

Acko Group Health OPD Wallet Policy Terms & Conditions

1 Preamble

We will provide the insurance cover specified in the Policy to the Insured Persons up to the Sum Insured specified against each Benefit, subject to (i) the terms, conditions and exclusions of this Policy, (ii) the receipt of premium as specified in the Policy Schedule / Certificate of Insurance, (iii) the statements in the proposal and information disclosed to Us, made by You or on Your behalf, and on behalf of all persons to be insured, which is incorporated into the Policy and forms the basis of it.

The group administrator's/Master Policyholder's role is that of only a facilitator in offering a group cover and facilitating insurance services including claims from a central point, except where Cashless Facility is available and claim payments are made in accordance.

This Policy is valid for the period as specified in the Policy Schedule / Certificate of Insurance. An Insured Person's coverage under the Policy is valid only during the Coverage Period specified in the Certificate of Insurance.

The terms listed in Section 7 (Definitions) and which have been used elsewhere in the Policy in Initial Capital letters shall have the meaning set out against them in Section 7, wherever they appear in the Policy.

2 Health Wallet

Health Wallet is a digital wallet extended by Us to the Insured Person(s) only to avail any of the Benefits specified to be available to the Insured Person under the Policy on a Cashless Facility or reimbursement basis. The Insured Persons will be provided with access to the Health Wallet on the Service Provider Platform, in which the Sum Insured will be loaded at the time of Policy issuance as mentioned in the Policy Schedule / Certificate of Insurance, and adjusted through the course of the Coverage Period to display the remaining Sum Insured available under the Policy.

2.1 Health Wallet Utilization Rules

The following rules are applicable for the utilization of the Health Wallet under the Policy:

- i. The currency of issue of the Health Wallet will be Indian Rupees only.
- ii. The Health Wallet can only be used by the Insured Person(s) covered under the Policy, for the Coverage Period specified in the Policy Schedule / Certificate of Insurance.
- iii. Any unutilized amount in the Health Wallet will not be carried forward to any subsequent Policy Year.
- iv. The amount in the Health Wallet is non-transferable to any bank account or any other wallet or to any other person.

In case a covered Benefit is availed on the Service Provider Platform on a Cashless Facility basis, an amount as specified in the Schedule of Cost in the Policy Schedule / Certificate of Insurance for the Benefit (indicating the value of such services availed), will be deducted from the Health Wallet.

In case an Insured Person is unable to avail the Cashless Facility, the expenses towards availing the covered Benefits will be reimbursed up to the applicable limit and an equal amount will be deducted from the Health Wallet.

The balance Sum Insured remaining in the Health Wallet after availing a Benefit or receiving a reimbursement for expenses for a covered Benefit will be calculated based on the above rules after each valid and applicable claim is approved under the Policy.

Claims made in respect of an Insured Person for any of the Benefits applicable to the Insured Person shall be subject to the applicable Sub-Limits/ Co-Payment /Deductibles/other conditions specified for

the Benefits, applicable Waiting Periods (if any), as specified in Policy Schedule / Certificate of Insurance and the terms, conditions and exclusions of this Policy.

We will pay only those costs that are Reasonable and Customary Charges.

All claims must be made in accordance with the procedure set out in Section 5.

3 Benefits

The Policy Schedule / Certificate of Insurance will specify which Benefits/Cover Options are in force for the Insured Person under the Policy.

Basis of Coverage

The Sum Insured available for the Benefits applicable to the Insured Person in this Section may be either on an Individual or Floater basis as specified in the Policy Schedule / Certificate of Insurance.

When the Insured Person's cover under the Policy is on an Individual basis, Our maximum, total, and cumulative liability for any and all claims made with respect to the Insured Person will be up to the Sum Insured for the Benefits specified to be in force for the Insured Person.

When the Insured Person's cover under the Policy is on a Floater basis, Our maximum, total, and cumulative liability for any and all claims made with respect to all the Insured Persons of the Floater unit will be up to the Sum Insured specified for each Benefit. The details of all Insured Persons constituting the Floater unit, if applicable, and other conditions applicable for the Sum Insured on a Floater basis will be as specified in the Policy Schedule / Certificate of Insurance.

3.1 Online Consultation

If an Insured Person avails an Online Consultation during the Coverage Period, We will pay for or reimburse the reasonable and necessary cost incurred for such consultation, and any allied costs specified to be covered in the Certificate of Insurance.

We shall not be liable to pay:

- a. Any charges incurred towards the recommendations provided through the Online Consultation other than those specified to be covered in the Certificate of Insurance.
- b. Any discrepancy in the information provided under this Benefit, and the Medical Advice shall be relied upon by the Insured Person purely upon his/her own discretion.

3.2 Physical Consultation

If an Insured Person avails a Physical Consultation during the Coverage Period, We will pay for or reimburse the reasonable and necessary cost incurred for such consultation, and any allied costs specified to be covered in the Certificate of Insurance.

We shall not be liable to pay:

- a. Any charges incurred towards the recommendations provided through the Physical Consultation other than those specified to be covered in the Certificate of Insurance.
- b. Any discrepancy in the information provided under this Benefit, and the Medical Advice shall be relied upon by the Insured Person purely upon his/her own discretion.

3.3 Prescribed Diagnostic Tests

If an Insured Person undergoes Diagnostic Test(s) prescribed by a Medical Practitioner during the Coverage Period, We will pay for or reimburse the reasonable and necessary cost incurred for such test(s).

3.4 Prescribed Pharmacy

If an Insured Person purchases medicines or drugs prescribed by a Medical Practitioner during the Coverage Period, We will pay for or reimburse the cost of such purchase.

3.5 Preventive Health Check-Up

If an Insured Person undergoes preventive Diagnostic Test(s) / medical examination specified in the Schedule / Certificate of Insurance during the Coverage Period, We will pay for or reimburse the reasonable and necessary cost incurred for such test(s) / examination.

3.6 Outpatient Treatment

If an Insured Person avails a Medically Necessary Treatment in an OPD facility of a Hospital or Clinic for any of the treatments covered under the Policy as specified in the Schedule / Certificate of Insurance, We will pay for or reimburse the reasonable and necessary cost incurred for such treatment.

3.7 Vaccination

If an Insured Person takes a medically necessary Vaccination as specified in the Schedule / Certificate of Insurance during the Coverage Period, We will pay for or reimburse the reasonable and necessary cost incurred for such Vaccination.

3.8 Outpatient Dental Treatment

We will pay for or reimburse the reasonable and necessary cost incurred for any of the benefits specified below, if specified to be applicable and in-force in the Certificate of Insurance.

Sr No.	Name of Benefit	What is covered
1	Emergency Dental Services Benefit	Treatment to relieve or stabilize severe pain, swelling or uncontrollable bleeding.
2	Preventive Dental Services	Oral examination, teeth cleaning and fluoride treatment
3	Dental Radiology Benefit	Bitewing intraoral x-ray, posterior/anterior or lateral skull, and facial bone survey x-ray and panoramic x-ray
4	OPD Dental Consultation	Cost of consultations for a Dental Treatment
5	Conservative Benefits (Filings)	Filing of following type: <ul style="list-style-type: none"> • amalgam, 1-2 surfaces, permanent or • composite/resin, 1-2 surfaces, permanent
6	Extraction Benefit (non-surgical)	Simple extraction or complicated extraction
7	Endodontic Benefit (Root Canal Treatment)	Root canal or therapeutic pulpotomy (excluding final restoration)

3.9 Eye Care

We will pay for or reimburse the reasonable and necessary cost incurred for any of the benefits specified below, if specified to be applicable and in-force in the Certificate of Insurance.

Sr No.	Name of Benefit	What is covered
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1	Eye Care Consultation	Cost of eye examination/consultations
2	Eye Care (change in eye power)	Cost of contact lenses or spectacles (due to a change in eye power)
3	Eye Care OPD	Cost of contact lenses or spectacles (due to any damage or crack)

3.10 Medical Equipment Cover

If an Insured Person purchases a medically necessary Medical Equipment specified to be covered in the Schedule / Certificate of Insurance during the Coverage Period, We will pay for or reimburse the reasonable and necessary cost incurred for such purchase, provided that the same is recommended in writing to the Insured Person by a Medical Practitioner.

3.11 Limit of Reimbursement

If this Benefit is in force for the Insured Person, the Insured Person can claim under a Benefit for reimbursement of any costs and expenses incurred, only up to the limits as specified in the Policy Schedule or Certificate of Insurance on reimbursement basis.

Cover Options

1. Additional Buffer Sum Insured for the Group

If this Cover Option is opted for under the Policy and specified to be applicable in the Policy Schedule / Certificate of Insurance, We will provide a separate amount specified in the Policy Schedule / Certificate of Insurance as additional Sum Insured available to the Insured Members of the Policy who have exhausted their Sum Insured in the current Policy Year. This Sum Insured is at the Group level on a Floater basis as per the conditions specified in the Policy Schedule / Certificate of Insurance, provided that:

- a. Any Benefit accrued under this cover cannot be carried forward to the subsequent Coverage Period.
- b. All other terms, exclusions and conditions contained in the Policy or endorsed thereon remain unchanged.

2. Group Deductible

If this Cover Option is opted for under the Policy and specified to be applicable in the Policy Schedule / Certificate of Insurance, any claim under the Benefits available to the Insured Person under the Policy will be payable to the Insured Person(s) only when the total admissible claim amount for all members of the Group during the Policy Year exceeds the amount specified as 'Group Deductible' in the Policy Schedule / Certificate of Insurance, and subject to other conditions under this Cover Option in the Policy Schedule / Certificate of Insurance, provided that:

- a. For the purpose of calculating the Group Deductible amount, and assessment of admissibility, all claims must be submitted in accordance with the claims process in Section 5 and Section 6 of the Policy, as applicable.
- b. The consumption of the Group Deductible amount will be on the basis of the admissible claim amount after applying the Sub-Limits as per of the Policy Schedule / Certificate of Insurance.

4 Waiting Periods and General Exclusions

We shall not be liable to make any payment under this Policy arising out or caused by any of the following. All the waiting period shall be applicable individually for each Insured Person except if you suffer an accident and claims shall be assessed accordingly.

4.1 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 number of months, as specified in the Schedule, 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 number of months, as specified in the Schedule, for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

Note: We will cover all Pre-Existing Diseases disclosed by the persons to be insured immediately after the expiry of the forty-eight months waiting period or such lower period as stipulated in the Schedule.

4.2 General Exclusions

We shall not be liable to make any payment for any claim in respect of any Insured Person arising from or caused by any of the following unless expressly stated to the contrary in this Policy:

Sr No.	Name of Exclusion	Discription
1	Hospitalization cover	In-patient care and day care treatments will not be covered
2	Alternative Treatment	Naturopathy treatment(s) will not be covered
3	Cosmetic Treatment / Nutrition	Consultations with respect to any nutrition, obesity or cosmetic treatments, or any other treatments which are not medically necessary
4	Breach of Law with Criminal Intent, Suicide and Self-Injury	Treatment directly or indirectly arising from or contributed or aggravated or accelerated by any of the following: a. Suicide or attempted suicide, while sane or insane, or due to use, misuse or abuse of narcotic or intoxicating drugs or alcohol or solvent b. Intentional self-injury c. Breach of Law: Code-Excl10 - Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent. e. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code-Excl12 (except under the direction of a Medical Practitioner)
5	External Congenital Anomaly	External Congenital Anomalies or in consequence thereof

6	Hazardous or AdventureSports	<p>Hazardous or Adventure sports: Code-Excl09: Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.</p>
7	Maternity Expenses	<p>Maternity: Code- Excl18</p> <ul style="list-style-type: none"> a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy; b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.
8	Medical Practitioner Related	<p>Any certification provided by a Medical Practitioner who shares the same residence as the Insured Person or who is a member of the Insured Person's family</p>

5 Claims Procedure & Requirements

All claims must be availed and reported to Us in the manner specified in this Section. Failure to follow these processes may render a claim inadmissible.

For details on the claims procedures and requirements or any assistance during the process, We may be contacted at Our call centre on the toll free number specified in the Policy Schedule or through Our website.

5.1 Condition Precedent

The fulfilment of the terms and conditions of this Policy (including the realisation of premium by their respective due dates) in so far as they relate to anything to be done or complied with by You/Insured Person, including complying with the following steps, shall be Condition Precedent to Our liability under this Policy and admissibility of a claim.

Completed claim forms and the necessary processing documents must be furnished to Us within 30 days for all claims. Failure to furnish this documentation within the time required shall not invalidate nor reduce any claim if You / Insured Person can satisfy Us that it was not reasonably possible for You/Insured Person to submit the required forms/documents within such time.

The due intimation, submission of documents and compliance with requirements as provided under the Claims Procedure set out under this Section by the Insured Person shall be essential failing which, We shall not be bound to accept a claim.

5.2 Policyholder's / Insured Person's Duty at the time of Claim

On occurrence of an event which may lead to a claim under this Policy, the Insured Person shall:

- i. Forthwith intimate, file and submit the claim form and documents as prescribed
- ii. If so, requested by Us, the Insured Person must submit himself / herself for a medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary. The cost of such examination will be borne by Us.
- iii. Allow the Medical Practitioner or any of Our representatives to inspect the medical and hospitalization records, investigate the facts and examine the Insured Person.
- iv. Assist and not hinder or prevent Our representatives in pursuance of their duties for ascertaining the admissibility of the claim, its circumstances and its quantum under the provisions of the Policy.

5.3 Claim Process

Upon the discovery or occurrence of an Illness / Injury or any other contingency that may give rise to a claim under this Policy, then as a Condition Precedent to Our liability under the Policy, the Insured Person must notify Us either at the call centre or in writing or by way of any claims intimation process extended by Us, such as the Servicer Provider Platform, and duly undertake the following.

For Cashless Claims

The Insured Person can avail Cashless Facility through the Service Provider Platform or by visiting Our Network Provider.

For all Cashless Facility authorisations, the Insured Person will, in any event, be required to settle all non-admissible expenses, any expenses above the specified Sub Limit (if applicable), Co-Payment and / or opted Deductible (Per claim / Aggregate / Group) (if applicable), directly with Our Network Provider.

(a) Claim through Service Provider Platform:

Acko General Insurance Limited

The Insured Person may visit the Service Provider Platform, as extended to the Insured Person by Us, and utilise or schedule an appointment for utilizing the services provided in relation to the Benefits under the Policy (such as consultation, diagnostic tests, health check-up and pharmacy). If such services under a Benefit(s) are utilised or an appointment is scheduled through Us for utilising the services on the Service Provider Platform, then the claim under the respective Benefit shall be deemed to be pre-authorized by Us, and such services will be provided on a Cashless Facility basis, up to the amount specified in the Policy Schedule / Certificate of Insurance against such Benefit. For Benefits utilized or booked through the Service Provider Platform, the Insured Person is not required to intimate or file the claim separately.

(b) Claims in our Network Provider:

The Insured Person can directly avail Cashless Facility from Our Network Provider with the help of various intimation mechanism including call centres/ mails.

The Insured Person may get a pre-authorization from Us before visiting the Network Provider or directly walk-in to the facility. The Insured Person will need to present the Policy details as provided by Us with this Policy or a pre-authorization for the claim received from Us, along with a photo identification proof (voter ID card / driving license / passport / PAN card / any other identity proof as approved by Us) to Our Network Provider to initiate the Cashless Facility.

If the claim is not pre-authorized, the Network Provider shall forward the request for authorisation to Us. Once We approve the request, the Insured Person can avail of Cashless Facility at our Network Provider.

The Network Provider will send the claim documents along with the invoice and discharge voucher, duly signed by the Insured Person directly to Us. The following claim documents should be submitted to Us within 15 days from the date of availing the services under the Benefit from the Network Provider–

- i. The claim form duly completed and signed;
- ii. Original pre-authorization request (if required);
- iii. Copy of pre-authorization approval letter (if required);
- iv. Copies of valid KYC documents of the Nominee/ claimant (such as Passport/ PAN Card/ Aadhar number etc);
- v. Copy of FIR/ MLC, in case of accident (if applicable);
- vi. Name and address of the attending Medical Practitioner;
- vii. Medical reports, case histories, investigation reports, treatment papers, Bills as applicable;
- viii. Additional documents required with respect to other coverages will be requested as and when required (if applicable).

For Reimbursement claim:

If the Insured Person is not able to obtain a pre-authorization of any Claim for utilising or scheduling an appointment for utilizing the services under the Service Provider Platform, the Insured Person can avail the services available under a Benefit(s) from any of Our Network Providers. We will consider such claims on a reimbursement basis, and the Insured Person may file a reimbursement claim directly with Us by sharing the applicable claim documents as specified below:

- i. The claim form duly completed and signed;
- ii. Copies of valid KYC documents of the Nominee/ claimant (such as Passport/ PAN Card/ Aadhar number etc);
- iii. Copy of FIR/ MLC, in case of accident (if applicable);
- iv. Name and address of the attending Medical Practitioner;
- v. Medical reports, case histories, investigation reports, treatment papers, Bills as applicable;
- vi. Additional documents required with respect to other coverages will be requested as and when required (if applicable).

5.4 Scrutiny of Claim Documents

- i. We shall scrutinise the claim form and the accompanying documents. Any deficiency in the documents shall be intimated to the Insured Person / Network Provider as the case may be.
- ii. If the deficiency in the necessary claim documents is not met or are partially met in 10 working days of the first intimation, We shall remind the Insured Person/Network Provider of the same every 10 (ten) days thereafter.
- iii. We will send a maximum of 3 (three) reminders.
- iv. We may, at Our sole discretion, decide to deduct the amount of claim for which deficiency is intimated to the Insured Person and settle the claim if we observe that such a claim is otherwise valid under the Policy.

5.5 Claims Investigation

We shall make the payment of admissible claim (as per terms and conditions of the Policy) OR communicate Our rejection/non admissibility of claim under the Policy within 30 days of submission of all necessary documents and information and any other additional information required for the settlement of the claim.

All claims which in Our view require an investigation, will be investigated and settled in accordance with the applicable regulatory guidelines, including the IRDAI (Protection of Policyholders Interests) Regulations, 2017. Where the circumstances of a claim warrant an investigation in Our opinion, We shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, We shall settle or reject the claim, as may be the case, within 30 days from the date of receipt of last necessary document.

5.6 Settlement and Repudiation of a claim

We shall settle the claim within 30 days from the date of receipt of last necessary document in accordance with the provisions of the IRDAI (Health Insurance) Regulations, 2016, as amended from time to time. In the case of delay in the payment of a claim We shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate. However, where the circumstances of a claim warrant an investigation in Our opinion, We shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, We shall settle the claim within 45 days from the date of receipt of last necessary document. In case of delay beyond stipulated 30 days We shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

5.7 Representation against Rejection

Where a rejection is communicated by Us, the Insured Person may, if so desired, within 15 days from the date of receipt of the claim's decision represents to Us for reconsideration of the decision.

5.8 Claim Payment Terms

- i. We shall have no liability to make payment of a claim under the Policy in respect of an Insured Person once the Sum Insured for that Insured Person (as well as any additional Sum Insured available for the Insured Person under an applicable Cover Option) is exhausted.
- ii. All claims will be payable in India and in Indian rupees only.
- iii. The Sum Insured opted under the Policy shall be reduced by the amount payable / paid under the Policy as per the Schedule of Cost and any Cover Options applicable under the Policy and only the balance shall be available as the Sum Insured for the unexpired Coverage Period or Policy Year, as the case may be.



- iv. If any claim is not made within the time period set out under the Policy, then We will condone such delay on merits only where the delay has been proved to be for reasons beyond the claimant's control.

6 General Terms & Conditions

- a. **Condition Precedent & Premium Payments:** The fulfilment of the terms and conditions of this Policy including the payment of premium by the due dates mentioned in the Schedule or the Certificate of Insurance and the correct disclosures in a complete manner in the proposal form insofar as they relate to anything to be done or complied with by You or any Insured Person shall be Conditions Precedent to Our liability. The premium for the Policy will remain the same for the Policy Period.
- b. **Disclosure to Information Norm:** This Policy has been issued on the basis of the Disclosure to Information Norm, including the information provided in respect of the Insured Persons in the Proposal Form, personal statement and any other details submitted in relation to the Proposal Form/personal statement. If at the time of issuance of Policy or during continuation of the Policy, any material fact in the information provided to Us in the Proposal Form or otherwise, by You or the Insured Person, or anyone acting on behalf of You or an Insured Person is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy/Certificate of Insurance shall be void and no benefit will be payable thereunder.
- c. **Dishonest & Fraudulent Claims:** If any claim is in any manner dishonest or fraudulent, or is supported by any dishonest or fraudulent means or devices, whether by You or any Insured Person or anyone acting on behalf of You or an Insured Person, then this Policy/Certificate of Insurance will be void and all benefits otherwise payable under it will be forfeited.
- d. **Material Information:** Material information to be disclosed includes every matter that You are aware of, or could reasonably be expected to know, that relates to questions in the Proposal Form/personal statement and which is relevant to Us in order to accept the risk of insurance. You must exercise the same duty to disclose those matters to Us before the Renewal, extension, variation, endorsement of the contract. We may, adjust the scope of cover and / or premium, if necessary, accordingly.
- e. **Geography & Policy Currency:** This Policy applies to events or occurrences taking place in India only, unless specified otherwise in the Certificate of Insurance. All payments payable under this Policy will be settled in Indian Rupees (INR) only, unless specified otherwise in the Schedule.
- f. **Insured Person:** Only those persons named as Insured Persons in the Certificate of insurance shall be covered under this Policy. Any eligible person may be added at Renewal after his application has been accepted by Us and premium has been received. Member addition is allowed only at Renewal and not during the Policy Period. Any Insured Person in the Policy has the option to migrate to similar indemnity health insurance policy available with Us at the time of Renewal subject to underwriting with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period etc. provided the policy has been maintained without a break as per the IRDAI's guidelines on portability, as amended from time to time.
If an Insured Person dies, he will cease to be an Insured Person upon Us receiving all relevant particulars in this regard. We will refund the premium on pro rata basis received for such person IF AND ONLY IF there are no claims in respect of that Insured Person under the Policy.
- g. **Alterations to the Policy:** This Policy constitutes the complete contract of insurance. This Policy cannot be changed by anyone (including an insurance agent or broker) except Us. Any change that We make will be evidenced by a written endorsement signed and stamped by Us.
- h. **Product Withdrawal:** Where we allow lower waiting period for the Pre Existing Diseases (PEDs) (say 12 / 24 / 36 months), in the event of withdrawal of the said product, we will give credit to the accrued waiting period benefits of PEDs gained under the withdrawn product and allow coverage on any of the health products available in his product portfolio with no additional waiting period beyond the chosen PED period of the withdrawn product.
- i. **Grace Period & Renewal:** The Policy may be renewed by mutual consent and in such event the Renewal premium should be paid to Us on or before the date of expiry of the Policy and in no case later than the Grace Period of 30 days from the expiry of the Policy. We will not be liable to pay for any claim arising out of an injury or accident that occurred during the Grace Period.

The Policy shall ordinarily be Renewable (provided the product is not withdrawn) except on the grounds of misrepresentation, moral hazard, fraud, non-disclosure of material facts or non-cooperation by the Insured Person. We may, revise the Renewal premium payable under the Policy or the terms of cover, provided that all such changes are approved in accordance with the IRDAI rules and regulations as applicable from time to time. Renewal premium will not alter based on individual claims experience. We will intimate You of any such changes at least 3 months prior to date of such revision or modification.

- j. **Change of Policyholder:** The Policyholder may be changed only at the time of renewal. The new policyholder must be a member of the Insured Person's immediate family. Such change would be subject to Our acceptance and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

The Policyholder may be changed in case of his demise or him moving out of India during the Policy Period.

- k. **Free Look Period:** You have a period of 15 days from the date of receipt of the Policy document to review the terms and conditions of this Policy. If You have any objections to any of the terms and conditions, You have the option of cancelling the Policy stating the reasons for cancellation and You will be refunded the premium paid by You after adjusting the amount spent on any medical check-up, stamp duty charges and proportionate risk premium. You can cancel Your Policy only if no claims have been made under the Policy. All Your rights under this Policy will immediately stand extinguished on the free look cancellation of the Policy. Free look provision is not applicable and available at the time of Renewal of the Policy.

l. Cancellation/Termination of the Policy (other than cancellation in the Free Look Period):

- i. You may terminate this Policy at any time by giving Us written notice, and the Policy will terminate when such written notice is received. If no claim has been made under the Policy, then We will refund premium in accordance with the table below:

CANCELLATION PERIOD	% OF PREMIUM
Within 25% of the Coverage Period	60%
25%-50% of the Coverage Period	40%
50%-75% of the Coverage Period	20%
Exceeding 75% of the Coverage Period	0%

- ii. We may at any time terminate this Policy on grounds of misrepresentation, fraud or non-disclosure of material facts by You or any Insured Person upon 30 days' notice by sending an endorsement to Your address shown in the Schedule without refund of premium.

- m. **Governing Law & Dispute Resolution:** Any and all disputes or differences under or in relation to this Policy will be determined by the Indian Courts and subject to Indian law.

- n. **Notices & Communications:** Any notice or communication in relation to this Policy will be in writing and if it is to:

- i) You or any Insured Person, then it will be sent to You at Your address specified in the Schedule and You will act for all Insured Persons for these purposes.
- ii) Us, it will be delivered to Our address specified in the Schedule. No insurance agents, insurance intermediaries or other person or entity is authorised to receive any notice or communication on Our behalf.

- o. **Electronic Transactions:** You agree to comply with all the terms and conditions of electronic transactions as We shall prescribe from time to time, and confirm that all transactions effected facilities for conducting remote transactions such as the Internet, World Wide Web, electronic data interchange, call centres, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, in respect of this Policy and claim related details, shall constitute legal binding when done in compliance with Our terms for such facilities.

- p. **Assignment:** The Policy and the benefits under this Policy can be assigned in only in accordance with applicable law.

7 Definitions

The terms defined below have the meanings ascribed to them wherever they appear in this Policy and, where appropriate, references to the singular include references to the plural; references to the male include references to the female and references to any statutory enactment include subsequent changes to the same:

- a. **Cashless Facility:** Cashless Facility means a facility extended by Us 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 service provider by Us.
- b. **Certificate of Insurance:** Certificate of Insurance means the certificate issued to the Insured Person confirming the Insured Person's cover under the Policy.
- c. **Clinic:** Clinic means an establishment or hospital department where outpatients are given medical treatment or advice, especially of a specialist nature.
- d. **Condition Precedent:** Condition Precedent means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
- e. **Congenital Anomaly:** Congenital Anomaly means 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.
- f. **Cover Option:** Cover Option means an additional benefit or condition which applies to the Insured Person. The Certificate of Insurance will specify the Cover Options which are applicable to the Insured Person under the Policy.
- g. **Coverage Period:** Coverage Period means the period specified in the Certificate of Insurance which commences on the coverage commencement date specified in the Certificate of Insurance and ends on the coverage expiry date specified in the Certificate of Insurance.
- h. **Deductible:** Deductible means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified 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.
- i. **Dental treatment:** Dental treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
- j. **Diagnostic Test(s):** A diagnostic test is a procedure performed to confirm or determine the presence of disease in an individual suspected of having a disease, usually following the report of symptoms, or based on other medical test results. This includes posthumous diagnosis.
- k. **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.
- l. **Grace Period:** Grace period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss

of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

- m. **Hazardous Activities:** Hazardous Activities means any sport or activity, which is potentially dangerous to the Insured Person whether he is trained in such sport or activity or not. Such sport/activity includes without limitation stunt activities of any kind, adventure racing, base jumping, biathlon, big game hunting, black water rafting, BMX stunt/obstacle riding, bobsleighting/using skeletons, bouldering, boxing, canyoning, caving/pot holing, cave tubing, rock climbing/trekking/mountaineering, cycle racing, cyclo cross, drag racing, endurance testing, hand gliding, harness racing, hell skiing, high diving (above 5 meters), hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, lugging, risky manual labour, marathon running, martial arts, micro-lighting, modern pentathlon, motor cycle racing, motor rallying, parachuting, paragliding/parapenting, piloting aircraft, polo, power lifting, power boat racing, quad biking, river boarding, scuba diving, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo riding, ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting or wrestling any type.
- n. **Hospital:** A hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under:
 - i. has qualified nursing staff under its employment round the clock;
 - ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 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.
- o. **Insured Person:** Insured Person means the person named in the Certificate of Insurance who is covered under this Policy.
- p. **Medical Advice:** Medical Advice means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
- q. **Medical Equipment:** The medical equipment is equipment required by the Insured Person on the advice of a Medical Practitioner including hearing aids, instrument used in the treatment of Sleep Apnoea Syndrome, Oxygen Concentrator for Bronchial Asthmatic condition, infusion pump or any other external devices, Prostheses, corrective devices and Medical Appliances, which are not required intra-operatively.
- r. **Medical Expenses:** Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of illness or accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.
- s. **Medical Practitioner:** Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.
- t. **Medically Necessary Treatment:** Medically necessary treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
 - i. is required for the medical management of the illness or injury suffered by the insured;
 - ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

- iii. must have been prescribed by a medical practitioner;
- iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
- u. **Migration:** Migration means, the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.
- v. **Network Provider:** Network Provider means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a Cashless Facility.
- w. **Nominee:** Nominee means the person named in the Certificate of Insurance to receive the benefits due under the Policy on the death of the Insured Person.
- x. **Notification of Claim:** Notification of claim means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
- y. **Online Consultation:** Online Consultation is a web-based consultation includes video conferencing, doctor on call or chat with doctor.
- z. **OPD Treatment:** OPD treatment means the one in which the Insured Person 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 Person is not admitted as a day care or in-patient.
- aa. **Physical Consultation:** Physical Consultation means the Medical Advice taken by the Insured Person from the Medical Practitioner or doctor by simply visiting the Clinic or any other consultation room.
- bb. **Policy:** Policy means the statements in the proposal form/personal statement, the terms and conditions, the benefits, endorsements (if any), annexures to the Policy, the Schedule (as amended from time to time), and the Certificates of Insurance issued to the Insured Persons.
- cc. **Policy Period:** Policy Period means the period between the commencement date and the Expiry Date of the Policy as specified in the Schedule.
- dd. **Policy Schedule:** Policy Schedule means the schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the Policy Period, special conditions, and the limits to which Benefits under the Policy are subject to, and as may be amended from time by way of endorsements made to or on it, and where more than one, then the latest in time.
- ee. **Policy Year:** Policy year means a period of 12 consecutive months commencing from the commencement date or any anniversary thereof.
- ff. **Portability:** Portability means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

Note: In case of portability, We may impose only the unexpired / residual waiting period not exceeding 48 months from the date of first issuance of porting out policy.
- gg. **Pre-Existing Disease:** Pre-Existing Disease means any condition, ailment, injury or disease:
 - a. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer **or**
 - b. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.
- hh. **Reasonable and Customary Charges:** Reasonable and Customary charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent

with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.

- ii. **Renewal:** Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of Grace Period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.
- jj. **Schedule of Cost:** Schedule of Cost means the schedule specifying the details pertaining to the deduction mechanism of any amounts from the Health Wallet (which represent the available Sum Insured), for all claims arising under this Policy for the opted Benefits.
- kk. **Service Provider Platform:** Service Provider Platform means the technology platform enabling the Insured Person(s) to avail scheduling/ booking health care services under any of the Benefits available under the Policy, as appointed by Us from time to time, and specified in the Policy Schedule / Certificate of Insurance.
- ll. **Sum Insured:** Sum Insured means, subject to the terms, conditions and exclusions of this Policy, the amount specified in the Policy Schedule / Certificate of Insurance, either against a Benefit, or a set of Benefits, that represents Our maximum, total liability for any or all claims arising under this Policy for the respective Benefit(s) in respect of an Insured Person or all Insured Persons constituting the Floater Unit, if applicable.
- mm. **Sub-limit:** Sub-limit means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit.
- nn. **Vaccination:** Vaccination is the administration of a vaccine to help the immune system develop protection from a disease. Vaccines contain a microorganism or virus in a weakened or killed state, or proteins or toxins from the organism.
- oo. **Waiting Period:** Waiting Period means a time-bound exclusion period related to condition(s) specified in the Schedule or Certificate of Insurance which shall be served before a claim related to such condition becomes admissible. No Waiting Periods shall be applicable in case of subsequent Renewals, subject to no break-in Policy.
- pp. **We/Our/Us:** We/Our/Us means Acko General Insurance Limited.
- qq. **You/Your:** You/Your means the employer or legally constituted entity named in the Schedule who has concluded this Policy with Us.

8 Grievance Redressal

If You/Insured Person may have a grievance that requires to be redressed, You/ Insured Person may contact Us with the details of the grievance through:

Our website: www.acko.com

Email: grievance@acko.com

Toll Free : **1860 266 2257**

Courier: Any of Our Branch office or corporate office during business hours.

You/Insured Person may also approach the grievance cell at any of Our branches with the details of the grievance during Our working hours from Monday to Friday.

If You/Insured Person are not satisfied with Our redressal of Your grievance through one of the above methods, You/Insured Person may contact the Grievance Officer at the following address:

Grievance Redressal Officer
Acko General Insurance Limited
3rd Floor, F-wing,
Lotus corporate park, Goregaon East,
Mumbai – 400063
grievance@acko.com

In the event of unsatisfactory response from the Grievance Officer, You may, register a complaint in the Integrated Grievance Management System (IGMS) of the IRDAI.

Where the grievance is not resolved, the Insured Person may, subject to vested jurisdiction, approach the Insurance Ombudsman for the redressal of grievance. The details of the Insurance Ombudsman are available below:

AHMEDABAD - Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor,

Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06, Email: bimalokpal.ahmedabad@ecoi.co.in

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@ecoi.co.in

BHOPAL - Office of the Insurance Ombudsman, 2nd Floor, Janak Vihar Complex, 6, Malviya Nagar, Bhopal(M.P.)-462 003. Tel.:- 0755-2769201/9202 Fax: 0755-2769203

Email: bimalokpal.bhopal@ecoi.co.in (States of Madhya Pradesh and Chattisgarh.)

BHUBANESHWAR - Office of the Insurance Ombudsman, 62, Forest Park, Bhubaneswar-751 009. Tel.:- 0674-2596455/2596003 Fax: 0674-2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in (State of Orissa.)

CHANDIGARH - Office of the Insurance,Ombudsman S.C.O. No.101-103,2nd Floor, Batra Building, Sector 17-D, Chandigarh-160017. Tel.:- 0172-2706468/2706196 Fax: 0172-2708274 Email: bimalokpal.chandigarh@ecoi.co.in (States of Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir and Union territory of Chandigarh.)

CHENNAI - Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, Chennai-600 018. Tel.:- 044-24333668 /24335284 Fax: 044-24333664 Email: bimalokpal.chennai@ecoi.co.in [State of Tamil Nadu and Union Territories - Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry).]

DELHI - Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi-110 002. Tel.:- 011-011-23239633/23237532 Fax: 011-23230858 Email: bimalokpal.delhi@ecoi.co.in (States of Delhi.)

GUWAHATI - Office of the Insurance Ombudsman, “Jeevan Nivesh”, 5th Floor, S.S. Road, Guwahati-781 001 Tel.:- 0361-2132204/5 Fax : 0361-2732937 Email: bimalokpal.guwahati@ecoi.co.in (States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.)

HYDERABAD - Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Main Court, A.C. Guards, Lakdi-Ka-Pool, Hyderabad-500 004. Tel: 040-65504123/23312122 Fax: 040- 23376599 Email: bimalokpal.hyderabad@ecoi.co.in (States of Andhra Pradesh and Union Territory of Yanam – a part of the Union Territory of Pondicherry.)

JAIPUR - Office of the Insurance Ombudsman, Ground Floor, Jeevan Nidhi II, Bhawani Singh Road, Jaipur – 302005 Tel: 0141-2740363 Email: bimalokpal.jaipur@ecoi.co.in (State of Rajasthan.)

ERNAKULAM - Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M.G. Road, Ernakulam-682 015. Tel: 0484-2358759/2359338 Fax: 0484-2359336 Email: bimalokpal.ernakulam@ecoi.co.in [State of Kerala and Union Territory of (a) Lakshadweep (b) Mahe-a part of Union Territory of Pondicherry.]

KOLKATA - Office of the Insurance Ombudsman, Hindustan Building. Annexe, 4th Floor, C.R. Avenue, Kolkata-700 072. Tel: 033-22124339/22124346 Fax: 033-22124341 Email: bimalokpal.kolkata@ecoi.co.in (States of West Bengal, Bihar, Sikkim, Jharkhand and Union Territories of Andaman and Nicobar Islands.)

LUCKNOW - Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-2, Nawal Kishore Road, Hazaratganj, Lucknow-226 001. Tel: 0522 -2231331/2231330 Fax: 0522-2231310 Email: bimalokpal.lucknow@ecoi.co.in (States of Uttar Pradesh and Uttaranchal.)

MUMBAI - Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz(W), Mumbai 400054. Tel: 022-26106960/26106552 Fax: 022-26106052, Email: bimalokpal.mumbai@ecoi.co.in (State of Goa and Mumbai Metropolitan Region excluding Navi Mumbai and Thane.)

PUNE - Office of the Insurance Ombudsman, 3rd Floor, Jeevan Darshan Bldg, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayanpeth, Pune – 411030. Tel: 020-41312555 Email: bimalokpal.pune@ecoi.co.in (State of Maharashtra including Navi Mumbai and Thane and excluding Mumbai Metropolitan Region.)

NOIDA - Office of the Insurance Ombudsman, 4th Floor, Bhagwan Sahai Palace, Main Road, Naya Bans, Sector-15, Distt: Gautam Buddh Nagar – 201301. Tel: 0120- 2514250/52/53 Email: bimalokpal.noida@ecoi.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 - Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna – 800006. Tel No: 06122680952 Email: bimalokpal.patna@ecoi.co.in (Bihar, Jharkhand.)

The updated details of Insurance Ombudsman offices are also available at the IRDAI website www.irda.gov.in, or on the website of Governing Body of Insurance Council www.ecoi.co.in or on the Company's website at www.acko.com.