinician on every abnormal result at no extra charge; publish the formula behind every score; and set retest intervals by biology rather than by the subscription cycle.

Legal structure

- **Private Limited** — recommended. Consumer contracting, laboratory partnerships, insurer tie-ups, data obligations and outside capital all assume it.
- **Clinicians employed on salary rather than paid per consultation — the structural precondition for including consultation in the price, since a per-consult clinician cannot be required to tell a customer that nothing needs doing.**
- **Quality and clinical-governance function reporting to the board, independent of growth and marketing — because the threshold that drops a test is the threshold that removes a revenue line.**

Regulatory anchor: the Clinical Establishments Act 2010 and state rules for the collection and laboratory operations we own or contract; NABL accreditation for partner laboratories, with **the reporting laboratory named on every report rather than hidden behind the brand**; the Drugs and Magic Remedies (Objectionable Advertisements) Act 1954 and ASCI codes, which **constrain precisely the "optimise", "detox", "balance" and "biological age" language on which this entire category markets itself**; the Consumer Protection Act 2019 and its e-commerce rules, under which a health claim made in a product listing is an actionable representation; the Digital Personal Data Protection Act 2023, under which **a wellness panel is health data of the most sensitive kind and D2C consent obtained through a checkout flow is the weakest consent in this vertical**; the NMC Telemedicine Practice Guidelines for the consultation we include; PCPNDT where any offered analyte could touch it; Legal Metrology and BIS for kit packaging; and EPF/ESI and POSH. **The decisive structural fact is that NOTHING REQUIRES A SELLER OF DIRECT-TO-CONSUMER TESTS TO KNOW, LET ALONE PUBLISH, HOW OFTEN ITS ABNORMAL RESULTS MEAN ANYTHING.**

3. Promoter & Ownership

Led by a promoter with consumer-health, diagnostics or D2C commerce background, with a physician as clinical director. Three competences decide outcomes. *Clinical epidemiology*, because the product is a probability rather than a chemistry — and nobody in this category currently employs anyone who thinks in those terms. *Direct-to-consumer economics*, since acquisition cost, repeat rate and average order value decide whether the business survives at all. And *the willingness to refuse a panel that sells well*, which is where this plan's proposition sits and which forgoes the easiest revenue in the category. Ownership, equity & investor terms are editable inputs; **the clinical-governance function reports to the board independently of growth, and no employee's pay is linked to panel size, order value or retest frequency.**

4. Market Analysis — India

Fast-growing consumer appetite for self-directed testing, sold almost everywhere on breadth rather than yield.

Demand drivers

- **Rising health awareness** among urban working adults with disposable income.
- **Convenience** — home collection and kits against a queue at a collection centre.
- **Distrust of episodic care** and a wish to track something continuously.
- **Corporate and insurer wellness budgets** funding population screening.
- **Wearables and quantified-self habits** creating appetite for a blood-level number.

- **Low friction of online purchase**, with no gatekeeper anywhere in the path.

Market sizing (illustrative framing)

Layer	Definition	Indicative scale
TAM	Indian consumer spend on self-directed wellness testing	Large; growing faster than clinical demand for it
SAM	Panels whose predictive value in a well population we can demonstrate	Bounded by MEASURED PPV, not by appetite
SOM (Yr 1-3)	Customers served under a published-PPV product rule	₹9cr → ₹48cr; 168k customers; 268k orders

Revenue mix and share (Year 3)

Stream	Share	Gross margin — and what the customer is actually buying
Wellness panels — venous collection at home	36.0%	44.0% — the core product; a phlebotomist still costs money
Subscription retesting programmes	20.0%	48.0% — where the billing cycle fights the biology
Corporate & insurer wellness programmes	17.0%	40.0% — volume pricing; the payer is not the patient
Self-collection kits — fingerprick and saliva	13.0%	52.0% — no phlebotomist, and no observer either
Speciality panels — hormone, metabolic, micronutrient	10.0%	56.0% — highest margin, lowest measured yield
White-label testing for partner brands	4.0%	74.0% — our rules travel with the contract

The second row is where the category makes its money and where this plan gives it up: a subscription that retests a healthy adult every quarter bills four times a year for a measurement whose biological variation cannot support it, and the customer experiences the frequency as diligence. The fifth row is the honest embarrassment — speciality hormone and micronutrient panels carry the best gross margin in the book and the worst measured actionable yield, which is exactly the combination that makes them the category's favourite product and this plan's most constrained one. The fourth row is where the pre-analytical problem lives without a phlebotomist to solve it, and the third is where the buyer is not the person being tested, so the corporate-canteen rule applies in full.

Constraints

- **Customer acquisition cost**, which is the single hardest number in D2C health.
- **Repeat rate**, since a one-off tester never repays acquisition.
- **Self-collection validity**, which limits the menu regardless of demand.
- **Partner-laboratory turnaround and consistency**, which we influence but do not own.

5. Competition & Position

Competitor type	Strength	Weakness this plan exploits
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D2C wellness-testing brands	Brand, app, breadth of panel, aggressive pricing, scale	No published PPV; consultation upsold; quarterly retesting
Diagnostic chains selling direct	Own laboratories, NABL, trust, physical network	Panels designed for referral volume, not for well people
Health-app and wearable ecosystems	Engagement, data, subscription habit already formed	Scores with no published formula or reference standard
Corporate wellness aggregators	Employer relationships, bundled pricing, HR access	Individual results flowing to the employer who paid
This plan	PPV published, panels refused, consultation included, formula shown	Narrower menu; higher cost per order; slower to scale

The positioning makes one claim a customer can check before paying: for every test in this panel, here is how often an abnormal result meant something in people like you, and here is the clinician who will call you if it does — at no extra charge. No competitor in this category publishes the first number, because none has measured it, and none includes the second, because the consultation is the upsell. The commercial difficulty is that our menu is visibly shorter than everybody else's on a comparison page, and a customer choosing between a 29-test panel and a 78-test panel at a similar price has no column for predictive value.

The cost of the honest position is stated in rupees rather than implied. Including a real clinician consultation in the price for every abnormal result, never upsold, cost ₹2.68 crore of Year-3 margin — the largest item and the entire difference between selling a result and selling an answer. Measuring and publishing PPV per test in our own D2C population, and dropping the 47 tests that failed the threshold, cost ₹1.86 crore. Setting retest intervals by biological variation rather than the billing cycle cost ₹1.12 crore. Publishing self-collection validity per analyte and withdrawing 22 analytes cost ₹94 lakh. Publishing the formula behind every score, and dropping the scores that had none, cost ₹68 lakh. Total ₹7.28 crore against ₹3.84 crore of profit — so an operator with the same customer base running trade-standard practice would earn ₹11.12 crore.

6. The Test Nobody Ordered

This is the finding, and it is structural rather than behavioural.

What a clinician normally does	Who does it in a D2C wellness purchase
Decides the test is indicated for this person	Nobody. The customer chose from a menu.
Knows the pre-test probability of disease	Nobody. It is as low as it ever gets.
Interprets the result in clinical context	Nobody. A reference range is printed.
Decides what, if anything, happens next	The customer, alone, at 11pm, on a search engine
Owns the consequence of a false positive	NOBODY AT ALL
Records whether the test helped anyone	Not measured, not published, not asked

The fifth row is the whole problem. The preventive-checkup plan established that a reference interval is built to contain 95% of a healthy population, so one healthy person in twenty falls outside it on any single test by design — and that in a well population most positives are therefore false. Everything about D2C makes that

worse: **THE PRE-TEST PROBABILITY IS THE LOWEST IN THE VERTICAL**, because nobody assessed this person before selling to them; and **THE SUPPORT AFTER AN ABNORMAL RESULT IS THE THINNEST IN THE VERTICAL**, because there is no clinician anywhere in the transaction. The customer receives a PDF with a red arrow beside a number and no one to ask what it means. What follows is a cascade — a repeat test, a consultation the customer arranges and pays for, an ultrasound, sometimes a specialist, and for most people several weeks of ordinary fear ending in the words "it's nothing". Nobody lies at any point: the assay was accurate, the reference interval correct, the report properly worded. **AND THE COMMERCIAL LOOP CLOSSES NEATLY**, because the relief of the eventual all-clear is experienced as value received, and the customer renews. The category has never been asked what proportion of its abnormal findings led anywhere, and has therefore never found out.

So the missing measurement is made, published, and allowed to remove products. **PPV IS MEASURED PER TEST IN THE POPULATION WE ACTUALLY SERVE** — not the manufacturer's figure from a diseased cohort, which is a different number entirely — and published test by test, reaching 100% of the menu by Year 3. **ANY TEST BELOW THE PUBLISHED THRESHOLD IS DROPPED**: 47 by Year 3, and NIL tests are sold whose PPV we have not measured. **A REAL CLINICIAN CONSULTATION IS INCLUDED IN THE PRICE FOR EVERY ABNORMAL RESULT**, at a seven-hour median, taken by 86% of those offered it — salaried, never per-consult, so the clinician is free to say that nothing needs doing. **AND THE CASCADE IS TRACKED AND PUBLISHED**: 97% of abnormal results followed to outcome, 22.4% leading to a real diagnosis and 77.6% **ENDING IN NOTHING**, at a median null-cascade cost of ₹4,200 borne by the customer. That 77.6% is worse than the preventive-checkup plan's 68.8%, exactly as the lower pre-test probability predicts, and it is printed anyway. Cost ₹4.54 crore across the two commitments. **WHERE NO CLINICIAN ORDERED THE TEST AND NONE WILL READ IT, THE SELLER MUST SUPPLY BOTH ENDS OR NOT SELL THE TEST.**

7. The Sample Nobody Watched and the Score With No Formula

Three further rules, each closing a gap the category leaves open.

□ **A SAMPLE COLLECTED BY AN UNTRAINED PERSON AT A KITCHEN TABLE IS THE PRE-ANALYTICAL PROBLEM WITH NO PHLEBOTOMIST AT ALL.** The home-collection plan showed how much a rushed venepuncture costs; a fingerprick taken by the customer has no trained hand, no tourniquet discipline, no order of draw and no observer — and haemolysis, insufficient volume, squeezing the finger and delayed return all corrupt specific analytes in specific directions. So **SELF-COLLECTION REJECTION RATE IS PUBLISHED** at 6.8% from 14.2%, **ANALYTE-SPECIFIC VALIDITY FOR SELF-COLLECTION IS PUBLISHED** for every analyte on the menu, **22 ANALYTES HAVE BEEN WITHDRAWN** because self-collection cannot support them, and every unusable kit is **REFUNDED AND REPLACED WITHOUT ARGUMENT** at 100%. Withdrawing an analyte from the kit menu while competitors still sell it is the visible cost, and the rejection rate is published while it is still embarrassing.

□ **AND "BIOLOGICAL AGE", "WELLNESS SCORE" AND "OPTIMISATION" ARE COMPOSITE NUMBERS WITH NO REFERENCE STANDARD.** Nobody can be wrong about a biological age, because there is nothing to be wrong against — which is precisely why the category likes it. So **EVERY SCORE IS PUBLISHED WITH ITS FORMULA AND INPUT WEIGHTS** or it is not published at all, NIL scores are issued without one, 100% of claims are stated as a measured quantity, and NIL unfalsifiable claims — "optimise", "detox", "balance" — appear in our marketing. This is also the Drugs and Magic Remedies Act and the ASCI code read literally rather than navigated.

□ **AND A SUBSCRIPTION THAT RETESTS A HEALTHY PERSON QUARTERLY IS BILLING, NOT MEDICINE.** Most analytes have a biological variation wide enough that a three-month change is noise, and the customer reads

noise as a trend. So **RETEST INTERVALS ARE SET BY BIOLOGICAL VARIATION PER ANALYTE** rather than by the billing cycle, **NIL** customers are retested sooner than the analyte justifies, 38% of subscription retest reminders are **SUPPRESSED** where no retest is indicated, and the median retest interval has moved from 6.0 to 11.2 months. A subscription business that suppresses its own reminders is giving up the mechanic the model is built on.

□ **AND A WELLNESS PANEL IS A DIAGNOSIS.** Per the online-pharmacy rule, **NIL** data is sold, shared or segmented to third parties, **NIL** individual results reach a corporate buyer, aggregate reporting carries a minimum group size of 25, and every employee can decline without the employer learning they declined.

What a customer can check in sixty seconds, before paying

Every commitment in this plan is verifiable from the product page itself. None of it requires trusting us.

- **Is the PPV printed next to each test?** If a brand cannot tell you how often an abnormal result meant something in customers like you, it has not measured it — and nobody in this category has.
- **Is the consultation included in the price, or offered at checkout?** An upsold consultation is a second product; an included one is an admission that the first product is incomplete without it.
- **Is the reporting laboratory named?** A brand is not a laboratory, and the sample goes somewhere with an address and an accreditation number.
- **Does the score come with its formula?** A biological age without published inputs and weights is a number that cannot be checked, disputed or reproduced by anyone.
- **What is the retest interval, and what justifies it?** If the answer is a billing cycle rather than an analyte's biological variation, the subscription is the product.
- **Is the self-collection rejection rate published?** A kit brand reporting no unusable samples has stopped counting, not stopped receiving them.

The asymmetry is the reason none of this is standard. A false positive costs the customer money, weeks of fear and sometimes an invasive procedure — and costs the seller **NOTHING**; indeed it earns a retest, a consultation fee and a renewal, because the eventual all-clear is experienced as reassurance purchased. A false negative costs the customer more and the seller still nothing, because nobody traces a missed condition back to a wellness panel taken eighteen months earlier. **THE ENTIRE COST OF BEING WRONG IN EITHER DIRECTION SITS WITH THE PERSON WHO PAID, AND EVERY COMMERCIAL SIGNAL THE SELLER RECEIVES FROM A HARMFUL RESULT IS POSITIVE.** That is not an industry of bad actors; it is an industry with no feedback loop, and a business that measures its own null-cascade rate has voluntarily built the one thing the market does not supply. It follows that these commitments cannot survive on goodwill — which is why the PPV threshold sits in the catalogue system as a hard constraint, the consultation sits inside the price rather than beside it, and no growth salary is exposed to panel size, order value or retest frequency.

8. Operations Plan (sell, collect, report, follow)

The product rule

- **PPV measured per test in our own D2C population** and published test by test.
- **Tests below the published threshold dropped** — 47 by Year 3.
- **Nil tests sold whose PPV we have not measured.**
- **Panels stratified by age, sex and stated risk**, never marketed on test count.

The clinician

- **Consultation included in the price for every abnormal result**, never upsold.
- **Clinicians salaried, not paid per consultation** — the precondition for "nothing needs doing".
- **Seven-hour median to consultation offered**; 86% of those offered take it.
- **Cascade followed to outcome** at 97% and published, including the null rate.

The sample

- **Self-collection rejection rate published** — 6.8% in Year 3.
- **Analyte-specific self-collection validity published** for every analyte offered.
- **Analytes self-collection cannot support withdrawn** — 22 by Year 3.
- **Unusable kits refunded and replaced** without argument, at 100%.

The claim and the cycle

- **Every score published with its formula** and input weights, or not published.
- **Nil unfalsifiable marketing claims**; every claim a measured quantity.
- **Retest intervals set by biological variation**, with 38% of reminders suppressed.
- **Reporting laboratory named** on every report, per the vertical anchor.

The operational hinge is a festive-season growth target with the speciality hormone panel forty per cent below its PPV threshold on three months of our own data — a panel that sells better than anything else in the catalogue, that every competitor lists, that a marketing calendar has already been built around, and whose withdrawal would take a visible bite out of the quarter for a reason no customer asked for and no regulator requires. So THE CATALOGUE SYSTEM CANNOT LIST A TEST FLAGGED BELOW THRESHOLD: it is a hard constraint with no seasonal, campaign or executive override, and the panel comes down. Withdrawals are published alongside the PPV data, because a brand that drops tests quietly and publishes only its survivors has produced a marketing document rather than a measurement. No marketing, growth or category pay is affected by panel size, order value or retest frequency.

9. Advertising, Consumer & Data Compliance (India)

- **Drugs and Magic Remedies (Objectionable Advertisements) Act 1954 and ASCI codes** — these constrain precisely the "optimise", "detox", "balance" and "biological age" language on which this category markets itself.
- **Consumer Protection Act 2019 and e-commerce rules** — a health claim in a product listing is an actionable representation, not puffery.
- **Clinical Establishments Act 2010** and state rules for collection and laboratory operations owned or contracted.
- **NABL accreditation for partner laboratories**, with **the reporting laboratory named on every report rather than hidden behind the brand**.
- **Digital Personal Data Protection Act 2023** — a wellness panel is health data of the most sensitive kind, and **D2C consent obtained in a checkout flow is the weakest consent in this vertical**.
- **NMC Telemedicine Practice Guidelines** for the included consultation; registered practitioners only.
- **PCPNDT** where any offered analyte could touch it; **Legal Metrology and BIS** for kit packaging and labelling.
- **EPF/ESI and POSH** across a distributed workforce. **Nothing requires a seller of direct-to-consumer tests to know, let alone publish, how often its abnormal results mean anything.**

10. Organisation & Manpower Plan

Function	Yr 1	Yr 3	Notes
Promoter / managing director	1	1	Owens the PPV threshold
Clinicians — consultation on every abnormal result	6	18	Salaried, never per consultation
Customer operations, support & kit fulfilment	18	56	Refund and replace without argument
Technology, platform, app & results engine	8	14	Threshold is a hard constraint in the catalogue
Marketing, brand & growth	6	12	Nil pay linked to panel size or retest frequency
Quality — PPV, self-collection validity & cascade tracking	4	9	Board-reporting; independent of growth
Admin, finance, legal & compliance	5	11	Advertising review before every campaign
Total	48	121	Clinicians at 15% of headcount

The clinician count is derived rather than assumed, and it reconciles three ways. By volume: 268,000 orders at an 18% abnormal rate is 48,240 consultations, and at twelve consultations a day across 240 working days that is 16.75 clinicians — carried at eighteen to hold the seven-hour median at peak. By cost: the ₹2.38 crore clinician salary line across eighteen people is a ₹13.2 lakh cost-to-company each, and median take-home sits below that because of provident fund, ESI and gratuity. And by direction of travel: the abnormal rate FALLS from 41% to 18% precisely because 47 low-PPV tests were dropped, so the PPV discipline pays for a large part of the consultation bill it creates — a business that kept the wide panels would need roughly forty clinicians to make the same promise, which is why nobody makes it. The quality function at nine people reports to the board rather than to growth, because the threshold that drops a test is the threshold that removes a revenue line.

11. Implementation Timeline & Milestones

Phase	Window	Milestones
Formation, platform & lab partnerships	Month 0–7	Incorporation, ordering and results engine, NABL partner labs contracted
PPV measurement programme opens	Month 4–14	Own-population PPV per test; first 14 tests dropped; threshold published
Clinician network & included consultation	Month 6–13	Six salaried clinicians; consultation included in price from launch
Self-collection validation	Month 9–22	Analyte-specific validity published; 9 → 16 analytes withdrawn
Formula publication & retest recalibration	Month 14–26	Every score with its formula; retest intervals moved to biological variation
Scale & publication	Month 24–36	168k customers; 47 tests dropped; 77.6% null cascade published

Training and competence

- **Pre-test probability and predictive value** — taught to marketing, not only to clinicians.
- **Delivering a normal result well**, which is most of the clinical work in this business.
- **Self-collection coaching** and recognising an unusable sample before it ships.
- **Advertising review** — how to tell a measured quantity from an unfalsifiable claim.

12. Financial Plan (Illustrative)

All figures are illustrative model assumptions, not forecasts or guarantees. They exist to show the drivers of a D2C wellness-testing P&L under a published-PPV product rule. Every input is editable. **The defining economics are that gross margin looks healthy and net margin is thin, because customer acquisition and an included clinician consultation both sit below the gross line — this is a business that must buy every customer and then spend money telling a good share of them that nothing is wrong.**

12.1 Project cost & funding

Item	₹ lakh	Notes
Technology platform, app, ordering & results engine	468	The PPV threshold is a hard constraint here
Working capital — inventory, fulfilment & receivables	268	Corporate and insurer contracts settle slowly
Laboratory onboarding, method & self-collection validation	236	Validity per analyte, not per kit
Kit design, packaging, cold chain & logistics setup	202	A kit that fails in transit is a rejected sample
Clinician network build — consultation capacity	154	Included in price; salaried from the start
Brand, launch marketing & acquisition seed	148	D2C acquisition is the hardest cost in the model
Quality infrastructure — PPV measurement & cascade tracking	84	Measures what the category has never measured
Licences, registrations, deposits & pre-operative	40	Establishment registration, advertising review, indemnity
Total project cost	1,600	₹720L investor + ₹440L term loan + ₹260L promoter + ₹180L WC

12.2 Operating metrics

Metric	Yr 1	Yr 2	Yr 3
PPV MEASURED AND PUBLISHED PER TEST IN OUR OWN D2C POPULATION / tests sold whose PPV we have NOT measured / tests DROPPED for failing the published threshold / abnormal results FOLLOWED TO OUTCOME	62% / NIL / 14 / 84%	88% / NIL / 31 / 92%	100% / NIL / 47 / 97%
CLINICIAN CONSULTATION INCLUDED IN THE PRICE for every abnormal result / consultations UPSOLD or charged separately / median hours to consultation offered / customers taking it / abnormal rate	100% / NIL / 26h / 61% / 41%	100% / NIL / 14h / 74% / 27%	100% / NIL / 7h / 86% / 18%

SELF-COLLECTION rejection rate, PUBLISHED / analyte-specific validity published for self-collection / analytes WITHDRAWN because self-collection cannot support them / unusable kits refunded and replaced	14.2% / 100% / 9 / 100%	9.6% / 100% / 16 / 100%	6.8% / 100% / 22 / 100%
WELLNESS SCORES published WITH their formula and input weights / scores published WITHOUT a formula / claims stated as a MEASURED QUANTITY / unfalsifiable claims used in marketing	100% / NIL / 100% / NIL	100% / NIL / 100% / NIL	100% / NIL / 100% / NIL
RETEST INTERVAL SET BY BIOLOGICAL VARIATION rather than billing cycle / customers retested sooner than the analyte justifies / subscription reminders SUPPRESSED where no retest indicated / median retest interval	100% / NIL / 12% / 6.0 mo	100% / NIL / 27% / 8.4 mo	100% / NIL / 38% / 11.2 mo
Customers / orders / repeat rate / customer acquisition cost / data sold, shared or segmented / individual results reaching a corporate buyer	32k / 44k / 24% / ₹1,210 / NIL / NIL	84k / 132k / 41% / ₹1,080 / NIL / NIL	168k / 268k / 58% / ₹880 / NIL / NIL

Row one contains the number no direct-to-consumer testing brand anywhere publishes: how often an abnormal result in its own customers meant anything at all. Row two is what that measurement pays for — an included consultation on every abnormal result, at a seven-hour median, from a salaried clinician who is free to say nothing needs doing; and the abnormal rate falling from 41% to 18% is not a change in our customers but a change in what we agreed to sell them. Row five is the one that costs a subscription business most: suppressing 38% of its own retest reminders is giving up the mechanic the model is built on, and the median interval nearly doubling from 6.0 to 11.2 months is the visible consequence. Row six's acquisition cost falling from ₹1,210 to ₹880 while repeat rate rises from 24% to 58% is what makes the rest affordable — and if it does not happen, none of it is.

12.3 Revenue build

Stream	Yr 1 (₹L)	Yr 2 (₹L)	Yr 3 (₹L)	Gross margin
Wellness panels — venous collection at home	324	864	1,728	44.0%
Subscription retesting programmes	180	480	960	48.0%
Corporate & insurer wellness programmes	153	408	816	40.0%
Self-collection kits — fingerprick and saliva	117	312	624	52.0%
Speciality panels — hormone, metabolic, micronutrient	90	240	480	56.0%
White-label testing for partner brands	36	96	192	74.0%
Total revenue	900	2,400	4,800	47.6% blended

12.4 P&L summary

Line	Yr 1 (₹L)	Yr 2 (₹L)	Yr 3 (₹L)
Revenue	900	2,400	4,800
Cost of testing — laboratory, collection, kits & logistics	(472)	(1,259)	(2,517)
Gross profit	428	1,141	2,283
Marketing & customer acquisition	(386)	(562)	(742)

Clinician consultation — included in the price	(64)	(142)	(268)
Customer operations, support & fulfilment	(78)	(128)	(208)
Technology, platform & results engine	(96)	(132)	(152)
Quality — PPV, self-collection validity & cascade tracking	(72)	(104)	(128)
Admin, finance, legal & compliance	(86)	(118)	(113)
EBITDA	(354)	(45)	672
Depreciation & amortisation	(92)	(146)	(196)
Finance cost	(32)	(52)	(68)
Other income — white-label platform fees (<i>disclosed</i>)	34	68	104
PBT	(444)	(175)	512
Tax	111	44	(128)
PAT	(333)	(131)	384
Net margin	(37.0%)	(5.5%)	8.0%
ROCE	(27.9%)	(11.9%)	29.8%

Marketing at ₹7.42 crore is 15.5% of revenue in Year 3 and 42.9% in Year 1, and that curve is the business: a D2C health brand is an acquisition machine before it is anything else, which is why the category reaches for the widest panel and the shortest retest interval. The clinician line at ₹2.68 crore is 5.6% of revenue spent largely on telling people that nothing is wrong — the least commercial expenditure in the model and the one the customer actually bought. Other income of ₹1.04 crore is white-label platform fees, disclosed as a line and 2.2% of revenue. Two loss-making years are not a modelling artefact but the honest shape of D2C: acquisition is paid up front and repeat revenue arrives later, and an operator unwilling to fund that will reach for the retest cycle instead. Commitments of ₹7.28 crore against ₹3.84 crore of profit mean an operator with the same customer base running trade-standard practice would earn ₹11.12 crore.

12.5 Break-even & sensitivity

Scenario	Yr 3 revenue	Yr 3 PAT	Comment
Base	₹48.0cr	₹3.84cr	As modelled, 47 tests dropped, consultation included
Trade-standard — no included consultation, no PPV refusal, billing-cycle retesting	₹55.2cr	₹11.54cr	The category's model, computed rather than dismissed
Acquisition cost rises 30%	₹48.0cr	₹2.17cr	The sharpest exposure in a D2C model
Subscription retention falls a third	₹44.8cr	₹2.69cr	Repeat revenue is what repays acquisition
Self-collection menu cut further on validity evidence	₹45.8cr	₹2.97cr	The rule is allowed to cost money again
Abnormal rate 30% above model	₹48.0cr	₹3.34cr	More consultations, all of them included

13. Funding Requirement & Bankability

Source	₹ lakh	Terms (indicative)
Investor equity	720	Platform, brand and acquisition; PPV-threshold covenant
Term loan	440	Technology, kit tooling and logistics; 5 years
Promoter contribution	260	Cash and clinical leadership
Working capital facility	180	Inventory and corporate receivables
Total	1,600	Illustrative structure

An investor should read acquisition cost, repeat rate and the published PPV series, and should understand that the product rule is a deliberate ceiling on catalogue breadth rather than a failure of merchandising. The starkest number in the sensitivity table is that dropping the included consultation, the PPV refusals and the biological retest interval would take profit from ₹3.84 crore to ₹11.54 crore with the same brand, the same customers and the same laboratories — a change no customer could detect, no regulator specifies, and no competitor would think twice about. That is precisely why it is a covenant. Acquisition cost is the sharpest operating exposure at ₹2.17 crore for a 30% movement, because in D2C the customer is bought rather than referred. Two loss-making years must be funded deliberately rather than survived, since the pressure to shorten the retest interval arrives exactly when cash is tightest.

- **Use of funds** — 29% technology platform, 17% working capital, 15% laboratory and self-collection validation, 13% kit and logistics, 10% clinician network, 9% brand and acquisition, 5% quality infrastructure, 2% licences.
- **Repayment** — term loan from Year 3 cash flow; working capital revolving against inventory and corporate receivables.
- **Investor exit** — sale to a diagnostics chain, an insurer, a consumer-health group or a digital-health platform; or promoter buyback. **PPV publication, included consultation and retest-interval commitments survive change of control.**

14. Risk Analysis & Mitigation

Risk	Impact	Mitigation
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The test nobody ordered	A D2C wellness test HAS NO CLINICIAN AT EITHER END. Nobody decided the test was indicated, nobody will interpret it, and NOBODY OWNS THE CONSEQUENCE OF A FALSE POSITIVE. A well person buying a panel online has THE LOWEST PRE-TEST PROBABILITY IN THE VERTICAL AND THE THINNEST SUPPORT WHEN SOMETHING COMES BACK ABNORMAL — a PDF with a red arrow and no one to ask. The cascade that follows costs money and weeks of ordinary fear, ends in "it's nothing" for most, AND CLOSES COMMERCIALY, because relief is experienced as value received and the customer renews	MAKE THE MISSING MEASUREMENT AND LET IT REMOVE PRODUCTS. PPV MEASURED PER TEST IN OUR OWN D2C POPULATION — not the manufacturer's figure from a diseased cohort — PUBLISHED TEST BY TEST (100%). ANY TEST BELOW THE THRESHOLD DROPPED (47), NIL sold whose PPV we have not measured. A REAL CLINICIAN CONSULTATION INCLUDED IN THE PRICE FOR EVERY ABNORMAL RESULT, NEVER UPSOLD, salaried so the clinician is free to say nothing needs doing. CASCADE PUBLISHED: 77.6% ENDING IN NOTHING at a ₹4,200 median cost borne by the customer, worse than preventive checkup's 68.8% exactly as lower pre-test probability predicts, AND PRINTED ANYWAY (₹4.54cr). WHERE NO CLINICIAN ORDERED THE TEST AND NONE WILL READ IT, THE SELLER MUST SUPPLY BOTH ENDS OR NOT SELL THE TEST
The festive quarter and the panel below threshold	The speciality hormone panel sits 40% BELOW its PPV threshold on our own data. It SELLS BETTER THAN ANYTHING ELSE, every competitor lists it, a marketing calendar is already built on it, and withdrawing it takes a VISIBLE BITE OUT OF THE QUARTER for a reason NO CUSTOMER ASKED FOR AND NO REGULATOR REQUIRES	THE CATALOGUE SYSTEM CANNOT LIST A TEST FLAGGED BELOW THRESHOLD — a hard constraint with NO SEASONAL, CAMPAIGN OR EXECUTIVE OVERRIDE. THE SYSTEM REFUSES RATHER THAN WARNS. WITHDRAWALS PUBLISHED ALONGSIDE THE PPV DATA, because a brand that drops tests quietly and publishes only its survivors has produced A MARKETING DOCUMENT RATHER THAN A MEASUREMENT; and NO MARKETING OR GROWTH PAY IS LINKED TO PANEL SIZE, ORDER VALUE OR RETEST FREQUENCY
The sample nobody watched	A fingerprick taken by the customer has NO TRAINED HAND, NO TOURNIQUET DISCIPLINE, NO ORDER OF DRAW AND NO OBSERVER — and haemolysis, insufficient volume, finger-squeezing and delayed return corrupt SPECIFIC ANALYTES IN SPECIFIC DIRECTIONS, invisibly	SELF-COLLECTION REJECTION RATE PUBLISHED at 6.8% (from 14.2%) WHILE STILL EMBARRASSING; ANALYTE-SPECIFIC VALIDITY PUBLISHED for every analyte offered; 22 ANALYTES WITHDRAWN BECAUSE SELF-COLLECTION CANNOT SUPPORT THEM while competitors still sell them; and every unusable kit REFUNDED AND REPLACED WITHOUT ARGUMENT (100%), because a rejection the customer pays for is a rejection they will not report (₹94L)
A score with no reference standard	"BIOLOGICAL AGE", "WELLNESS SCORE" AND "OPTIMISATION" are composite numbers NOBODY CAN BE WRONG ABOUT, because there is NOTHING TO BE WRONG AGAINST — which is exactly why the category likes them, and exactly what the Drugs and Magic Remedies Act constrains	EVERY SCORE PUBLISHED WITH ITS FORMULA AND INPUT WEIGHTS OR NOT PUBLISHED AT ALL; NIL scores issued without one; 100% of claims stated as A MEASURED QUANTITY; and NIL unfalsifiable claims — "optimise", "detox", "balance" — in any marketing. The Act and the ASCI code read literally rather than navigated, with advertising review before every campaign (₹68L)
The subscription that retests a healthy person quarterly	Most analytes have a BIOLOGICAL VARIATION WIDE ENOUGH THAT A THREE-MONTH CHANGE IS NOISE, and the customer READS NOISE AS A TREND while the business bills four times a year	RETEST INTERVALS SET BY BIOLOGICAL VARIATION PER ANALYTE, not by the billing cycle; NIL customers retested sooner than the analyte justifies; 38% OF SUBSCRIPTION REMINDERS SUPPRESSED where no retest is indicated — giving up the mechanic the model is built on; median interval 6.0 → 11.2 months (₹1.12cr)

A wellness panel is a diagnosis	Health data of the most sensitive kind, with D2C checkout consent THE WEAKEST IN THIS VERTICAL — and in corporate programmes the employer paid but the employee was tested	NIL data sold, shared or segmented; NIL individual results to a corporate buyer; aggregate minimum group size 25; every employee able to decline WITHOUT THE EMPLOYER LEARNING THEY DECLINED; reporting laboratory named on every report per the vertical anchor
Acquisition cost, repeat rate and funding the loss years	A 30% rise in acquisition cost takes profit to ₹2.17cr; retention falling a third takes it to ₹2.69cr; and two loss-making years must be funded deliberately	Repeat rate driven 24% → 58% and reported as the primary operating metric; corporate and insurer contracts as lower-CAC volume; white-label revenue at 74% margin; and loss years funded up front, since the pressure to shorten retest intervals arrives when cash is tightest

15. SWOT Analysis

Strengths • PPV published per test in our own D2C population • 47 tests dropped for failing the threshold • Clinician consultation included, never upsold • Self-collection validity published; 22 analytes withdrawn • Every score published with its formula	Weaknesses • ₹7.28cr forgone against ₹3.84cr of profit • Visibly shorter menu on any comparison page • Two loss-making years before Year 3 • Suppresses 38% of its own retest reminders
Opportunities • Customers who have been frightened by a result before • Insurers and employers wanting yield, not test counts • White-label contracts carrying our rules with them • Any advertising enforcement on wellness claims favours us • Clinicians seeking salaried consumer-health work	Threats • Competitors selling breadth at lower cost per test • Acquisition cost inflation across digital channels • Self-collection evidence forcing further menu cuts • Partner-laboratory turnaround and consistency

16. Recommended AiSevak Tools for This Business

- **PPV threshold gate** — a test below its measured threshold cannot be listed; no override role exists.
- **Own-population PPV engine** — measures predictive value per test in our customers, not in a manufacturer's cohort.
- **Cascade tracker** — follows every abnormal result to outcome and publishes the null rate.
- **Consultation router** — books a salaried clinician on every abnormal result, at no extra charge.
- **Self-collection validity register** — analyte-level evidence, with withdrawal when it fails.
- **Formula publisher** — no score ships without its inputs and weights disclosed.
- **Retest-interval calculator** — biological variation per analyte, with reminder suppression built in.

17. Key Assumptions & Notes

- **All financials are illustrative model assumptions, not forecasts, projections or guarantees.** Revenue, customer counts, acquisition cost, repeat rate, PPV thresholds, abnormal rates and rejection rates are editable inputs; actual outcomes depend on channel economics, laboratory partnerships, advertising enforcement and consumer demand. Figures are in Indian rupees. **This plan inherits the diagnostics vertical's anchor rules and extends the**

preventive-checkup finding to its limiting case.

- **The central integrity finding is that a direct-to-consumer wellness test has no clinician at either end.**

Nobody assessed whether the test was indicated, nobody will interpret the result, and nobody is responsible for what the customer does next — so the entire apparatus of clinical justification, pre-test probability and follow-up that the rest of this vertical relies on is simply absent. **A well person buying a panel on the internet has the lowest pre-test probability of any customer in this vertical and the least support when something comes back abnormal, and the category markets itself in language that is unfalsifiable rather than false.**

- **So the missing measurement is made and allowed to remove products.** PPV is measured per test in the population we actually serve — not the manufacturer's figure from a diseased cohort, which is a different number entirely — and published test by test, reaching 100% of the menu. Any test below the published threshold is dropped: 47 by Year 3, with nil tests sold whose PPV we have not measured. **A real clinician consultation is included in the price for every abnormal result, at a seven-hour median, from a salaried clinician who is free to say that nothing needs doing — and the cascade is tracked and published, with 77.6% ending in nothing at a ₹4,200 median cost borne by the customer. It costs ₹4.54 crore. WHERE NO CLINICIAN ORDERED THE TEST AND NONE WILL READ IT, THE SELLER MUST SUPPLY BOTH ENDS OR NOT SELL THE TEST.**
- **A sample collected by an untrained person at a kitchen table is the pre-analytical problem with no phlebotomist at all.** There is no trained hand, no tourniquet discipline, no order of draw and no observer, and haemolysis, insufficient volume, finger-squeezing and delayed return corrupt specific analytes in specific directions. **So the self-collection rejection rate is published at 6.8% while it is still embarrassing, analyte-specific validity is published for every analyte offered, 22 analytes have been withdrawn because self-collection cannot support them, and every unusable kit is refunded and replaced without argument — because a rejection the customer pays for is a rejection they will not report.**
- **A wellness score is a composite number with no reference standard.** Nobody can be wrong about a biological age because there is nothing to be wrong against, which is precisely why the category likes it and precisely what the Drugs and Magic Remedies Act constrains. **Every score is published with its formula and input weights or it is not published at all; nil scores are issued without one; every claim is stated as a measured quantity; and nil unfalsifiable claims appear in our marketing.**
- **A subscription that retests a healthy person quarterly is billing rather than medicine.** Most analytes have a biological variation wide enough that a three-month change is noise, and the customer reads noise as a trend. **So retest intervals are set by biological variation per analyte, nil customers are retested sooner than the analyte justifies, 38% of subscription reminders are suppressed where no retest is indicated, and the median interval has moved from 6.0 to 11.2 months — a subscription business giving up the mechanic the model is built on.**
- **The economics are the honest weakness of this plan rather than its strength.** Gross margin at 47.6% looks healthy and net margin at 8.0% is thin, because acquisition and an included clinician both sit below the gross line: this is a business that must buy every customer and then spend money telling a good share of them that nothing is wrong. **Marketing runs at 42.9% of revenue in Year 1 and 15.5% by Year 3, there are two loss-making years, and the starkest figure in the model is that dropping the included consultation, the PPV refusals and the biological retest interval would take profit from ₹3.84 crore to ₹11.54 crore with the same brand, the same customers and the same laboratories.** Commitments of ₹7.28 crore against ₹3.84 crore of profit mean a trade-standard operator would earn ₹11.12 crore, and acquisition cost rising 30% takes profit to ₹2.17 crore.
- **Compliance and professional advice.** The Drugs and Magic Remedies (Objectionable Advertisements) Act 1954 and ASCI codes, which constrain precisely the language on which this category markets itself; the Consumer Protection Act 2019 and its e-commerce rules, under which a health claim in a product listing is an actionable representation; the Clinical Establishments Act 2010 and state rules for collection and laboratory operations; NABL accreditation for partner laboratories, with the reporting laboratory named on every report; **the Digital Personal Data Protection Act 2023,**

under which a wellness panel is health data of the most sensitive kind and D2C checkout consent is the weakest consent in this vertical; the NMC Telemedicine Practice Guidelines for the included consultation; PCPNDT where any analyte could touch it; Legal Metrology and BIS for kit packaging; and EPF/ESI and POSH. **Nothing requires a seller of direct-to-consumer tests to know, let alone publish, how often its abnormal results mean anything — which is why the PPV threshold is a business decision rather than a compliance one.** Professional advice should be taken on advertising claims, consumer representations, data consent design and laboratory contracting.

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