Acko Health II: Policy Wordings

Table of Contents

Section 1: Preamble

This Policy Wording, together with the Schedule of Benefits, is an insurance contract between you and us. On receipt of premium as specified in the Schedule, we promise to provide you insurance for the covers specified in the Schedule, subject to terms and conditions explained in this document.
We promise to cover you basis the statements made in the proposal form, by you or on your behalf and on behalf of all Insured Persons, which is incorporated into the Policy as a copy of the duly completed proposal form. In case such statements and/or information are incorrect, in complete or inaccurate in any way, we shall have the right to re-evaluate the terms of the Benefits for the remainder of the Policy Period. Please do review these details for accuracy completeness and reach out to Us for any amendments required.
Some keywords related to and used in the Policy have been defined in Section 2 (Definitions). This document explains the following details related to Your Policy:

- General conditions applicable to Benefits
- Basic Benefits
- Basic Benefit Options
- Exclusions
- Add-on Benefits
- Claim process
- Other terms and conditions

Section 2: Definitions

2.1 Standard Definitions

1. **Accident** means sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Ayush Treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
3. **Any one illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
4. **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
    a. Central or State Government AYUSH Hospital; or
    b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
    c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
        1. Having at least 5 in-patient beds;
        2. Having qualified AYUSH Medical Practitioner in charge round the clock;
        3. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
        4. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
5. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health center which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:
    a. Having qualified registered AYUSH Medical Practitioner(s) in charge;
    b. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
    c. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
6. **Cashless facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the Network Provider by the insurer to the extent pre-authorization is approved.
7. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
8. **Congenital Anomaly** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
    a. Internal Congenital Anomaly- Congenital anomaly which is not in the visible and accessible parts of the body.

b. External Congenital Anomaly- Congenital anomaly which is in the visible and accessible parts of the body.

9. **Co-Payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.
10. **Cumulative Bonus:** Cumulative Bonus means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium and/or Discount in renewal premium
11. **Day Care Centre** means any institution established for Day Care Treatment of illness and/or injuries or a medical setup with a Hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criterion as under –
    a. has qualified nursing staff under its employment;
    b. has qualified Medical Practitioner/s in charge;
    c. has fully equipped operation theatre of its own where surgical procedures are carried out;
    d. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
12. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:
    a. undertaken under General or Local Anesthesia in a hospital/Day Care Centre in less than 24 hrs. because of technological advancement, and
    b. Which would have otherwise required hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.
13. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.
14. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and Surgery.
15. **Disclosure to information norm:** The policy shall be void and all premiums paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non- disclosure of any material fact.
16. **Domiciliary Hospitalization** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
    a. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
    b. the patient takes treatment at home on account of non-availability of room in a hospital.
17. **Emergency Care** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the insured person's health.
18. **Family Member** means any one or more of the following family members of the Insured Person:
    a. Legally wedded spouse.
    b. Parents and parents-in-law.
    c. Children (i.e. natural or legally adopted)
19. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in installments during the policy period.
20. **Hospital** means any institution established for in-patient care and Day Care Treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said act Or complies with all minimum criteria as under:
    a. has qualified nursing staff under its employment round the clock;
    b. 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;
    c. has qualified Medical Practitioner(s) in charge round the clock;
    d. has a fully equipped operation theatre of its own where surgical procedures are carried out;
    e. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;
21. **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

22. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    a. **Acute condition** - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery
    b. **Chronic condition** - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
        i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
        ii. it needs ongoing or long-term control or relief of symptoms
        iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
        iv. it continues indefinitely
        v. it recurs or is likely to recur
23. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.
24. **Inpatient care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.
25. **Intensive care unit** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
26. **ICU Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.
27. **Maternity expenses** means;
    a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
    b. expenses towards lawful medical termination of pregnancy during the policy period.
28. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
29. **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.
30. **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.
31. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
    a. is required for the medical management of the illness or injury suffered by the insured;
    b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    c. must have been prescribed by a Medical Practitioner;
    d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
32. **Migration** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.
33. **Moratorium Period** means the period of sixty continuous months of coverage (including portability and migration) in health insurance policy. Upon completion of which, no policy and claim shall be contestable by Us on grounds of non-disclosure and/or misrepresentation, except on grounds of established fraud and permanent exclusions specified in the policy schedule. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits. The policies would however be subject to all limits, sub-limits, co-payments, and/or deductibles as per the policy schedule.
34. **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.
35. **New Born Baby** means baby born during the Policy Period and is aged up to 90 days.
36. **Non-Network** means any hospital, day care center or other provider that is not part of the Network Provider.

37. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
38. **OPD treatment** means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.
39. **Pre-Existing Disease** means any condition, ailment, injury or disease:
    a. That is/are diagnosed by a physician within 36 months prior to the date of commencement of the policy issued by the insurer or
    b. For which Medical Advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.
40. **Pre-hospitalization Medical Expenses** means medical expenses incurred during pre- defined number of days preceding the hospitalization of the Insured Person, provided that:
    a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
    b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
41. **Portability** means a facility provided to the health insurance policyholders (including all renewal members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.
42. **Post-hospitalization Medical Expenses** means medical expenses incurred during pre- defined number of days immediately after the insured person is discharged from the hospital provided that:
    a. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
    b. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.
43. **Qualified nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
44. **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.
45. **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.
46. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.
47. **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or Day Care Centre by a Medical Practitioner.
48. **Specific waiting** means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.
49. **Sum Insured** represents the maximum, total and cumulative liability of the Company for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year.
50. **Unproven/Experimental treatment** means the treatment including drug experimental therapy which is not based on established medical practice in India.

2.2 Specific Definitions

1. **Age or Aged** means the age as on last birthday.
2. **Admission** means Your admission in a Hospital as an in-patient for the purpose of medical treatment of an Injury and/ or Illness.
3. **Aggregate Deductible** refers to a cost-sharing agreement between the Insurer and the Insured. The Insured agrees to bear a self-opted amount known as 'Aggregate Deductible' once during each Policy Year post which the Insurer's liability under the Policy shall commence for that Policy Year. The Aggregate Deductible does not reduce the Sum Insured.
4. **Ambulance** means a road vehicle operated by a licensed/authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.
5. **Annexure** means a document attached and marked as Annexure to this Policy.
6. **Annual Renewal Date** means the anniversary of the Commencement Date each Policy Year or any other date which We and You may agree in writing.
7. **Bank Rate** means the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year, which shall be applied depending on the year in which a claim is due.
8. **Benefit** means any Benefit shown in the Schedule.

9. **Base Sum Insured** referred herein means the specified amount of Sum Insured against a Benefit or set of Benefits, as specified in the Schedule.
10. **Break in Policy** means the period of gap that occurs at the end of the existing policy term/installment premium due date, where the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.
11. **Claim** means a demand by You or on Your behalf, for payment of Medical Expenses or any other Benefits as covered under the Policy.
12. **Commencement Date:** Commencement Date means the start date of the Policy as specified in the Schedule.
13. **Covered In-patient Medical Expenses** shall include Room Rent, ICU/CCU/HDU charges, nursing charges, operation theatre charges, Surgical Appliance and/or Medical Appliance cost, fees of Medical Practitioner/ surgeon / anesthetist / Specialist / radiologist / pathologist and diagnostic tests conducted within the same Hospital where the Insured Person has been admitted.
14. **Coverage Period:** Coverage Period means the period specified in the Schedule which commences on the Risk Commencement Date specified in the Schedule and ends on the coverage expiry date specified in the Schedule.
15. **Date of Admission** means the date of the Insured Person's first admission to a Hospital or Day Care Centre in relation to Any One Illness or the Injury sustained in any single Accident.
16. **Dependent** means the Member's parents, Spouse, child or any other insured who have been enrolled in the Policy.
17. **Emergency** shall mean a serious medical condition or symptom resulting from Injury or Illness which arises suddenly and unexpectedly and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the Insured Person's health, until stabilization at which time this medical condition or symptom is not considered an Emergency anymore.
18. **Empaneled Service Provider**: Empaneled Service Provider means the service provider specified in the Schedule, appointed by Us from time to time.
19. **Exclusions** mean specified coverage, hazards, services, conditions, and the like that are not provided for (not covered) under this Policy.
20. **Floater Benefit** means the amount of Sum Insured mentioned in the Schedule which is common to the whole family covered under the Policy which will be the maximum amount payable under this Policy for all the covered family members put together, during the Policy Period if opted to be a Floater policy.
21. **HDU** - High Dependency Unit is an area in a Hospital, usually located closely to the Intensive Care Unit where patients can be cared for more extensively than in a normal ward but not to the point of care provided in the Intensive Care Unit.
22. **Insured Person** means the Primary Insured and/or the Dependents of the Primary Insured named in the Schedule for whom the insurance is proposed and the appropriate premium is paid, and who is covered under this Policy.
23. **IRDAI** means the Insurance Regulatory and Development Authority of India.
24. **Loss of Independent Living:** Loss of Independent Living means inability to perform one or more of the following activities of daily living:
    a. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;
    b. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
    c. Transferring: The ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa;
    d. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
    e. Feeding: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available;
    f. Mobility: The ability to move indoors from room to room on level surfaces at the normal place of residence.
25. **Nominee** means the person named in the Schedule (as applicable) who is nominated by the Policyholder to receive the Benefits due in respect of an Insured Person or Dependent covered under the Policy in accordance with the terms and conditions of the Policy, if such person is deceased when the Benefit becomes payable.
26. **Out-Patient** means a person who undergoes an OPD treatment or a temporary Hospitalization for a stay of less than 24 hours.
27. **Partner** means the proposer's live-in partner, who is proposed to be covered under the Policy.
28. **Policy** means the statements in the proposal form/personal statement, these terms and conditions, and

the Schedule including any Annexures and endorsements, as amended from time-to-time which form part of the Policy contract and CIS shall be read together.

29. **Policy Anniversary Date** means the day of the subsequent calendar year on which the Coverage Period under the current Policy commenced.
30. **Policy Period** means the period between the Commencement Date and the expiry date of the Policy as specified in the Schedule or the date of cancellation of this Policy, whichever is earlier.
31. **Policyholder** means a person who has proposed the Policy and in whose name the Policy is issued.
32. **Policy Year** means a period of 12 consecutive months within the Coverage Period commencing from the Policy commencement Date.
33. **Risk Commencement Date**: Risk Commencement Date means the date specified in the Schedule on which the Coverage Period and Our coverage under the Policy in respect of the Insured Person commences.
34. **Room Category** means the type of room accommodation and associated boarding expenses at a Hospital and may be in the nature of a Deluxe AC room, Private/Single AC room, Twin sharing AC room, Non-AC sharing room, or a general ward in a Hospital etc.
35. **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.
36. **Spouse** means the Proposer's legal husband or wife, who is proposed to be covered under the Policy.
37. **Specialist Medical Practitioner** is a Medical Practitioner who:
    a. Has received advanced specialist training;
    b. Practices a particular branch of medicine or Surgery;
    c. Is or has been appointed as a consultant in a Hospital or is or has been appointed to a position in a Hospital which is deemed by Us or 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 as being of equivalent status.

    It is clarified that a physiotherapist who is registered or licensed as such under the laws of the country, state or other regulated area in which the Treatment is provided is only a Specialist Medical Practitioner for the purpose of physiotherapy as described in the list of Benefits.
38. **Sum Insured** means, subject to the terms, conditions and Exclusions of this Policy, the amount specified in the Schedule against a Benefit, or 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, and is as specified in the Policy Schedule against the particular Benefit(s).
39. **Surgical Appliance** and/or Medical Appliance means:
    a. An artificial limb, prosthesis or device which is required for the purpose of or in connection with a Surgery;
    b. An artificial device or prosthesis which is a necessary part of the Treatment immediately following Surgery for as long as such device or prosthesis is required by medical necessity.
    c. A prosthesis or appliance which is medically necessary and is part of the recuperation process for a reasonably short period of time.
40. **Sub Limit** means the limitation on the amount of coverage available to cover a specific type of claim. A Sub limit is part of, rather than an addition to, the limit that would otherwise apply to the admissible claim amount.
41. **TPA** means any person who is licensed under the IRDAI (Third Party Administrators – Health Services) Regulations 2016 (as may be amended, replaced or modified by the IRDAI) and is engaged for a fee or remuneration by Us for the purposes of providing health services. The list and details of TPA are set out on Our website.
42. **Treatment** means any relevant treatment controlled or administered by a Medical Practitioner to cure or substantially relieve an Illness or an Injury.
43. **Waiting Period** means a period from the inception of this Policy during which specified diseases/ treatments are not covered. On completion of the Waiting Period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.
44. **We/Our/Ours/Us** means the Acko General Insurance Limited.
45. **You/Your/Yours/Yourself/Policyholder** means the person named in the Schedule who has concluded this Policy with Us.

Section 3: Benefits

3.1 General Conditions Applicable to Benefits

a. **Schedule**: The Schedule specifies which Benefits are in force for the Insured Person(s) under the Policy together with the cover conditions applicable to the Benefits.

b. **Limitations on the Benefits covered**: Claims made in respect of an Insured Person for any of the Benefits applicable to the Insured Person shall be subject to the availability of the applicable Sum Insured as well as applicable Sub-limits/ Co-Payment /Deductibles/other conditions specified for the Benefits, applicable Waiting Periods (if any), as specified in the Schedule and the terms, conditions and exclusions of this Policy.

c. **Sum Insured Basis**: The Sum Insured available for the Benefits applicable to the Insured Persons may be available either on Individual or Floater basis as specified in the Schedule.

   i. In case of **Individual basis**, Our maximum, total, and cumulative liability for any and all claims made under a Benefit with respect to the Insured Person will be up to the Sum Insured specified against the Benefit.

   ii. In case of **Floater basis**, Our maximum, total, and cumulative liability for any and all claims made under a Benefit with respect to all the Insured Persons under the Policy, will be up to the Sum Insured specified against the Benefit.

d. **Application of Sum Insured (SI) limits**: Each Benefit is subject to a Sum Insured limit which is Our maximum, cumulative and total liability for the Benefit for all the Insured Person(s) in the Policy as following:

   1. The claim amount payable will always be subject to availability of Sum Insured for the particular Benefit, as specified in the Schedule. Where the Coverage Period is for a period of more than one year, the Sum Insured will be applicable for each Policy Year, unless specified otherwise in the Schedule.
   2. The type of Sum Insured available for the Basic Benefit, are as follows:
      - Base Sum Insured
      - Inflation Protect Sum Insured (If opted for)
      - Restore Sum Insured (if opted for)
      - No Claim Bonus (NCB) Sum Insured (if opted for)
   3. Our total, cumulative and maximum liability for a Basic Benefit in a Policy Year is the sum of the Base Sum Insured, Inflation Protect Sum Insured (if opted), Restore Sum Insured(if opted), and NCB Sum Insured (if opted).
   4. Each Add-on Benefit has its own Sum Insured which is in addition to the Sum Insured applicable to the Basic Benefit.
   5. Any Sum Insured which is not availed in any particular Policy Year, shall not be carried forward to any subsequent Policy Year, unless explicitly specified in the Schedule.

e. **Consequential losses not covered**: We do not assume any liability and shall not be deemed to assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations made by the Network Provider / Empaneled Service Providers in relation to the services availed under this Policy. The Insured Person's recourse for any such loss or damage shall be solely against the respective Network Provider or Empaneled Service Provider, and not against Us

f. **Reasonable and Customary**: We will indemnify only those costs and expenses whether medical or non-medical related, that are Reasonable and Customary Charges. “Reasonable and Customary Charges” shall be as determined by Us with reference to a benchmark tariff database maintained and periodically updated by Us, based on prevailing charges in the geographical area.

g. **Medically Necessary Treatment:** The Hospitalization must be for Medically Necessary Treatment, and prescribed in writing by Medical Practitioner.

h. **Claim Process**: All claims must be made in accordance with the procedure set out in Section 6.1.

3.2 Basic Benefits

All the benefits listed in this part are available to anyone insured under the policy.

3.2.1 In-patient Hospitalization

In the event of hospitalization, we will cover the following medical expenses for anyone insured in the policy -

- Hospital room rent (Includes associated medical expenses like RMO, Nursing and Monitoring charges)
- ICU/CCU/HDU charges
- Operation room charges
- Treating Medical practitioner / doctor fees
- Medicines prescribed by the treating medical practitioner / doctor, used in the treatment
- Diagnostic tests directly related to the current hospitalization
- Surgical or medical appliance(s) prescribed by the treating medical practitioner/doctor (e.g. a stent)
- Associated medical expenditures including Intravenous fluids, blood transfusion, surgical appliances used, consumables (if opted) and/or enteral feedings. Operation theatre charges.
- The cost of prosthetics and other devices or equipment, if implanted internally during Surgery.(Note: External prosthesis are not covered)

Note:
Some expenses in Annexure 1 may not be covered in your policy, unless you buy a plan including those benefits. The terms of your policy will be written in your policy schedule.

3.2.2 Room Rent /ICU

If anyone insured under the policy is hospitalized, we will cover the room rent charges for the room category and ICU charges during hospitalization stay as specified in the policy schedule.
Note:

- While the nomenclature of the Room Category might differ from one hospital to another, we will use the specification and description of the room category to determine the applicable room category and rent limits for each hospitalization.
- If you avail a room with room category / room rent / ICU charges higher than those mentioned in the policy schedule, then you will have to bear a part of the total admissible in-patient medical expenses (including surcharges, taxes, etc.). The expenses that you will have to bear in such a case would be proportional to the difference between the room rent actually availed and the room rent limit specified in the policy schedule.

Example: If you have opted for a room category with a limit of Rs. 2000 per day in the policy but you select a room with charges of Rs. 4000 per day during hospitalization, the availed room rent is two times the specified limit. So, we will cover and pay for only half the medical expenses in the final bill (i.e. reduce the bill proportionally by two). This is done as medical expenses such as doctor's fee, surgery costs, etc. depend on the room rent opted for. However, the proportional deduction will not be applicable for medicines and other items that are billed at MRP.

3.2.3 Day Care Treatment

If anyone insured under the policy undertakes Day Care Treatment in a hospital / nursing home / day care center, we will cover the expenses of the day care treatment. Please find the list of day care procedures covered here - acko.com/gi
Note: Any treatment undertaken as an Out-Patient or in an out-patient department is not covered unless section 3.4.3 is in force.

3.2.4 Pre and Post Hospitalization Medical Expenses

We will cover all the relevant (to the hospitalization/daycare event) medical expenses including consultations, investigations, diagnostics and medicines that are incurred towards pre-hospitalization and post-hospitalization of anyone insured under the policy.

3.2.5 Road Ambulance Limit

If anyone insured under the policy needs to be transported to a hospital or day care center by an ambulance or public transport for emergency care, then we will cover the reasonable cost of such transportation.
We will cover the reasonable costs incurred during transportation to a hospital or day care center by ambulance or public transport for anyone insured under the policy requiring emergency care.
Note:

- We will pay the costs associated with this benefit only if we have accepted a claim under Section 3.2 Basic Benefit.
- We will pay the costs associated with this benefit only if it is medically necessary to transport anyone insured under the policy & requiring emergency care by an ambulance or public transport.

3.2.6 Domestic Emergency Evacuation Limit

If anyone insured under the policy has a medical emergency and if adequate medical facilities are not available locally, we will cover the emergency evacuation costs of transporting the person requiring emergency medical care to the nearest medical facility that is able to provide adequate care.

Note:

- You will have to certify the emergency evacuation in writing by the attending Medical Practitioner for the evacuation to be medically necessary to prevent the immediate and significant effects of an Illness/Injury, which if left untreated could result in a significant deterioration of health.
- You will have to get the emergency evacuation pre-authorized by us. You can get the pre-authorization by calling our call center. Only in cases where it can be demonstrated to our satisfaction that it was not reasonably possible to get pre-authorization before evacuation, you can seek authorization as soon as possible post the emergency evacuation.
- We will consider the nature of the Insured Person's Illness or Injury, the Insured Person's condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions and distance to be covered while considering such requests.
- The Insured Person's medical condition must require the accompaniment of a qualified Medical Practitioner during the entire course of the transportation to be considered as requiring emergency evacuation.
- You can avail transportation by medically equipped specialty aircraft, commercial airline, train, Ambulance or air ambulance depending upon the medical needs and available transportation specific to each case, and within the geographical territory of India only.

3.2.7 Domiciliary Treatment

If anyone insured under the policy undergoes Domiciliary Hospitalization i.e. medical treatments or procedures taken at home, we will cover the cost of such domiciliary hospitalization.

Note:

- We will cover such costs only if the domiciliary hospitalization continues for at least 3 consecutive days. In such a case, we will cover the medical expenses incurred from the first day.
- However, we will not make any payment if the Domiciliary Hospitalization is for less than 3 consecutive days.
- We will only make payments for such costs if the treating Medical Practitioner confirms in writing that Domiciliary Hospitalization was medically necessary.
- We will cover the medical expenses under this benefit on reimbursement basis only.

3.2.8 Organ Donor Expenses

If anyone insured under the policy requires organ donation, we will cover all the in-patient hospitalization expenses incurred by the person's organ donor for harvesting of the organ.

Note:

- We will cover the in-patient hospitalization expenses for the person's organ donor only upto the insured's sum insured, if the following conditions are met –
- We admit the claim under Section 3.2.1 (In-patient Hospitalization) for the Insured Person under this Policy and is related to the same Illness or Injury
- The organ donation is in accordance with the Transplantation of Human Organs Act 1994 (as amended from time to time) and other applicable laws and rules.
- The organ donated is for the use of the Insured Person who has been advised to undergo an organ transplant in writing by the treating Medical Practitioner.
- However, we will not cover the following expenses -
  - Pre-hospitalization and post-hospitalization expenses of the organ donor
  - Costs incurred towards donor screening
  - Costs related to the acquisition of the organ
  - Expenses related to transportation or preservation of the organ
  - Transplant of any organ/tissue where the transplant is experimental or investigational.

3.2.9 Second Opinion

If anyone insured under the policy seeks a second opinion for an alternate evaluation of the diagnosis or treatment, we will cover the expenses associated with seeking the second opinion.

You have the sole discretion on the option to avail a second opinion. You are free to choose whether or not to obtain the second opinion, and if obtained, then whether or not to act on it, without any assumption or deemed assumption of liability by Us.

Note: We will cover such expenses only if –

- The expenses are for consultation on an out-patient basis
- The person is advised hospitalization or day care treatment in the first opinion

3.2.10 AYUSH Treatment

If anyone insured under the policy undergoes medically necessary treatment at any AYUSH Hospitals or health care facilities for any of the listed AYUSH treatments namely Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy, we will indemnify the medical expenses incurred towards in-patient Medical care towards the medical treatment. Any medical expense other than in-patient care AYUSH treatment expenses are not covered under this policy. Please find the list of standard treatment guidelines & treatment covered namayush.gov.in/content/standard-treatment-guidelines.

3.2.11 Modern Treatment

If anyone insured under the policy undergoes in-patient or day care medical treatment as warranted for the following medical procedures, we will indemnify the medical expenses related to the medical procedures:

- Uterine Artery Embolization and HIFU
- Balloon Sinuplasty
- Deep Brain stimulation
- Oral chemotherapy
- Immunotherapy-Monoclonal Antibody to be given as Intravenous injection
- Intravitreal injections
- Robotic surgeries
- Stereotactic radiosurgeries
- Bronchial Thermoplasty
- Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
- IONM - (Intra-Operative Neuro Monitoring), if used in association with any surgery which warrants such a procedure
- Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for hematological conditions

3.3 Basic benefit options

The benefits listed in this section are available as optional add-ons with the basic benefits. Only those benefits under this section that are opted for by the insured and specifically mentioned in the policy schedule will be applicable.

3.3.1 Worldwide in-patient hospitalization

If this benefit is in force and if anyone insured under the policy undergoes hospitalization anywhere outside India, we will cover the in-patient medical expenses of such hospitalization.

Note: We will cover the expenses only if –

- They are incurred for an injury or illness as specified in the policy schedule and in line with Basic Benefit 3.2.1.
- They need to be for a medically necessary treatment and on the written advice of the treating Medical Practitioner.
- We need to be intimated of such a hospitalization within 48 hours of admission.
- We will make the payment of any claim under this benefit based on the rate of exchange, published by Reserve Bank of India (RBI), from the currency of the country of treatment to Indian Rupees as on the date of payment (or the next available date for which exchange rate is available) to the Hospital.
- We will waive the Permanent Exclusion under Exclusion 5 of Section 4.2.2 for the purpose of this Benefit in respect of that Insured Person.

3.3.2 Restore Sum Insured

We will refill the sum insured of the policy, as defined in the policy schedule, if you use the total of the base sum insured, inflation protect sum insured (if applicable) and any NCB sum insured (if applicable) in previous claims and it is insufficient to pay for any other medical expenses of anyone insured under the policy.
Note:

- The Restore Sum Insured will be available for conditions (whether related or related and unrelated both) as mentioned in the policy schedule.
- Restoration of Sum Insured will not trigger for the first claim made in the policy year
- If the restore sum insured is not utilized in a policy year, it will not be carried forward to the next policy year.
- For individual policies, Restore Sum Insured will be available on individual basis whereas for floater policies, it will be available on floater basis.

Example: You have a policy with a total Sum Insured of Rs. 25 lakhs and have the Restore benefit for unlimited times. Now, unfortunately you suffer from a cardiac arrest and incur a total hospitalization bill of Rs. 30 lakhs.

The amount of claim payable by us would be Rs. 25 lakhs i.e. the maximum sum insured amount. As you have used up the sum insured amount in total, the sum insured will be restored by 100% i.e. Rs. 25 lakhs. This Rs. 25 lakhs would be available for use against any claims apart from cardiac arrest. Say unfortunately you also need to use the insurance amount for a liver disease with the total hospitalization bill of Rs. 28 lakhs. In this case, the total amount payable for the liver disease claim would be Rs. 25 lakhs i.e. the maximum sum insured amount. The sum insured having been used up will be restored again by 100% to Rs. 25 lakhs. This Rs. 25 lakhs would be available for use against any claims apart from cardiac arrest and liver disease. So, if you need to make another claim, say related to knee replacement costing Rs. 2 lakhs, the amount payable by us would be Rs. 2 lakhs.

3.3.3 Cumulative Bonus

If this benefit is in force, we will provide an additional sum insured in the subsequent policy year called Cumulative Bonus Sum Insured. The additional Cumulative Bonus Sum Insured provided in the subsequent year will be a fixed percentage of the base sum insured of the current policy year, as specified in the policy schedule.

- We will provide the Cumulative Bonus Sum Insured next year only if the policy is active or is renewed the next year.
- During any Policy Year, the Cumulative Bonus Sum Insured will be capped at the maximum number of times of base sum insured as defined in the policy schedule.
- If the policyholder has opted for reduced Base Sum Insured at the time of Renewal, the applicable Cumulative Bonus Sum Insured shall be calculated on the revised Base Sum Insured.
- If the policyholder has opted for reduced Base Sum Insured at the time of Renewal, the Cumulative Bonus Sum Insured will be calculated on the Base Sum Insured of the last completed Policy Year.
- The Cumulative Bonus shall be applicable on an annual basis subject to continuation of the Policy
- If the Insured Persons in the expiring policy are covered on Individual basis and thus have accumulated the Cumulative Bonus for each Insured Person in the expiring policy, and such expiring policy is renewed with the Company on a Floater basis, then the Cumulative Bonus to be carried forward for credit in this Policy would be the least Cumulative Bonus amongst all the Insured Persons.
- The Cumulative Bonus accumulated in the previous Policy Years, will only be available to those Insured Person(s) who were Insured in the previous Policy Years and continue to be Insured with the Company in the subsequent Policy Years.
- If the Insured Persons in the expiring policy are covered on a Floater basis and such Insured Persons renew their expiring Policy with the Company by splitting the Floater Sum Insured in to two or more Individual/ Floater covers, then the Cumulative Bonus of the expiring Policy shall be apportioned to such renewed Policy in the proportion of the Sum Insured of each of the renewed Policy
- In the event of a Claim there is no impact on the accrual of Cumulative Bonus.
- Accrued Cumulative Bonus can be utilized for all the covers specified under the Policy Schedule.

3.3.4 No Claim Bonus Sum Insured

If this benefit is in force and if anyone insured under the policy makes no claim in the current policy year under in-patient hospitalization (Basic Benefit 3.2.1) or day care treatment (Basic Benefit 3.2.3), we will provide an additional sum insured in the subsequent policy year. The additional NCB Sum Insured we will provide in the subsequent year, will be a fixed percentage of the base sum insured of the current policy year.
Note:

- We will provide the NCB Sum Insured subsequent year only if the policy is active or is renewed the next year.
- During any Policy Year, the NCB Sum Insured cannot be more than the Base Sum Insured.
- Any NCB Sum Insured that has accrued will be available for any claims made in the subsequent Policy Year.
- If you do not renew this Basic Benefit Option at the time of Renewal of this Policy, then the NCB Sum Insured under the Policy shall be forfeited.
- If the Base Sum Insured has been reduced at the time of Renewal, the applicable NCB Sum Insured shall be calculated on the revised Base Sum Insured on a pro-rata basis.
- If the Base Sum Insured under the Policy has been increased at the time of Renewal, the NCB Sum Insured shall be calculated on the Base Sum Insured of the last completed Policy Year.

Example: You have a policy with a total sum insured of Rs. 25 lakhs with a NCB benefit of 20%. Say you do not make any claims in the current policy year. The NCB benefit amounting to Rs. 5 lakhs (i.e. 20% of Rs. 25 lakhs) would be available and added to your total sum insured, making it Rs. 30 lakhs.

3.3.5 No Claim Discount

If this benefit is in force and if anyone insured under the policy makes no claim in the current policy year under in-patient hospitalization (Basic Benefit 3.2.1) or day care treatment (Basic Benefit 3.2.3), we will provide a

discount in premium in the subsequent policy year.
Note:

- We will provide the No Claim Discount in subsequent year's policy premium only if the policy is active or is renewed next year.
- No Claim Discount will not be provided for the year where claim has been made in the previous year.
- No Claim Discount will not be given to the newly added member
- For every claim free year, No Claim Discount as a fixed percentage of the total premium, as mentioned in the policy schedule, will be provided.

3.3.6 First Notification of Claim

If this benefit is in force, then anyone insured under the policy agrees to notify us within 48 hours of hospitalization or before discharge (whichever is earlier) in case of in-patient hospitalization (Basic Benefit 3.2.1) or day care treatment (Basic Benefit 3.2.3).
We will offer a discount in premium for this agreement. If you fail to notify us, as specified above, we will charge a compulsory co-payment percentage of the final claim amount. The co-payment percentage will be as specified in the policy schedule and after the assessment of the claim amount by us.

3.3.7 Preferred Providers Network

If this benefit is in force, anyone insured under the policy agrees to only use services of hospitals in our preferred provider network for in-patient hospitalizations (Basic Benefit 3.2.1) or day care treatments (Basic Benefit 3.2.3). The list of our preferred provider network will be available in the policy schedule or our website www.acko.com/gi
We will offer a discount in premium for this agreement. If you make a claim for hospitalization outside of our preferred provider network, we will charge a compulsory co-payment percentage of the final claim amount. The co-payment percentage will be as specified in the policy schedule and after the assessment of the claim amount by us.

3.3.8 Co-pay

If this benefit is in force, anyone insured under the policy agrees to bear a compulsory co- payment percentage in the final admissible claim amount assessed by us for every claim. We will offer a discount in premium for this agreement.

3.3.9 Super Top-up

If this benefit is in force and if anyone insured under the policy claims any medical expenses in the policy year, we will cover those expenses only after the cumulative claims amount crosses the deductible limit. We will only pay the cumulative amount that is in excess of the deductible limit.
Note:

- We will make the payment for claims subject to any other conditions specified in the policy schedule.
- The Annual Aggregate Deductible amount will be consumed on the basis of the admissible claim amount after applying the Sub-limits as per of the policy schedule.
- No Deductible under this Basic Benefit Option shall be applicable for the claims under Basic Benefit Options 3.3.11 if applicable (Preventive Health Check-up).

Example: Suppose you have a super top-up policy with Sum Insured of Rs. 1 crore and a deductible of Rs. 5 lakhs. The following will be the amount you will have to shell out in each case
(assuming all costs mentioned in the final bill are covered and there is no non-payable item in the final bill)

	Only base plan of Rs. 5 lakhs sum insured	**Base plan of Rs. 5 lakhs sum insured + Super top-up plan of Rs. 1Cr sum insured and Rs. 5 lakhs deductible**	**Only Super top-up plan of Rs. 1Cr sum insured and Rs. 5 lakhs deductible**
Total cover	Rs. 5 lakhs	Rs. 1 Cr	Rs. 1 Cr (over deductible)
Deductible		Rs. 5 lakhs (this is also covered by base plan)	Rs. 5 lakhs
1st claim of the year	Rs. 3 lakhs	Rs. 3 lakhs	Rs. 3 lakhs
Cumulative claim amount after 1st claim	Rs. 3 lakhs	Rs. 3 lakhs	Rs. 3 lakhs

Amount to be paid by you	0 (as 3 lakhs will be paid from base policy)	0 (as 3 lakhs will be paid from base policy)	Rs. 3 lakhs (as claim is less than deductible of Rs. 5 lakhs)
2nd claim of the year	Rs. 6 lakhs	Rs. 6 lakhs	Rs. 6 lakhs
Cumulative claim amount after 2nd claim	Rs. 9 lakhs	Rs. 9 lakhs	Rs. 9 lakhs
Amount to be paid by you	Rs. 4 lakhs (Rs. 2 lakhs out of 2nd claims of Rs. 6 lakhs is covered by insurer, remaining to be paid out of pocket)	0 (as Rs. 2 lakhs will be paid from base policy and Rs. 4 lakhs from super top-up)	Rs. 2 lakhs paid by you (only the cumulative claim amount over the deductible of Rs 5 lakhs is payable by insurer, which is 4 lakhs)

3.3.10 Waiver of non-payable medical expenses

If this benefit is in force, we will cover all the expenses listed in the Annexure 1 "List of non-payable medical expenses" and on Our website www.acko.com/gi
Note: We will only cover these expenses if -

- The expenses are medically necessary.
- We admit the claim for in-patient hospitalization (Basic Benefit 3.2.1) or day care treatment (Basic Benefit 3.2.3) or domiciliary treatment (Basic Benefit 3.2.7).

3.3.11 All medically necessary hospitalization

If this benefit is in force, we will cover all the expenses listed in the Section 4.2.2, which are under permanent exclusions and are not payable under normal circumstances in case of a claim.
Note: We will only cover these expenses if -

- The expenses are medically necessary.
- We admit the claim for in-patient hospitalization (Basic Benefit 3.2.1) or day care treatment (Basic Benefit 3.2.3) or domiciliary treatment (Basic Benefit 3.2.7).

3.3.12 Reduction in Specific Illness Waiting Period - Comprehensive

In case of a policy containing basic benefits (Basic Benefits 3.2), there are waiting periods that are applicable to specific diseases and procedures. These specific waiting periods are mentioned in Section 4.1.2 (Specific Disease/Procedure Waiting Period). The waiting periods are applicable as per the time of inception of the first policy period.
If this benefit is in force, we will reduce the waiting periods for these specific diseases/procedures mentioned in Section 4.1.2. The reduced waiting period will be specified in the policy schedule.
Note:

- This benefit will only be available at the time of inception of the first policy.
- Once opted for, this benefit cannot be excluded in the subsequent year.

3.3.13 Reduction in Specific Illness Waiting Period - Essential

In case of a policy containing basic benefits (Basic Benefits 3.2), there are waiting periods that are applicable to specific diseases and procedures. These specific waiting periods are mentioned in Section 4.1.2 (Specific Disease/Procedure Waiting Period). The waiting periods are applicable as per the time of inception of the first policy period.
If this benefit is in force, we will reduce the waiting periods for these specific diseases/procedures mentioned in Section 4.1.2 except for cataract and arthropathies (excluding infectious aetiology) for insured above age 50.
The reduced waiting period will be specified in the policy schedule.
Note:

- This benefit will only be available at the time of inception of the first policy.
- Once opted for, this benefit cannot be excluded in the subsequent year.

3.3.14 Preventive Health Check-up

If this Benefit is in force, we will facilitate and provide the following preventive health check-ups, to anyone insured under the policy if they are above 18 years of Age, as mentioned in the policy schedule. The list of tests included in the check-ups are -

1. Complete Blood Count (CBC)

2. Erythrocyte Sedimentation Rate (ESR)
3. Glycated Hemoglobin (HbA1C)
4. Serum Creatinine (Sr Creatinine)
5. Serum Cholesterol (Sr Cholesterol)
6. Serum HDL Cholesterol (Sr HDL Cholesterol)
7. Serum Triglycerides (Sr Triglycerides)
8. Routine Urine Analysis (RUA)
9. Serum Glutamate Oxaloacetate Transaminase (SGOT)
10. Serum Glutamate Pyruvate Transaminase (SGPT)
11. Gamma-Glutamyl Transferase (GGT)
12. Uric Acid

Note: We will provide the preventive health check-ups with the following conditions -

- We shall arrange and pay for the test(s) at Our Network Providers/ Empaneled Service Providers only;
- If we are not able to provide a network provider for the tests then we will cover these tests at our sole discretion if the report and invoice/payment proof of such tests is submitted to Us for an amount up to Rs 900. Any test done over and above the specified list would not be paid for.
- Section 4.1.4 is not applicable in respect of coverage under this Basic Benefit option.

3.3.15 Inflation Protect Sum Insured

If this benefit is in force, we will provide an additional sum insured in the subsequent policy year called the Inflation Protect Sum Insured. The additional Inflation Protect Sum Insured provided in the subsequent year will be a fixed percentage of the base sum insured of the current policy year on payment of required premium towards additional sum insured, as specified in the policy schedule.

Note:

- We will provide the Inflation Protect Sum Insured next year only if the policy is active or is renewed the next year.
- During any Policy Year, the Inflation Protect Sum Insured cannot be more than the Base Sum Insured.
- If the Base Sum Insured has been reduced at the time of Renewal, the applicable Inflation Protect Sum Insured shall be calculated on the revised Base Sum Insured.
- If the Base Sum Insured is increased at the time of Renewal, the Inflation Protect Sum Insured will be calculated on the Base Sum Insured of the last completed Policy Year.
- The Inflation Protect shall be applicable on an annual basis subject to continuation of the Policy
- If the Insured Persons in the expiring policy are covered on Individual basis and thus have accumulated the Inflation Protect for each Insured Person in the expiring policy, and such expiring policy is renewed with the Company on a Floater basis, then the Inflation Protect to be carried forward for credit in this Policy would be the least Inflation Protect amongst all the Insured Persons.
- The Inflation Protect accumulated in the previous Policy Years, will only be available to those Insured Person(s) who were Insured in the previous Policy Years and continue to be Insured with the Company in the subsequent Policy Years.
- If the Insured Persons in the expiring policy are covered on a Floater basis and such Insured Persons renew their expiring Policy with the Company by splitting the Floater Sum Insured into two or more Individual/ Floater covers, then the Inflation Protect of the expiring Policy shall be apportioned to such renewed Policy in the proportion of the Sum Insured of each of the renewed Policy
- In the event of a Claim there is no impact on the accrual of Inflation Protect. Accrued Inflation Protect can be utilized for all the covers specified under the Policy Schedule
- Accrued Cumulative Bonus can be utilized for all the covers specified under the Policy Schedule.

3.3.16 Initial 30 days waiting period waiver

In case of a policy containing basic benefits (Basic Benefits 3.2), there exists an initial 30-day waiting period for any claims for treatments or procedures in the policy. This is specified in Section 4.1.3 (30-day waiting period-Code-Excl03). This waiting period is applicable as per the time of inception of the first policy period.
If this benefit is in force, we will waive off this initial 30-day waiting period.

Note:

- This benefit will only be available at the time of inception of the first policy.
- Once opted for, this benefit cannot be excluded in the subsequent year.

3.4 Add-on benefits

The benefits listed in this section are available as add-ons with the basic benefits. Only those benefits under this section that are opted for by the insured and specifically mentioned in the policy schedule will be applicable. The amount specified in the Policy schedule against this benefit denotes the Company's maximum liability in respect to the benefit and shall not reduce the Sum Insured of the policy.

3.4.1 Doctor-on-call

If this benefit is in force, we will provide access to a doctor or a general medical practitioner any time of the day for a medical consultation. We will provide the consultation either through an online portal or a chat service or a call back service or a voice call service or a video call service.
Further, we will make the consultation available either directly by us or facilitate it through our empaneled service provider.
Note:

- For the consultation to be provided, it has to be requested by the insured person to either us or our empaneled service provider.
- The consultation provided must not be considered a substitute to medical opinion or Medical Advice nor shall the same be pursued over a medical opinion or a Medical Advice given by a treating physician or doctor.
- We do not make any warranties or representations as to the correctness of the medical consultation and shall not assume or deem to assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the general Medical Practitioner.
- Consultation under this Add-on Benefit shall not be valid for any medico-legal purposes.

3.4.2 Family physician

If this benefit is in force, we will assign a qualified Medical Practitioner who is a general physician as a 'Family Physician' to anyone insured under the policy in the locality of his/her place of residence. You can visit the medical practitioner for physical consultations.
We will provide a general physician and not a Specialist Medical Practitioner for any disease as the Family Practitioner.
We will provide a choice of at least one Family Physician within 5 kilometers from the Insured Person's current address on a best efforts basis. In case no such Family Physician is available, We will assign the Insured Person a Family Physician outside such radius or assign a general physician of his/her choice.
In case of the Insured Person's movement from the current address, we will reassign a different Family Physician for the new address.

3.4.3 Out-Patient Department (OPD) Medical Services

If this benefit is in force, we will cover the following mentioned OPD costs if incurred due to a medically necessary treatment in a hospital or day care center or any service provider of out- patient facility -

- **Physical Consultation:** Medical advice taken from a general or Specialist Medical Practitioner during a physical visit;
- **Prescribed Diagnostics:** Any diagnostic procedures undergone by the Insured Person on the advice of the treating Medical Practitioner;
- **Prescribed Pharmacy:** Discounts on medicine/pharmacy costs or/and covering indemnification of the costs of medicines/pharmacy duly supported by the prescriptions of the Medical Practitioner attending to the Insured Person;
- **OPD Treatment/procedure:** Any Minor Surgical or Medical Procedure such as POP, Suturing, Dressings for Accidents and Animal Bite Related Outpatient Procedures Etc. carried out by a Medical Practitioner in an Out Patient facility

The above services will be available only at a network of service providers as specified in the policy schedule and on Our website.
However, please note that the costs associated with below mentioned services, procedures or treatments or consultations would not be covered unless specified in the policy schedule -

- Facilities and services availed for pleasure or rejuvenation or as a preventive aid, such as beauty treatments, Panchakarma, purification or detoxification.
- Cost of spectacles, hearing aids, braces, implants, prosthetic devices, and lenses etc. as medical aid and physiotherapy.
- Any OPD treatment taken outside India.
- All routine examinations and preventive health check-ups.
- Preventive care, vaccination including inoculation and immunizations (except in case of post-bite treatment).
- Cost incurred for any health check-up or for the purpose of issuance of medical certificates and

examinations required for employment or travel or any other such purpose.

- Sterility, infertility, sub-fertility or other related conditions and complications arising out of the same, assisted conception, surrogate, vicarious pregnancy or Pregnancy, birth control, and similar procedures; contraceptive supplies or services including complications arising due to supplying services.
- Complications arising out of pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness), maternity or birth (including caesarean section) except in the case of ectopic pregnancy for in-patient only.
- Investigational treatments, Unproven / Experimental treatment, or drugs yet under trial, including experimental devices and pharmacological regimens.
- Correction of eyesight due to refractive error including routine examination.
- Weight management programs or treatment in relation to the same including vitamins and tonics, treatment of obesity (including morbid obesity).
- Dentures, implants and artificial teeth, Dental Treatment and Surgery of any kind, unless requiring due to an Accident.

3.4.4 Access to our Out-Patient Medical Services Network

If this benefit is in force, anyone insured under the policy are entitled to avail of a physical consultation or prescribed diagnostics, as specified in the Schedule, at a discount on their retail rates as specified in the Schedule.
For each service, You will be able to see the original retail rates for Our Empaneled Service Providers, which You would have paid if this Add-on Benefit was not in force.

3.4.5 Monthly No Claim Bonus OPD Sum Insured

If this benefit is in force, We will provide You No Claim Bonus (NCB) OPD Sum Insured at the end of each claim free month during the Coverage Period, i.e., “Policy Month”, as specified on the Schedule, provided that:

- Such NCB OPD Sum Insured will be solely available for OPD Medical Services mentioned in Add-on Benefit 3.4.3 (Out-Patient Medical Services)
- The Sum Insured accrued at the end of a Policy Month, will expire after 12 months or at the end of the policy period, whichever is earlier, in case the Sum Insured is not utilized.
- In case a claim is admitted under Basic Benefit 3.2.1 (In-patient Hospitalization) or Basic Benefit 3.2.3 (Day Care Treatment) in a Policy Month, the No Claim Bonus Sum Insured will not accrue for 12 subsequent Policy Months or at the end of the policy period, whichever is earlier.

3.4.6 Daily Hospital Cash

If this benefit is in force, in case a claim is admitted under Basic Benefit 3.2.1 (In-patient Hospitalization), we will pay the daily allowance amount as specified in the policy schedule, for each continuous and completed period of 24 hours of Hospitalization for a maximum of 45 days.
If Basic Benefit Options 3.3.4 (First Notification of Claim) or 3.3.5 (Preferred Provider Network) or 3.3.6 (Co-pay) are in force, we will deduct a Co-payment of the percentage specified in the Schedule from the daily allowance amount as per the conditions specified in Basic Benefit Options 3.3.4, 3.3.5 and 3.3.6.

3.4.7 Accidental Death or Disability Cover

If this benefit is in force, and if anyone insured under the policy suffers death or disability from an injury due to an accident that occurs during the coverage period and that Injury solely and directly results in the Insured Person’s death within 365 days from the date of the Accident, we will make a payout. The payout will be made if the death or disability is directly a result of the accidental injury and of the nature specified below in the table. The payout against each event will be a percentage of the sum insured as defined in the policy schedule –

Insured Event	Percentage of the Sum Insured payable
1. Accidental death	100%
2. Total and irrecoverable loss of sight in both eyes	100%
3. Loss by physical separation or total and permanent loss of use of both hands or both feet	100%
4. Loss by physical separation or total and permanent loss of use of one hand and one foot	100%
5. Total and irrecoverable loss of sight in one eye and loss of a Limb	100%
6. Total and irrecoverable loss of hearing in both ears and loss of one Limb/ loss of sight in one eye	100%

7. Total and irrecoverable loss of hearing in both ears and loss of speech	100%
8. Total and irrecoverable loss of speech and loss of one Limb/ loss of sight in one eye	100%
9. Permanent, total and absolute disability (not falling under any one the above) which results in the Insured Person being unable to engage in any employment or occupation or business for remuneration or profit, of any description whatsoever which results in Loss of Independent Living	100%
10. Total and irrecoverable loss of sight in one eye	50%
11. Loss of one hand or one foot	50%
12. Loss of all toes - any one foot	10%
13. Loss of toe great - any one foot	5%
14. Loss of toes other than great, if more than one toe lost, each	2%
15. Total and irrecoverable loss of hearing in both ears	50%
16. Total and irrecoverable loss of hearing in one ear	15%
17. Total and irrecoverable loss of speech	50%
18. Loss of four fingers and thumb of one hand	40%
19. Loss of four fingers	35%
20. Loss of thumb- both phalanges	25%
21. Loss of thumb- one phalanx	10%
22. Loss of index finger-three phalanges	10%
23. Loss of index finger-two phalanges	8%
24. Loss of index finger-one phalanx	4%
25. Loss of middle/ring/little finger-three phalanges	6%
26. Loss of middle/ring/little finger-two phalanges	4%
27. Loss of middle/ring/little finger-one phalanx	2%

For the purpose of this Add-on Benefit:

- Limb means a hand at or above the wrist or a foot above the ankle;
- Physical separation of one hand or foot means separation at or above wrist and/or at or above ankle, respectively.

Note:

This Add-on Benefit will be payable provided that:

- The Disability, of the nature specified in the foregoing table, continues for a period of at least 180 days from the commencement of the Disability, and the Disability Certificate issued by the treating Medical Practitioner at the expiry of the 180 days confirms that there is no reasonable medical hope of improvement. It is clarified that this condition is not application for any Disability in the nature of a physical separation;
- If the Insured Person suffers a loss that is not of the nature of a Disability specified in the table above, then Our independent medical advisors will determine the degree and percentage of such disability;
- Our maximum total and cumulative liability under this benefit will be the Sum Insured of the policy. If cumulative claims submitted under this benefit exceed the sum insured, then the maximum payout will be capped at the sum insured, as specified in the policy schedule.
- Once the total claim paid under this Add-on Benefit reaches 100% of Sum Insured for an Insured Person, the cover under this Add-on Benefit will cease for the remainder of the Coverage Period and the Insured Person will not be eligible for this Add-on Benefit in subsequent Policy Years.

3.4.8 Accidental Disability Cover

If this benefit is in force, and if anyone insured under the policy suffers permanent total disability from an injury due to an accident that occurs during the coverage period and that Injury solely and directly results in the Permanent Total Disability of the Insured Person which is of the nature specified in the table below, within 365 days from the date of the Accident, we will make a payout. The payout will be made if the permanent total disability is of the nature mentioned below. The payout will be equal to the sum insured of the policy as defined in the policy schedule –

Nature of Total Disability
Total and irrecoverable loss of sight in both eyes
Loss by physical separation or total and permanent loss of use of both hands or both feet
Loss by physical separation or total and permanent loss of use of one hand and one foot
Total and irrecoverable loss of sight in one eye and loss of a Limb
Total and irrecoverable loss of hearing in both ears and loss of one Limb/ loss of sight in one eye
Total and irrecoverable loss of hearing in both ears and loss of speech
Total and irrecoverable loss of speech and loss of one Limb/ loss of sight in one eye
Permanent, total and absolute disability (not falling under any one the above) which results in the Insured Person being unable to engage in any employment or occupation or business for remuneration or profit, of any description whatsoever which results in Loss of Independent Living

For the purpose of this Add-on Benefit:

- Limb means a hand at or above the wrist or a foot above the ankle;
- Physical separation of one hand or foot means separation at or above wrist and/or at or above ankle, respectively.

Note:
This Add-on Benefit will be payable provided that:

- The Permanent Total Disability continues for a period of at least 180 days from the commencement of the Permanent Total Disability, and the Disability Certificate issued by the treating Medical Practitioner at the expiry of the 180 days confirms that there is no reasonable medical hope of improvement. It is clarified that this condition is not application for any Disability in the nature of a physical separation;
- Our maximum total liability against this benefit is limited to the sum insured; if an insured person suffers injuries resulting in more than one of the permanent total disabilities specified in the table above, then our maximum liability and payout will be capped at sum insured as defined in the policy schedule
- On the acceptance of a claim under this Add-on Benefit, all cover under this Policy shall immediately and automatically cease in respect of that Insured Person.

3.4.9 Value Added Services

If this benefit is in force, anyone insured under the policy would be made available with the below mentioned Value Added Services, either some or all, as mentioned in the policy schedule. By way of these preventive and wellness services, We intend to incentivize the Insured Persons to take care of their health and maintain a healthy lifestyle.

Note:

- You will have to bear the cost of utilizing these services, unless they are specifically covered under the policy.
- We will facilitate the services for the insured person's use through our Empaneled Service Providers.
- We do not assume any liability for the services or advice provided under this benefit by our Empaneled Service Providers.

Sr No.	Name of Service	Description
1.	e-Consultation	We will facilitate a digital appointment with a qualified Medical Practitioner who can help Insured Person(s) by providing round-the clock medical helpline services through an online portal as a chat service, a call back service or a voice call service.

2.	Wellness Coach	In order to educate, empower and engage the Insured Person to become more aware of the Insured Person's health and proactively manage it, We will, through periodic communications like e mailers, blogs and online platform provide the Insured Person information on wellness coaching in areas such as: • Weight management • Activity and fitness • Nutrition • Tobacco cessation • Alcohol abuse de-addiction program • Information on various diseases • Dietary plans
3.	Lab Services (Home Collection)	We will facilitate collection of test samples such as blood, urine, stool etc. from the Insured Person's home address for further testing and analysis at a special rate. The cost of these tests and reports will have to be borne by the Insured Person.
4.	Pharmacy (Home Delivery)	We will facilitate home delivery of the medications prescribed by a qualified Medical Practitioner from the nearby pharmacy empaneled with Us on Our Out-Patient Medical Services Network at a special rate, subject to copy of the prescription being shared (where ever required) and availability of the medication with the pharmacy. The cost of the medication will have to be borne by the Insured Person.
5.	Vital/Physical Activity Monitoring Services	We will facilitate integration of the Insured Person's health device(s) such as blood-pressure monitors, glucometers, wireless pedometers, smart watches and other digital well-being devices/appliances to an online database that will track and assess the Insured Person's vitals as reported by the health device. It can provide periodic updates and reports of the Insured Person's health status at a special rate. The cost of the device will have to be borne by the Insured Person.
6.	Reminder Notifications	We will facilitate routine notification messages via mail or a messaging portal or a follow-up call to the Insured Person as a reminder to schedule his/her medical appointments and/or take daily dosage of his/her prescribed medication as per the information shared by the Insured Person
7.	Medical Wallet	We will arrange for a 'medical wallet' for the online storage of the Insured Person's medical reports. This will be a digital cloud service which will allow the Insured Person(s) to store all his/her medical reports online. It will provide easy access of the Insured Person's medical history and reports to the treating Medical Practitioner(s) and to any other person with whom the Insured Person may share the login and access codes, easing the Insured Person's need to physically carry documents with the Insured Person. For the purpose of this Value-Added Service, the Insured Person is requested to not share the login/access codes or any other credentials for such medical wallet with any unauthorized parties, and we do not assume any liability for any unauthorized disclosure of such confidential medical information in this regard.
8.	Report Aggregation	We will facilitate the regular analysis of the Insured Person's health status as per the medical records/reports shared by the Insured Person. It will highlight the Insured Person's wellbeing or any areas of concern or deterioration in the Insured Person's health, allowing the Insured Person to take necessary calls about his/her health.

9.	Home Care Services	We will facilitate the following home care services for the Insured Person in case of need: • Home Care Nursing • Patient Assistant • Physiotherapy • Yoga Trainer • Psychologist • Palliative Care • Renting Medical equipment such as Wheelchair, Patient Bed, Oxygen Cylinder etc. at a special rate. The cost of the foregoing services/equipment will have to be borne by the Insured Person.
10.	Ambulance Arrangement Services	We will facilitate provision of an Ambulance for the Insured Person's transportation subject to availability of Ambulance in the area where such service needs to be arranged at a special rate. The cost of the transportation will have to be borne by the Insured Person.
11.	Pick-up and Drop Services for Consultation	We will facilitate pick-up and drop Service by road, for the Insured Person's transportation to the Network Provider or any health care facility empaneled with Us for treatment/diagnostics, subject to availability of vehicle/taxi in the area where such service needs to be arranged at a special rate. The cost of the transportation will have to be borne by the Insured Person.
12.	Prioritizing Appointments	We will facilitate prioritization of the Insured Person's appointment, based on the urgency, with the Network Providers offering the necessary treatment/ diagnostics subject to availability of the service(s). The cost of the consultancy/diagnostic will have to be borne by the Insured Person.

Terms and Conditions applicable to Wellness Program:

- Any Information provided by the Insured Person shall be kept confidential by Us and Our Network Providers/Empaneled Service Provider.
- For services which are provided through Our Network Providers/Empaneled Service Provider/, We act solely as a facilitator, and We would not be liable for any incidental, consequential or incremental costs of the services incurred by the Insured Person, of any nature.
- Any advice or recommendations provided under this Add-on Benefit should not be construed to constitute medical advice and/or substitute the Insured Person's visit/ consultation to an independent Medical Practitioner.
- We shall not be liable for any discrepancy in the information or services provided by the Network Provider and / or Empaneled Service Provider under this Add-on Benefit.
- All medical services are being provided by Network Providers/Empaneled Service Providers who are empaneled after proper due diligence. The Insured Person is free to consult their personal/ family doctor/Medical Practitioner before availing the medical services. The decisions to utilize the services will solely be at the discretion of the Insured Person.
- Availing the services under this Add-on Benefit is purely upon the customer's own discretion and at own risk. We shall have no liability and shall not be deemed to have any liability if the Insured Person fails to follow the advice of his or her Medical Practitioner or avails any of these services against the advice of his or her Medical Practitioner.
- We do not assume any liability and shall not be deemed to assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by any Medical Practitioner or the Network Providers/Empaneled Service Provider. The Insured Person's recourse for any such loss or damage shall be solely against the respective Network Provider or Empaneled Service Provider, and not against Us.

.

Section 4: Exclusions

We shall not be liable to make any payment under this Policy caused by, arising out of or attributable to any of the following. All the Waiting Periods shall be applicable individually for each Insured Person and claims shall be assessed accordingly.

4.1 Standard Exclusions

4.1.1 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 Policy 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 (Insurance Product) Regulations 2024, 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 Policy Schedule, for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer without any specific condition exclusion.

4.1.2 Specified disease/procedure waiting period- Code- Excl02

a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of number of months, as specified in the Policy Schedule, of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c. If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
d. The waiting period for listed conditions shall apply even if contracted after the policy.
e. The waiting period for listed conditions shall apply even if declared and accepted without a specific exclusion or Pre-existing disease waiting period.
f. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a waiting period.
g. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
h. List of specific diseases/procedures:
   1. **Eyes:** Cataract, Glaucoma and other disorders of lens, disorders of Retina
   2. **Stone:** Pancreatitis and Stones in Biliary and Urinary System
   3. **Genitourinary:** Abnormal Utero-vaginal bleeding, female genital Prolapse, Endometriosis/Adenomyosis, Fibroids, PCOD, or any condition requiring dilation and curettage or Hysterectomy, Any Surgery of the genitourinary system unless necessitated by malignancy.
   4. **Cysts, Tumor:** All internal or external benign or In Situ Neoplasms/Tumors, Cyst, Sinus, Polyp, Nodules, Swelling, Mass or Lump,
   5. **Prostate:** Hyperplasia of Prostate, Hydrocele, Varicocele and spermatocele
   6. **Rectal:** Hemorrhoids, Fissure or Fistula or Abscess of anal and rectal region, Pilonidal Sinus & Rectal Prolapse under Rectal disease.
   7. **Hernia:** Hernia of all sites
   8. **Arthritis:** Osteoarthritis, Systemic Connective Tissue disorders, Dorsopathies, Spondylopathies, inflammatory Polyarthritis, Arthrosis such as Rheumatoid Arthritis, Gout, Intervertebral Disc disorders, Joint Replacement Surgeries (other than caused by Accident)
   9. **Kidney:** Chronic kidney disease and failure
   10. **Varicose veins:** Varicose veins of lower extremities
   11. **Ear, Nose, Throat:** Disease of middle ear and mastoid including Otitis Media, Cholesteatoma, Perforation of Tympanic Membrane, Tonsils and Adenoids, Nasal Septum and Nasal Sinuses/Polyp
   12. **Internal Congenital:** Internal Congenital Anomaly
   13. **Gastro: Gastritis,** Gastroesophageal Reflux Disorder**,** Ulcer, Erosion and Varices of Upper Gastrointestinal Tract
   14. Ligament, Tendon & Meniscal Tear
   15. **Neurodegenerative disorders:** Conditions affecting the brain and nervous system like Parkinson's,

Alzheimer's disease, Dementia etc.

16. **Any other specific conditions in Schedule:** Any other condition or treatment mentioned under this head in the Schedule will have a waiting period as specified in the Schedule.

4.1.3 30-day waiting period- Code- Excl03

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

4.1.4 Investigation & Evaluation- Code- Excl04

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

4.1.5 Rest Cure, rehabilitation and respite care- Code- Excl05

Expenses related to any admission primarily for enforced bed rest and not for receiving active treatment. This also includes:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

4.1.6 Obesity/ Weight Control: Code- Excl06

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

1. Surgery to be conducted is upon the advice of the Doctor
2. The surgery/Procedure conducted should be supported by clinical protocols
3. The member has to be 18 years of age or older and
4. Body Mass Index (BMI);
   a) greater than or equal to 40 or
   b) greater than or equal to 35 in conjunction with any of the following severe co- morbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type 2 Diabetes

4.1.7 Change-of-Gender treatments: Code- Excl07

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

4.1.8 Cosmetic or plastic Surgery: Code- Excl08

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

4.1.9 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.

4.1.10 Excluded Providers: Code- Excl11

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/ notified to the policyholders are not admissible. However, in case of life-threatening situations **or** following an accident, expenses up to the stage of stabilization limited to sum insured are payable but not the complete claim.

4.1.11 Code- Excl13

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

4.1.12 Code- Excl14

Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure.

4.1.13 Refractive Error: Code- Excl15

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

4.1.14 Unproven Treatments: Code- Excl16

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness and have not been approved for medical use basis prevailing medical protocols

4.1.15 Sterility and Infertility: Code- Excl17

Expenses related to sterility and infertility. This includes:

(i) Any type of contraception, sterilization
(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
(iii) Gestational Surrogacy
(iv) Reversal of sterilization

4.1.16 Maternity: Code Excl18

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization or pre/post-hospitalisation) except ectopic pregnancy;
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

4.2 Specific Exclusions

4.2.1 Non-Payable Medical Expenses

We shall not be liable to pay the expenses towards those listed in Annexure 1 for any claim under Basic Benefit 3.2.1 (In-patient Hospitalization), Basic Benefit 3.2.3 (Day Care Treatment) or Basic Benefit 3.2.7 (Domiciliary Treatment Cover).

4.2.2 Permanent Exclusions Set 1 (Can be Waived if opted)

We shall not be liable to make any payment under this Policy for any Basic Benefits or Basic Benefit Options arising from or caused by any of the following (applicable for other than Personal Accident Add-on Benefits):

1. **Other sexually transmitted diseases**: Expenses for venereal disease or any sexually transmitted disease except HIV.
2. **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.
3. **Treatment taken outside India:** Any treatment outside of India is not covered unless specifically covered under Basic Benefit Option 3.3.1
4. **External Congenital Anomaly or defects**
5. **Specific Treatments:**
   a. Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure;
   b. Muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities;
6. **OPD Treatment:** OPD consultations, diagnostics tests, pharmacy costs shall not be payable unless covered as an Add-on Benefit (3.4.3) or is covered as a part of an admitted claim under Basic Benefit 3.2.1 (In-patient Hospitalization) or Basic Benefit 3.2.3 (Day care Treatment).

4.2.3 Permanent Exclusions Set 2 (Cannot be Waived)

We shall not be liable to make any payment under this Policy for any Basic Benefits or Basic Benefit Options arising from or caused by any of the following applicable for other than Personal Accident Add-on Benefits):

1. **Suicide:** Treatment for condition arising out of any insured Person committing or attempting to commit self harm or attempted suicide.
2. **Dental**: Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and Gingiva unless necessitated under inpatient or pre/post hospitalization care due to an Accident.
3. **Circumcision:** Circumcisions (unless necessitated by Illness or Injury and forming part of treatment); aesthetic.
4. **Prosthetics and Other Devices:** Prosthetics and other devices not implanted internally by surgery.
5. **War and Exposure to Hazardous Substances**: Treatment for any Injury or Illness resulting directly or indirectly from nuclear, radiological emissions, war or war like situations (whether war is declared or not), rebellion (act of armed resistance to an established government or leader), acts of terrorism, nuclear, biological or chemical emissions, rebellion, revolution, acts of terrorism.
6. **Hormonal Therapies:** Growth hormone therapy and/or any form of hormone replacement therapy (HRT) and/or administration of other hormonal medication.
7. **Substance abuse and addictions:** Expenses incurred for the treatment of any illness or injury which is a consequence of:
   - Alcohol intake, drug or substance abuse or any addictive condition and consequences thereof and.
   - Withdrawal and de-addiction
   - Treatment of Withdrawal and de-addiction.; and
   - Cancer of oral, oropharynx and respiratory system is specifically excluded in a tobacco user.

   However, it is hereby clarified that the foregoing exclusions do not exclude any cover under the Policy towards impairment of Persons' intellectual faculties by usage of drugs, stimulants or depressants as prescribed by a Medical Practitioner.
8. **Sleep Disorders:** Treatment for any conditions related to disturbance of normal sleep patterns or behaviors such as Sleep-apnea, snoring, etc.

4.2.4 Permanent Exclusions for Personal Accident Add-on Benefit

We shall not be liable to make any payment for any claim in respect of any Insured Person, directly or indirectly for, caused by or arising from or in any way attributable to any of the following unless otherwise stated in the Policy -

1. Any Pre-existing condition or Disability arising out of a Pre-existing Diseases or any complication arising therefrom.
2. Any payment in case of more than one claim under the Policy during any one Policy Period by which our maximum liability in that period would exceed the Sum Insured.
3. Suicide or attempted Suicide, intentional self-inflicted injury or acts of self-destruction.
4. Certification by a Medical Practitioner who shares the same residence as the Insured Person or who is a member of the Insured Person's Family.
5. Death or disablement arising out of or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country during war or at peace time), participation in any naval, military or air force operation, civil war, public defense, rebellion, revolution, insurrection, military or usurped power.
6. Death or disablement caused due to any condition other than accident shall not be covered except as necessary solely and directly as a result of an Accident.
7. Death or disablement directly or indirectly caused by or associated with any venereal disease, sexually transmitted disease.
8. Congenital external diseases, defects or anomalies or in consequence thereof
9. Benefit under Accidental Death, Permanent Total Disablement, Permanent Partial Disablement and Emergency Ambulance Cover arising from Bacterial infections (except pyogenic infection which occurs through an Accidental cut or wound).
10. Benefit under Accidental Death, Permanent Total Disablement, Permanent Partial Disablement and Emergency Ambulance Cover arising from Medical or surgical treatment except as necessary solely and directly as a result of an Accident.
11. Benefit under Accidental Death, Permanent Total Disablement, Permanent Partial Disablement and Emergency Ambulance Cover arising from Hernia.
12. Any change of profession after inception of the Policy which results in the enhancement of Our risk under the Policy, if not accepted and endorsed by Us on the Policy Schedule.
13. Death or disablement arising or resulting from the Insured Person committing any breach of law or

participating in an actual or attempted felony, riot, crime, misdemeanor or civil commotion with criminal intent.

14. Death or disablement arising from or caused due to use, abuse or a consequence or influence of an abuse of any substance, intoxicant, drug, alcohol or hallucinogen.
15. Death or disablement resulting directly or indirectly contributed or aggravated or prolonged by childbirth or from pregnancy or a consequence thereof;
16. Death or disablement caused by participation of the Insured Person in any flying activity, except as a bona fide, fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable.
17. Insured Persons whilst engaging in a speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports in so far as they involve the training for or participation in competitions or professional sports, or involving a naval, military or air force operation and is specifically specified in the Policy Schedule.
18. Working in underground mines, tunnelling or explosives, or involving electrical installation with high tension supply, or as jockeys or circus personnel, or engaged in Hazardous Activities.
19. Death or disablement arising from or caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.
20. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
21. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) microorganisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.
22. Any physical, medical condition or treatment or service that is specifically excluded in the Policy.

4.2.5 Medical Exclusion

Any treatment or part of a treatment that is not of a reasonable charge and/or not Medically Necessary as per the professional standards widely accepted in international medical practice or by the medical community in India.

4.2.6 Named Ailment Waiting Period or exclusion

Named ailment waiting period or exclusion on a disease, medical condition or procedure will supersede standard waiting periods specified in the policy terms for the insured.

4.2.7 Medical Practitioner Exclusion

Medical Practitioner who is sharing the same residence as the Insured Person and/or is a Family Member of the Insured Person are not considered as Medical Practitioner for the scope of coverage under this Policy.

Section 5: General Terms And Conditions

5.1 Standard General Terms and Clauses

5.1.1 Disclosure of Information

The Policy shall be void ab-initio and all premium paid thereon shall be forfeited to the Company in the event of established fraud or misrepresentation, mis-description or non-disclosure of any material fact.
"Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

5.1.2 Condition Precedent to Admission of Liability

The due observance and fulfilment of the terms and conditions of the policy, by the insured person, shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the policy.

5.1.3 Records to be maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the

Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

5.1.4 Complete Discharge

Any payment to the Insured Person or his/ her nominees or his/ her legal representative or to the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the Policy shall in all cases be a full, valid and an effectual discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

5.1.5 Notice and Communication

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

5.1.6 Territorial Limit

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

5.1.7 Multiple Policies

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

5.1.8 Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, the Policy shall be void ab-initio and all premium paid thereon shall be forfeited to the Company and all benefits under this policy shall be forfeited.
Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by the policyholder to the insurer.
For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue a insurance Policy:

1. the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
2. the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
3. any other act fitted to deceive; and
4. any such act or omission as the law specially declares to be fraudulent

The company shall not repudiate the policy on the ground of fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries. The Company shall not be precluded from repudiating the policy on the ground of fraud or misrepresentation of a material fact, unless the Insured Person can demonstrate that such material fact was explicitly disclosed to and acknowledged in writing by the Company prior to policy inception.

5.1.9 Cancellation

1. The Insured may cancel this Policy by giving 7 days' written notice, and in such an event, the Company shall refund to the Insured a proportionate premium for the unexpired policy period. Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy.
2. The Company may cancel the Policy at any time on grounds of established fraud by the Insured Person, by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds established fraud.

5.1.10 Automatic change in Coverage under the policy

The coverage for the Insured Person(s) shall automatically terminate:

1. In the case of his/ her (Insured Person) demise.
   However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to the company along with the application. Provided no claim has been made, and termination takes place on account of death of the insured person, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be effective.
2. Upon exhaustion of sum insured and cumulative bonus, for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

5.1.11 Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

5.1.12 Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per extant Guidelines related to Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, as per Guidelines on migration, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per below:

1. The waiting periods specified in Section 4.1.1, 4.1.2 & 4.1.3 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
2. Migration benefit will be offered to the extent of sum of previous sum insured and accrued bonus/multiplier benefit (as part of the base sum insured), migration benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Migration, kindly refer the link:
https://irdai.gov.in/document-detail?documentId=393128

5.1.13 Renewal of Policy

The policy shall ordinarily be renewable except on grounds of established fraud, non-disclosure, misrepresentation by the insured person, provided the policy is not withdrawn. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

1. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years
2. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
3. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits. Coverage is not available during the grace period for which premium payment had not been made.
4. No loading shall apply on renewals based on individual claims experience.
5. If not renewed within Grace Period after due renewal date, the Policy shall terminate.
6. The Company shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the Policyholder, the Insurer may underwrite only to the extent of increased sum insured or enhancement in coverage.
7. Renewal premium due can be paid prior to the due date as per norms set out by the Company

5.1.14 Premium Payment in Instalments

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

1. Grace Period of 15 days would be given to pay the monthly instalment premium and 30 days for quarterly and half yearly instalment option.
2. During such grace period, Coverage will be available from the instalment premium payment due date till the date of receipt of premium by Company.
3. The Benefits provided under – “Waiting Periods”, “Specific Waiting Periods” Sections shall continue in the event of payment of premium within the stipulated grace Period.
4. No interest will be charged If the instalment premium is not paid on due date.
5. In case of instalment premium due not received within the grace Period, the Policy will get cancelled.
6. In the event of a claim, all subsequent premium instalments may immediately become due and payable.
7. The Company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

5.1.15 Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are affected.

5.1.16 Free look period

The Free Look Period shall be applicable at the inception of the Policy and not on renewals or at the time of porting the policy.

The insured shall be allowed a period of thirty days (30 days) from date of receipt of the Policy to review the terms and conditions of the Policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

1. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges; or
2. where the risk has already commenced and the option of return of the Policy is exercised by the insured, a deduction towards the proportionate risk premium for period of cover or
3. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

5.1.17 Endorsements (Changes in Policy)

1. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.
2. The policyholder may be changed only at the time of renewal. The new policyholder must be the legal heir/immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

The policyholder may be changed during the Policy Period only in case of his/her demise or him/her moving out of India.

5.1.18 Change of Sum Insured

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

5.1.19 Terms and conditions of the Policy

The terms and conditions contained herein and, in the Policy Schedule, shall be deemed to form part of the Policy and shall be read together as one document.

5.1.20 Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. For Claim settlement under reimbursement, the Company will pay the policyholder. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

5.1.21 Claim Settlement (provision for Penal Interest)

1. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of intimation (unless there is any pending requirement to process the claim)
2. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Policyholder from the date of receipt of intimation to the date of payment of claim at a rate 2% above the bank rate.

5.2 Specific Terms and Clauses

5.2.1 Alterations in the Policy

This Policy constitutes the complete contract of insurance. No change or alteration will be effective or valid unless approved in writing which will be evidenced by a written endorsement, signed and stamped by Us.

5.2.2 Material Information for administration

You must give Us all the written information that is reasonably required to work out the premium and pay any claim / Benefit available under the Policy. You must give Us written notification specifying the details of the Insured Persons to be deleted and the details of the eligible persons proposed to be added to the Policy as Insured Persons. Billing for the Policy will be processed on the exact number of Insured Persons covered under the Policy.

Material information to be disclosed includes every matter that You and/or the Insured Person is aware of, or could reasonably be expected to know, that relates to questions in the proposal form and which is relevant to Us in order to accept the risk of insurance and if so on what terms. You must exercise the same duty to disclose those matters to Us before the Renewal, extension, variation, endorsement or reinstatement of the Policy. Accordingly, We reserve the right to apply additional options, exclusions and/or adjust the scope of cover and / or premium, if necessary, to reflect any circumstances or material facts declared to Us.

5.2.3 Geography

The geographical scope of this Policy applies to events limited to India unless specified otherwise under this Policy. All admitted or payable claims will only be settled in India.

Zone-wise classification

For the purpose of calculating premium, based on Your city of residence, We have classified two zones. In case of family floater policies, a single zone shall be applied to all the members covered under the same Policy. The two zones are defined below:

Zone A: Delhi/NCR, Mumbai including (Navi Mumbai, Thane and Kalyan), Kolkata (including Howrah)

Zone B: Rest of India

Zone opted by You is mentioned in Your Schedule.

5.2.4 Premium

The premium payable under this Policy shall be the amount specified in the Schedule. No receipt for premium shall be valid except on Our official form signed by Our duly authorized official. Payment of premium instalments under this Policy will be allowed on a monthly/quarterly/half yearly or yearly basis. In the event of a claim under the Policy, if the annual premium has not been received in full (applicable for monthly, quarterly, or half-yearly premium payment modes), the outstanding balance of the annual premium for the current Policy Year shall be deducted from the admissible claim amount at the time of settlement.

Premium will be subject to revision at the time of Renewal of the Policy and approved in accordance with the IRDAI rules and regulations as applicable from time to time. Further, premium shall be paid only in Indian Rupees and in favor of Acko General Insurance Limited.

5.2.5 Parties to the Policy

The only contracting parties to this Policy are You and Us.

5.2.6 Currency

All payments payable under this Policy will be settled in Indian Rupees (INR) only.

5.2.7 Addition and Deletion of a Member

We shall include/exclude any person as an Insured Person under the Policy in accordance with the following procedure:

(a) Additions

Any person may be added to the Policy as an Insured Person during the Policy Year provided that the application for cover has been accepted by Us, applicable premium for the risk coverage duration for the Insured Person has been received by Us and We have issued an endorsement confirming the addition of such person as an Insured Person under the Policy.

(b) Deletions
Any Insured Person who is covered under the Policy may be deleted upon Your request during the Policy Year. Refund of premium can be made on pro-rata basis, provided that no claim is paid / outstanding in respect of that Insured Person or his/her dependents.
In case of refund of premium being generated on the Policy due to deletion of an Insured Person, the same will be refunded or adjusted against any future premium instalments due and payable under the Policy.
Throughout the Policy Year, You will notify Us in writing, of any and all changes in the membership of the Policy in the same month in which the change occurs.

5.2.8 No Constructive Notice
Any knowledge or information of any circumstance or condition in relation to You/Insured Person in Our possession or in the possession of any of Our officials shall not be deemed to be notice or be held to bind or prejudicially affect Us or absolve You/Insured Person from their duty of disclosure, notwithstanding subsequent acceptance of any premium.

5.2.9 Endorsements
The Policy will allow endorsements during the Policy Year. Any request for endorsement must be made only in writing by You. Any endorsement would be effective from the date of the request received from You, or the date of receipt of premium, whichever is later other than for rectification of date of birth or gender which will be with effect from the Commencement Date. All endorsement requests may be assessed by the underwriting team and if required additional information/documents may be requested.

5.2.10 Special Conditions
Any special conditions subject to which this Policy has been entered into and endorsed in the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have
effect accordingly. It is further clarified that if any special condition is stipulated in the Schedule, then such special condition shall have effect accordingly.

5.2.11 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 coverage expiry date and in no case later than the Grace Period of 30 days (15 days for monthly premium payments) from the expiry of the Policy. We will not be liable to pay for any claim arising out of an insured event if such insured event occurs during the Grace Period for which the premium has not been paid. Renewals will not be denied except on 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. The provisions of Section 64VB of the Insurance Act, 1938 shall be applicable for commencement of any cover under the Policy. If the Policy is Renewed within the Grace Period, the Insured Persons shall be eligible for continuity of cover.

5.2.12 Our Right of Termination
Termination of Policy
Prior to the termination of the Policy, at the expiry of the period shown in the Schedule, cover will end immediately for all Insured Persons, if:

a. there is misrepresentation, fraud, non-disclosure of material fact by You / Insured Person and without any refund of premium, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.
b. there is non-cooperation by You / Insured person, and with refund of premium on pro rata basis after deducting Our expenses, by giving 15 days' notice in writing by Registered Post Acknowledgment Due /recorded delivery to Your last known address.
c. You/Insured Person does not pay the premiums owed under the Policy within the Grace Period/applicable revival period (where premium payment is in instalments).

Upon termination, cover and services under the Policy shall end immediately. Costs incurred towards any Treatment undergone after the date of termination shall not be paid. If Treatment has been authorised or an approval for Cashless Facility has been issued, We will not be held responsible for any Treatment costs if the Policy ends or member or dependent leaves the Policy before Treatment has taken place. However, We will be liable to pay in respect of all claims where the Treatment/admission has commenced before the date of termination of such Policy.
Termination for Insured Person's cover
The cover under the Policy will end for an Insured Person or Dependent on occurrence of the

following:

a. If You/Insured Person stops paying premiums for the Insured Person(s) and their Dependents (if any).
b. When this Policy terminates at the coverage expiry date specified shown in the Schedule.
c. If he or she dies.
d. When he or she ceases to be a Dependent.

5.2.13 Portability

The Insured Person will have the option to port the Policy to other insurers as per extant Guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

1. The waiting periods specified in Section 4.1.1, 4.1.2 & 4.1.3 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
2. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.
3. Continuity of Benefits will be provided for the period based on the number of years of continuous coverage under this Policy with Us.
4. The application of Portability should have been received by Us at least 30 days before, but not earlier than 60 days from the due date for renewal.
5. We can consider proposal for portability even if the Policyholder has approached within 15 days from the renewal date of the existing policy, but there shall not be any break in policy.
6. For porting to another health insurance policy available with Us, We may subject such proposal to Our medical underwriting and decide the terms and conditions upon which We may offer cover, the decision as to which shall be in Our sole and absolute discretion.
7. Subject to the decision of Our underwriting team, We will decide the terms and conditions upon which We may offer cover, the decision as to which shall be in Our sole and absolute discretion, subject to board approved Underwriting Policy.
8. After maintaining the retail health insurance policy with Us, the Insured Person may port the policy to any other retail product offered in the market in accordance with applicable law.

For Detailed Guidelines on Portability, kindly refer the link:
https://irdai.gov.in/document-detail?documentId=393128

5.2.14 Underwriting Loadings & Conditions

a. We may apply risk loading on the premium payable (excluding statutory levies and taxes) or special conditions on the Policy based upon the health status of the persons proposed to be insured and declarations made at the time of enrolment. These loadings be applied from the Commencement Date of the first Policy including subsequent Renewal(s) with Us. There will be no loadings based on individual claims experience.
b. We may apply a specific Sub Limit on a medical condition/ailment depending on the past history and declarations, or additional Waiting Periods on Pre-Existing Diseases or exclusion as part of the special Conditions specified in the Schedule.
c. We shall inform You about the applicable risk loading or special condition through a counteroffer letter and You would be required to respond with Your consent and additional premium (if any) within 7 working days of the issuance of such counter offer letter.
d. In case, You neither accept the counteroffer nor respond to Us within 7 working days, We shall cancel Your application and refund the premium paid. Your Policy will not be issued unless We receive Your consent.

5.2.15 Operation of Policy & Policy Schedule

The Policy shall be issued for the duration as specified in the Schedule. The Policy for the Insured Person takes effect on the Risk Commencement Date specified in the Schedule and ends on the coverage expiry date of the Policy.

5.2.16 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 centers, 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, or Our other products and services, shall constitute legally binding when done in compliance with Our terms for such facilities.

Section 6: Other Terms And Conditions

6.1 Claims Procedure

There are two modes of submitting a claim and you can utilize either one of the following -

1. You can file a reimbursement claim directly with ACKO.
2. You can file a cashless claim with ACKO or at any of our cashless network hospital providers.

You can view our network hospital list directly in the ACKO app or on the ACKO website, or by calling our customer service number. Please refer to the app or website for details of excluded provider in your vicinity.
Note: Our network and excluded provider/hospital list occasionally changes, so ACKO recommends you to check acko.com/gi/p/health/network hospitals or acko.com/download before your hospitalization for the most updated list of hospitals. As an insurance company, ACKO reserves the right to modify, add or restrict the list of network hospitals where you can avail a cashless policy or add/remove an excluded provider.

6.1.1 Claims Conditions

- For claims, we require you to submit any requested claims document within a set timeline to receive a payout.
- If you do not submit all of your documentation on time, we unfortunately may not be able to pay your claim.
- However, if it is not possible for you to submit the documentation earlier, we will make exceptions to pay your claim to you.
- If you buy a policy from ACKO, you agree to assist our representatives in understanding whether your claim is admissible under the policy you have bought.
- As an ACKO customer, you agree to allow our medical practitioners and ACKO representatives to review your medical and hospitalization records and to investigate facts around your claim.
- There may be cases where we require you to go through a medical examination for confirmation before we pay your claim. ACKO will pay for your medical examination in such cases.
- The Company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted.
- In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the legible copies of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company. The Company reserves the right to independently verify the authenticity of such documents and the claim settlement from the other insurer and/or the Hospital, and its acceptance of such copies shall be contingent upon such verification being satisfactory to the Company.
- If requested by the Company, at the Company's cost, the Insured Person must submit to medical examination by Medical Practitioner appointed by the Company as often as it is considered reasonable and necessary and Company's representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment, and to investigate the circumstances pertaining to the claim.
- Any delay in notification or submission may at the Company's sole discretion be condoned on merit where delay is satisfactorily proved by the Insured Person to be for reasons beyond their control.
- The Pre and Post-Hospitalisation Medical Expenses Cover claim per Basic Benefit 3.2.4 (Pre and Post-Hospitalization Medical Expenses) shall be processed only after the Hospitalization claim has been admitted under Basic Benefit 3.2.1 (In-patient Hospitalization) or Basic Benefit 3.2.3 (Day Care Treatment).

6.1.2 Claim Registration

When you decide to go for a hospitalization which you plan to claim for, you or your dependents / nominee must notify ACKO - either directly through our app, email or call center or through our TPA partners at the hospital cashless desk.
If you are planning a hospitalization, as an ACKO customer, you agree to inform us about the hospitalization ~3 days in advance of the planned hospitalization. If you have to undergo an emergency hospitalization, as an ACKO customer, you agree to inform us about your hospitalization within 48 hours of being admitted, before discharge. In case you delay informing ACKO outside these timelines, your smooth claim process may be impacted.
When you notify ACKO or our network hospitals that you plan to go for a cashless hospitalization, you will be required to provide ACKO with the following -

- a copy of your policy card (available in the app)
- a photo ID proof
- an address proof (e.g. a voter ID card / driving license / passport / PAN card / any other identity proof as approved by ACKO).
- When you file a claim with ACKO, you may be required to inform ACKO of the following:
- Your policy number / UHID number
- The name of the policyholder

- The name of the insured person for whom you are claiming
- The nature of the injury / medical issue
- The name and address of the hospital and name of your doctor
- The date of admission (start date of the hospitalization)
- Other information related to your claim

6.1.3 Cashless Claims Process

Cashless claim is a process where you can have your insurance company pay a network hospital directly before discharge rather than requiring you to register a reimbursement claim after discharge from a hospital.
In most cases, you will have some part of the claim to pay after you are discharged (except if you have paid for add-ons that cover these costs and they are applicable), e.g. any non- covered expenses, any expenses exceeding your sum insured or sub-limits, a co-pay or a deductible. You will be responsible to pay this amount directly to the hospital.

Pre-Authorization Process

The Insured Person can avail Cashless facility at the time of admission into any Network Provider by presenting the health card as provided by Us with this Policy along with a photo identification proof and address proof (voter ID card / driving license / passport / PAN card / any other identity proof as approved by Us).

1. For Planned Hospitalization:
   a) You shall at least 3 days prior to the Date of Admission to the Hospital approach the Network Provider for Hospitalization for undergoing medical Treatment.
   b) The Network Provider will issue the request for authorization letter for Hospitalization in the pre-authorization form.
   c) The Network Provider shall send the pre-authorization form along with all the relevant details to the 24-hour authorization/ cashless department along with contact details of the treating Medical Practitioner and the Insured Person.
   d) Upon receiving the pre-authorization form and all related medical information from the Network Provider, We will verify the eligibility of cover under the Policy.
   e) Wherever the information provided in the request is sufficient to ascertain the authorization and the claim is admissible, We shall issue the authorization letter to the Network Provider.
   f) Wherever additional information or documents are required, We will call for the same from the Network Provider and upon satisfactory receipt of the last necessary documents, the authorization will be issued.
   g) The authorization letter will include details of the sanctioned amount, diagnosis, and date of approval.
   h) The authorization letter shall be valid only for a period of 15 days from the date of issuance of authorization or policy expiry date, whichever is earlier.
2. In case of Emergency Hospitalization
   a) You may approach the Network Provider for Hospitalization for medical Treatment.
   b) The Network Provider shall forward the request for authorization to You & Us within 48 hours of admission to the Hospital as per the process specified under Section 6.1.3(1) above.
   c) It is agreed and understood that We may continue to discuss the Insured Person's condition with the treating Medical Practitioner till Our recommendations on eligibility of coverage for the Insured Person are finalized.
   d) In the interim, the Network Provider may either consider treating the Insured Person by taking a token deposit or treating him as per their norms in the event of any situation which requires saving of life, limb, sight or any other Emergency Care.
   e) The Network Provider shall refund such deposit amount to the Insured Person less any token amount to take care of non-covered expenses once the pre- authorization is issued.

Enhancement to Pre-Authorized Amount:

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

- The Network Provider shall request Us for an enhancement of authorization limit including details of the specific circumstances which have led to the need for increase in the previously authorized limit. We will verify the eligibility and evaluate the request for enhancement on the availability of further limits.
- We shall duly intimate Our acceptance or declinature of such request for enhancement of preauthorized limit for enhancement to the Network Provider.
- In the event of any change in the diagnosis, plan of Treatment, cost of Treatment during Hospitalization to the Insured Person, the Network Provider shall obtain a fresh authorization letter from Us in accordance with the process described under 6.1.3(1) above, as the earlier issued authorization be invalid due to change in approved conditions.

Discharge Process:

At the time of discharge -

- The Network Provider may forward a final request for authorization for any residual amount to Us along with the discharge summary and the detailed bill break up in accordance with the process described at 6.1.3(1) above.
- Upon receipt of the final authorization letter from Us, the Insured Person may be discharged by the Network Provider.
- In the event of any change in the diagnosis, plan of Treatment, cost of Treatment during Hospitalization to the Insured Person, the Network Provider shall obtain a fresh authorization letter from Us in accordance with the process described under 6.1.3(1) above, as the earlier issued authorization be invalid due to change in approved conditions.

Note:

- Applicable to Section 6.1.3(1) and Section 6.1.3(2) Cashless Facility for Hospitalization expenses shall be limited exclusively to Medical Expenses incurred for Treatment undertaken in a Network Provider for Illness or Injury, as the case may be which are specified to be covered under the applicable Benefits under the Policy.
- For all cashless authorizations, the Insured Person will, in any event, be required to settle all non-admissible expenses, expenses above specified Sub Limits (if applicable), Co Payments and / or opted Deductible (Per claim / Aggregate) (if applicable), directly with the Hospital.

Submission of Claim Documents:

- 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 discharge of the Insured Person from the Hospital:
  - Original pre-authorization request
  - Copy of pre-authorization letter (s)
  - Documents listed under Section 6.1.4 (Reimbursement Claim Process).
- We may call for any additional documents from the network provider as required based on the circumstances of the claim, before making final claim payment to the provider on your behalf.

Note: There can be instances where We may deny Cashless Facility for Hospitalization due to insufficient Sum Insured or insufficient information to determine admissibility in which case the Insured Person may be required to pay for the Treatment and submit the claim for reimbursement to Us in accordance with Section 6.1.4, which will be considered subject to the Policy terms and conditions.

6.1.4 Claim Reimbursement Process

Wherever you have opted for a reimbursement of Medical Expenses, you may submit the following documents for reimbursement of the claim to Our branch or head office at your own expense not later than 15 days from the date of discharge from the Hospital. You can download a copy of claim form from Our website www.acko.com/gi or initiate the reimbursement claim process on app or website directly.

The list of necessary claim documents to be submitted for reimbursement in case of hospitalization are as following:

(Note: The Company reserves the right to verify the authenticity and validity of such documents and the Hospital's credentials)

- Claim form duly filled and signed by the insured
- Original Discharge/Day Care/Transfer summary
- Original Death Summary (in case of death)
- Copy of the Hospital's Registration Certificate/ Hospital Registration number in case of Hospitalization in any non-Network Provider of the Company or certificate from Hospital authorities detailing the facilities available including number of beds (to be submitted wherever required by the Company)
- Original hospital bill with detailed break-up of charges applied by hospital
- Original payment receipts with receipt numbers & stamp/ seal of the provider
- Original Pharmacy/ medicine receipts with receipt numbers & stamp / seal of the provider
- Copy of Invoice/Stickers/barcode in case of implants
- Copy of all Laboratory and test reports along with prescription by Medical Practitioner and invoice / bill with receipt from diagnostic center
- First consultation paper from doctor stating the origin duration and progress of illness
- All previous consultation papers indicating history and treatment details for current Illness and advice for current Hospitalization
- Copy of FIR/ MLC certificate (Accident claims)

- History of alcohol consumption or any intoxication at the time of incident, certified by first treating doctor in case of Accident cases
- Copy of medical prescription
- Copy of indoor case papers with nursing sheet detailing medical history of the Insured Person, treatment details, and patient's progress (to be submitted wherever required by the Company)
- Original invoices for the expenses incurred towards ambulance facility along with details of loss in the Company's prescribed format
- Invoice for vaccination and payment receipt
- Duly filled NEFT Mandate form (NEFT details and cancelled cheque of the proposer with Name of the client/ Bank Name / IFSC code and account number or First page of passbook with Name of the client/ Bank Name/IFSC code and account number)
- A copy of your Aadhaar card, or any other government photo ID and PAN Card. This is not mandatory if your ID card is linked with the policy while issuance or in a previous claim
- KYC documents must be resubmitted if there are any changes to the individual eligible to receive claim reimbursement or to the Policyholder's KYC information, in accordance with AML guidelines.
- Legal heir/succession certificate, wherever applicable
- Certificate from the treating doctor stating the circumstances due to which domiciliary treatment was administered (for domiciliary hospitalization claims only)
- For claims outside India, written advice from the overseas treating Medical Practitioner for requirement of an accompanying person during treatment.
- Other documents as may be required by Acko General Insurance to determine the admissibility of claim

Additional documents needed in case of –

Domestic Emergency Evacuation:

- Medical Certificate from the treating doctor stating the detailed clinical condition of the insured and the necessity for emergency medical evacuation
- Fit to fly certificate from the treating doctor

Second Opinion:

- Medical certificate from the treating doctor recommending in-patient hospitalization
- Copy of all medical records (Consultation papers/ investigation reports)
- Original second opinion consultation paper
- Original payment receipt with receipt number stamp and seal of the provider (Second Opinion)

Daily Hospital Cash:

- A copy of the hospital discharge card
- A copy of the hospital bill, money receipt, duly signed with a revenue stamp card

Accidental Death or Disability Cover:

- Attested copy of the death certificate
- Attested copy of the FIR/Panchanama/Inquest Panchanama
- Attested copy of the post-mortem report
- Attested copy of the viscera report (Only if it is preserved and sent for further analysis that is mentioned on the post-mortem report)
- Attested copy of the disability certificate from a civil surgeon of a government hospital stating percentage and type of disability
- All X-ray/investigation reports and films supporting the disability
- Photograph of the patient before and after the accident to support the disability

6.1.5 Scrutiny of Claim Documents

- We shall scrutinize 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.
- 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.
- We will send a maximum of 3 (three) reminders.
- 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.
- In case a reimbursement claim is received when a pre-authorization letter has been issued, before approving such a claim, a check will be made with the Network Provider whether the pre-authorization has

been utilized as well as whether the Insured Person has settled all the dues with the Network Provider. Once such a check and declaration is received from the Network Provider, the case will be processed.

6.1.6 Claim Assessment

We will pay the fixed or indemnity amount as specified in the applicable Basic Benefit or Basic Benefit Option in accordance with the terms of this Policy.
We will assess all admissible claims under the Policy in the following progressive order –

- If any Sub-Limit on Medical Expenses are applicable as specified in the Schedule, Our liability to make payment shall be limited to the extent of the applicable Sub Limit for that Medical Expense.
- Opted Deductible (Per claim / Aggregate), if any, shall be applicable on the amount payable by Us after applying for the above.
- Co-Payments if any, shall be applicable on the amount payable by Us after applying the above.
- The claim amount assessed under the Policy will be deducted from the following amounts in the following progressive order (after applying Sub Limit, where applicable)

Claim Assessment for fixed benefits:
We will pay fixed benefit amounts as specified in the Schedule in accordance with the terms of this Policy. We are not liable to make any reimbursements of Medical Expenses or pay any other amounts not expressly specified in the Policy.

6.1.7 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 15 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 issued by IRDAI and as amended from time to time. 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 15 days from the date of receipt of the last necessary document. In such cases, We shall settle or reject the claim, as may be the case, within 15 days from the date of receipt of the last necessary document.

6.1.8 Pre and Post-Hospitalization Medical Expenses Cover claims

The Insured Person should submit the Post-Hospitalization Medical Expenses claim documents at his/her own expense within 15 days of completion of the Post-Hospitalization period of cover.
We shall receive Pre and Post- Hospitalization Medical Expenses Cover claim documents either along with papers for Basic Benefit 3.2.1 (In-patient Hospitalization) or separately and process the same based on merit of the claim derived on the basis of the documents received.

6.1.9 Settlement and Repudiation of a claim

As an insurance company, We shall settle the claim within 15 days from the date of receipt of the last necessary document in accordance with the provisions of the IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024 , 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 intimation to the date of payment of claim at a rate 2% above the bank rate.

6.1.10 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 represent to Us for reconsideration of the decision.

6.1.11 Claim Payment Terms

- We shall have no liability to make payment of a claim under the Policy in respect of an Insured Person once the applicable Sum Insured for that Insured Person is exhausted.
- All claims will be payable in India and in Indian rupees.
- The Sum Insured opted under the Policy shall be reduced by the amount payable / paid under the Policy terms and conditions and any covers 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.
- If the Insured Person suffers a relapse within 45 days from the date of discharge from the Hospital for which a claim has been made, then such relapse shall be deemed to be part of the same claim and all the limits for "Any one illness" under this Policy shall be applied as if they were under a single claim.

For Cashless claims, the payment shall be made to the Network Provider whose discharge would be complete and final.

For Reimbursement claims, the payment shall be made to the Insured Person. In the unfortunate event of the Insured Person's death, We will pay the Nominee (as named in the Schedule) and in case of no Nominee, to the legal heir who holds a succession certificate or indemnity bond to that effect, whichever is available and whose discharge shall be treated as full and final discharge of Our liability under the Policy.

Section 7: Grievance Redressal

For resolution of any query or grievance, insured may contact the company on our helpline number **1800 266 2256** or toll free number **1860 266 2256** or may write an e-mail at hello@acko.com.

If there is lack of response or if the response provided does not meet your expectation, you can write to grievance@acko.com. Your complaint will be acknowledged by us within 24 working hours.

If in case you are dissatisfied with the decision/resolution provided through details indicated above on your Complaint or have not received any response within 14 working days, you may write or email to,

Chief Grievance Officer

Acko General Insurance Limited, 36/5 Hustlehub One East, Somasandrapalya, 27th Main Road, Sector 2, HSR Layout, Karnataka Bangalore – 560102

Phone: 1800 266 2256 (Toll-Free) or 1860 266 2256 Email: gro@acko.com

If your issue remains unresolved within 14 days of lodging a complaint with us and you wish to pursue other avenues for redressal of grievances, you may approach IRDAI by calling on the Toll-Free no. 155255 or you can register an online complaint on the website Bima Bharosa

Insurance Ombudsman for Redressal, whose details are given below:

General Manager Consumer Affairs Department- Grievance Redressal Cell

Website: https://cioins.co.in/Ombudsman

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

Where the grievance is not resolved, the insured 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, Near S.V College, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/ Email: oio.ahmedabad@cioins.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: oio.bengaluru@cioins.co.in

BHOPAL - Office of the Insurance Ombudsman, LIC of India Zona! Office Bldg.. 1st Floor, South Wing,Jeevan Shikha, opp. Gayatri Mandir, Hoshangabad Road, Bhopal-462011. Tel.: - 0755-2769201/02/03/00, Email: oio.bhopal@cioins.co.in

BHUBANESHWAR - Office of the Insurance Ombudsman, 62, Forest Park, Bhubaneshwar-751 009. Tel.:- 0674- 2596461/55/29/03 Email: oio.bhubaneswar@cioins.co.in

CHANDIGARH - Office of the Insurance Ombudsman, Jeevan Deep Ground Floor, LIC of India Bldg**.,** SCO 20-27, Sector 17-A, Chandigarh -160017, Tel: 0172-2706468/7468, Email: oio.chandigarh@cioins.co.in

CHENNAI - Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453(Old 312), Anna Salai, Teynampet, CHENNAI-600018. Tel.: - 044-24333668/78 Email: oio.chennai@cioins.co.in

DELHI - Office of the Insurance Ombudsman, 2/2 A,1st Floor Universal Insurance Building, Asaf Ali Road, New Delhi-110 002. Tel.: - 011- 46013992 Email: oio.delhi@cioins.co.in

GUWAHATI - Office of the Insurance Ombudsman, Jeevan Nivesh Bldg, 5th Floor, S.S. Road, Guwahati-781001 (ASSAM) Tel: 0361- 2632204 / 2632205/ 2631307 Email: oio.guwahati@cioins.co.in

HYDERABAD - Office of the Insurance Ombudsman, 6-2-46, 1st Floor, "Moin Court", Lane Opp. Hyundai Showroom, A.C. Guards, Lakdi-Ka-Pool, Hyderabad-500 004. Tel: 040 – 23312122/ 223376991/23376599/23328709/23325325 Email: oio.hyderabad@cioins.co.in

JAIPUR - Office of the Insurance Ombudsman, Jeevan Nidhi – II, Ground Floor, Bhawani Singh Road, Ambedkar Circle, Jaipur – 302 005 Tel: 0141-2740363 Email: oio.jaipur@cioins.co.in

KOCHI - Office of the Insurance Ombudsman, 10th Floor, LIC Bldg, Jeevan Prakash, Opp to Maharaja

College Ground M.G Road, Ernakulam, Kochi-682011 Tel: 0484-2358759 Email: oio.ernakulam@cioins.co.in

KOLKATA - Office of the Insurance Ombudsman, Hindustan Building. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA 700072. Tel.: 033-22124339/22124341 Email: oio.kolkata@cioins.co.in

LUCKNOW - Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226001. Tel.: 0522-4002082/3500613 Email: oio.lucknow@cioins.co.in

MUMBAI - Office of the Insurance Ombudsman, IIIrd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz west, Mumbai – 400054. Tel:69038800/33, Email: oio.mumbai@cioins.co.in

NOIDA - Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P - 201301. Tel.: 0120- 2514252 / 2514253 Email: oio.noida@cioins.co.in

PATNA - Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800001. Tel.: 0612- 2547068 Email: oio.patna@cioins.co.in

PUNE - Office of the Insurance Ombudsman, Jeevan Darshan LIC of India Bldg., 3rd Floor, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: oio.pune@cioins.co.in

Thane- Office of the Insurance Ombudsman, 2nd floor , Jeevan Chintamani Building, Vasanat Rao Naik Mahamarg, Thane(West), Thane -400604, Tel: 022-20812868, 20812869, Email: oio.thane@cioins.co.in

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/gi.

Annexure

Annexure 1: List of Non-payable Medical expenses

Sr. No.	Item
1	Baby Food
2	Baby Utilities Charges
3	Beauty Services
4	Belts/ Braces
5	Buds
6	Cold Pack/Hot Pack
7	Carry Bags
8	Email / Internet Charges
9	Food Charges (Other Than Patient's Diet Provided By Hospital)
10	Leggings
11	Laundry Charges
12	Mineral Water
13	Sanitary Pad
14	Telephone Charges
15	Guest Services
16	Crepe Bandage
17	Diaper Of Any Type
18	Eyelet Collar
19	Slings
20	Blood Grouping And Cross Matching Of Donors Samples
21	Service Charges Where Nursing Charge Also Charged
22	Television Charges
23	Surcharges
24	Attendant Charges
25	Extra Diet Of Patient (Other Than That Which Forms Part Of Bed Charge)
26	Birth Certificate
27	Certificate Charges
28	Courier Charges
29	Conveyance Charges
30	Medical Certificate
31	Medical Records
32	Photocopies Charges
33	Mortuary Charges
34	Walking Aids Charges
35	Oxygen Cylinder (For Usage Outside The Hospital)
36	Spacer
37	Spirometre
38	Nebulizer Kit
39	Steam Inhaler
40	Armsling
41	Thermometer
42	Cervical Collar
43	Splint
44	Diabetic Foot Wearfootwear
45	Knee Braces (Long/ Short/ Hinged)
46	Knee Immobilizer/Shoulder Immobilizer
47	Lumbo Sacral Belt
48	Nimbus Bed Or Water Or Air Bed Charges
49	Ambulance Collar
50	Ambulance Equipment
51	Abdominal Binder
52	Private Nurses Charges- Special Nursing Charges
53	Sugar Free Tablets
54	CREAMS POWDERS LOTIONS (Toiletries Are Not Payable, Only Prescribed Medic Pharmaceuticals Payable)
55	Ecg Electrodes
56	Gloves

57	Nebulisation Kit
58	Any Kit With No Details Mentioned [Delivery Kit, Orthokit, Recovery Kit, Etc]
59	Kidney Tray
60	Mask
61	Ounce Glass
62	Oxygen Mask
63	Pelvic Traction Belt
64	Pan Can
65	Trolly Cover
66	Urometer, Urine Jug
67	Ambulance
68	Vasofix Safety
69	Administrative Charges
70	Registration Fees
71	Bio – Medical Waste Charges
72	House Keeping Charges