Acko Personal Health Policy

Prospectus

Section 1: Introduction

A unique and innovative indemnity product which covers expenses incurred on hospitalization due to illness or accident in India and overseas alike. It is essential that people understand the features, advantages and the necessity of insurance policies in detail.

Acko General Insurance provides the following benefits to its customers:

- Wide range of Sum Insured Limit
- Easy & Transparent buying Process
- Guidance from Trained Professionals: Get unbiased insurance related advice from Acko's trained professionals.
- Quick Claim Settlement: When a claim is filed, Acko tries to settle it in a quick and hassle-free manner.

Section 2: Policy Information

2.1 Eligibility Criteria

1. This Policy covers persons in the age group 91 days onwards (* 18 years for PA add-on benefits).
2. There is no maximum entry age restricted (*75 years for PA add-on benefits).
3. Child above 91 days will be added in the policy as per underwriting assessment process.
4. The maximum entry age for a dependent child is 24 years. Post this age, the child will be treated as an Adult in the Policy.
5. There is no maximum cover ceasing age.
6. Age means "age as on last birthday" as on the date of first policy issuance or at renewal. If any age changes during proposal stage, then "age" at submission of proposal from would be considered for premium calculation.
7. This policy can be issued to an individual and/ or a family floater basis.
8. The Sum Insured for hospitalization cover may be taken on Individual or Floater basis for the family.
9. Relationship allowed in a policy: Self, spouse, son, daughter-in-law, daughter, son-in-law, father, mother, father-in-law, mother-in-law, grandfather, grandmother, grandson, granddaughter, brother, sister, sister-in-law, brother-in-law, nephew, niece, Partner.

2.2 Policy Period

This policy will be issued for a period of 1 year / 2 year / 3 year

2.3 Sum Insured

Sum Insured options 3 lacs, 5 lacs, 10 lacs, 15 lacs, 25 lacs, 50 lacs, 1 cr,1.5 cr, 2.5 cr, 5 cr, 10 cr, Unlimited.

2.4 Premium Payment Option

Mode of payment: Any, as per the allowed IRDAI options
Frequency of payment: For 1 Year Policy- Monthly / Quarterly / Half Yearly / Single payment
For 2 Years or 3 Years Policy- Single payment

Section 3: Benefits

3.1 Basic Benefits

All the Benefits under this Section are available to the Insured Person(s). The Sum Insured limits, Exclusions including waiting periods and cover options applicable are as opted by You in the proposal form and as specified in the Schedule.

Claims under the Basic Benefits "In-patient Hospitalization" and "Day-care treatment" will be admissible subject to the fulfilment of the following conditions with respect to the Insured Person's Hospitalization:

- The Hospitalization of the Insured Person is caused solely and directly due to an Illness contracted or an Injury sustained by the Insured Person, during the Coverage Period, as specified in the Schedule.
- The Date of Admission is within the Coverage Period.
- The Hospitalization is for a Medically Necessary Treatment condition and commences and continues on the written advice of the treating Medical Practitioner.

3.1.1 In-patient Hospitalization

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

- Hospital room rent
- ICU/CCU/HDU charges
- Operation room charges
- 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)
- Ayush Treatment : Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines

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.

3.1.2 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.

3.1.3 Day Care Treatment

If anyone insured under the policy undertakes Day Care Treatment in a hospital / nursing home / day care centre, we will cover the expenses of the day care treatment.

Note:

- Any treatment undertaken as an Out-Patient or in an out-patient department is not covered

3.1.4 Pre or Post Hospitalization Medical Expenses

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

3.1.5 Road Ambulance Limit

If anyone insured under the policy needs to be transported to a hospital or day care centre by an ambulance or public transport for emergency care, then we will cover the reasonable cost of such transportation.

3.1.6 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.

3.1.7 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.

3.1.8 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.

3.1.9 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.

3.2 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 insurer and specifically mentioned in the policy schedule will be applicable.

3.2.1 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.

3.2.2 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.

3.2.3 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 3.1.1) or day care treatment (Basic Benefit 3.1.3), 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.

3.2.4 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 3.1.1) or day care treatment (Basic Benefit 3.1.3).

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.

3.2.5 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 3.1.1) or day care treatments (Basic Benefit 3.1.3). The list of our preferred provider network will be available in the policy schedule or our website www.acko.com.

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.

3.2.6 Co-pay

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

3.2.7 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.

3.2.8 Waiver of non-payable medical expenses

If this benefit is in force, we will cover all the reasonable medical expenses listed in the Annexure 1 "List of excluded expenses (non-medical)" and on Our website www.acko.com

3.2.9 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.

3.2.10 Reduction in Specific illness waiting Period

In case of a policy containing basic benefits (Basic Benefits 3.1), 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.

3.2.11 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 Medical Examination by a Medical Practitioner
2. Complete Blood Count (CBC)
3. Erythrocyte sedimentation rate (ESR)
4. Fasting Blood Sugar (FBS)
5. Electrocardiogram (ECG)
6. Serum Creatinine,
7. Serum Gamma-Glutamyl Transferase (GGT)
8. Serum Total Cholesterol (T Chol)
9. Serum Triglyceride (S. Trig)

3.2.12 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, as specified in the policy schedule.

3.2.13 Initial 30 days waiting period waiver

In case of a policy containing basic benefits (Basic Benefits 3.1), there exists an initial 30-day waiting period for any claims for treatments or procedures within the first 30 days of 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.

3.3 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 insurer and specifically mentioned in the policy schedule will be applicable.

3.3.1 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 empanelled service provider.

3.3.2 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.

3.3.3 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 centre 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:** 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.

3.3.4 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.

3.3.5 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.

3.3.6 Daily Hospital Cash

If this benefit is in force, in case a claim is admitted under Basic Benefit 3.1.1 (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.

3.3.7 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, 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 will be made within 365 days from the date of accident. 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%

3.3.8 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, 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 and be made within 365 days from the date of accident, 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

3.3.9 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.

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 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.

Sr No.	Name of Service	Description
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: o Weight management o Activity and fitness o Nutrition o Tobacco cessation o Alcohol abuse de-addiction program o Information on various diseases o 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. 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 empanelled with Us on Our Out-Patient Medical Services Network, 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 asses 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. 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 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

Sr No.	Name of Service	Description
		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 unauthorised parties, and we do not assume any liability for any unauthorised 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: o Home Care Nursing o Patient Assistant o Physiotherapy o Yoga Trainer o Psychologist O Palliative Care o Renting Medical equipment such as Wheelchair, Patient Bed, Oxygen Cylinder etc 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. 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 empanelled with Us for treatment/diagnostics, subject to availability of vehicle/taxi in the area where such service needs to be arranged. 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.

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 (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d. Coverage under the policy after the expiry of number of months, as specified in the Policy Schedule,for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

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 or declared and accepted without a specific exclusion.
e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f. List of specific diseases/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
   4. **Cysts, Tumour:** All internal or external benign or In Situ Neoplasms/Tumours, Cyst, Sinus, Polyp, Nodules, Swelling, Mass

or Lump,

5. **Prostate:** Hyperplasia of Prostate, Hydrocele and spermatocele
6. **Rectal:** Haemorrhoids, Fissure or Fistula or Abscess of anal and rectal region
7. **Hernia:** Hernia of all sites
8. **Arthritis:** Osteoarthritis, Systemic Connective Tissue disorders, Dorsopathies, Spondylopathies, inflammatory Polyarthropathies, Arthrosis such as RA, Gout, Intervertebral Disc disorders
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
12. **Internal Congenital:** Internal Congenital Anomaly
13. **Gastro:** Ulcer, Erosion and Varices of Upper Gastrointestinal Tract
14. **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 insuredin 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 purposesonly 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

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

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

4.1.6 Obesity/ Weight Control: Code- Excl06

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

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 Type2 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 Excluded Providers: Code- Excl11

Expenses incurred towards treatment in any hospital or by any Medical Practitioner orany 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 are payable but not the complete claim.

4.1.10 Code- Excl13

Treatments received in heath 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.

4.1.11 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.

4.1.12 Refractive Error: Code- Excl15

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

4.1.13 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

4.1.14 Maternity: Code Excl18

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) 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 Excluded Medical Expenses

We shall not be liable to pay the expenses towards Non-Medical Expenses as listed in Annexure 1 for any claim under Basic Benefit 3.1.1 (In-patient Hospitalization), Basic Benefit 3.1.3 (Day Care Treatment) or Basic Benefit 3.1.7 (Domiciliary Treatment Cover).

4.2.2 Permanent Exclusions Set 1 (Can 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. **Self-inflicted Injury**: Any condition occurring as a result of self-injury inflicted by the Insured Person.
2. **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.
3. **HIV and AIDS**: Treatment of HIV and Acquired Immune Deficiency Syndrome (AIDS), whether or not sexually transmitted.
4. **Other sexually transmitted diseases**: Treatment of any sexually transmitted diseases or infections (other than HIV and AIDS), including the screening and prevention of such diseases or infections.
5. **Hazardous or Adventure Sports: Code-Excl09**
   Expenses related to any treatment necessitated due to participation as a professionalin 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.

6. **Unproven and Experimental Treatment:**
   - **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.
   - **Radio Frequency Ablation:** Use of Radio Frequency (RF) probe for ablation or other procedure unless specifically approved by Us in writing in advance.
7. **Treatment taken outside India:** Any treatment outside of India is not covered unless specifically covered under Basic Benefit Option 3.2.1

8. **External Congenital Anomaly or defects**
9. **Treatment undergone other than Allopathic treatment or AYUSH Treatment;**
10. **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 (excludinghairline fractures) and dislocations of the mandible and extremities;
    c. Treatment for Rotational Field Quantum Magnetic Resonance (RFQMR), External Counterpulsation (ECP), Enhanced External Counterpulsation (EECP);
    d. Hyperbaric Oxygen Therapy, high intensity focused ultrasound, balloon sinuplasty, Deep Brain Simulation, Holmium Laser Enucleation of Prostate, KTP Laser Surgeries, cyber knife treatment, Femto laser surgeries;
    e. Bioabsorbable stents, bioabsorbable valves, bioabsorbable implants, use of Infliximab, rituximab, Avastin, Lucentis;
    f. Remicade, Avastin or similar injectable treatment.
11. **Sleep Disorders:** Treatment for any conditions related to disturbance of normal sleep patterns or behaviours such as Sleep-apnoea, snoring, etc.
12. **Substance abuse and addictions:** Expenses incurred for the treatment of any illness or injury which is a consequence of:
    - Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.
    - 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.
13. **OPD Treatment:** OPD consultations, diagnostics tests, pharmacy costs shall not be payable unless covered as an Add-on Benefit or is covered as a part of an admitted claim under Basic Benefit 3.1.1 (In-patient Hospitalization) or Basic Benefit 3.1.3 (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**
2. **Dental**: Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and Gingiva unless necessitated due to an Accident.
3. **Medically unnecessary Treatment:**
    a. **Circumcision:** Circumcisions (unless necessitated by Illness or Injury and forming part of treatment); aesthetic or change-of-life treatments of any description such as sex transformation operations.

4. **Prosthetics and Other Devices:** Prosthetics and other devices not implanted internally by surgery, cost of cochlear implant(s) unless necessitated by an Accident or required intra operatively.
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.

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. This would not apply to payments made under Emergency Ambulance Cover, Orphan Benefit, Loss of Employment, Funeral Expenses, Education fund of the Policy.
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 defence, rebellion, revolution, insurrection, military or usurped power.
6. Death or disablement directly or indirectly caused by or associated with any venereal disease, sexually transmitted disease.
7. Congenital external diseases, defects or anomalies or in consequence thereof
8. 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).
9. 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.
10. Benefit under Accidental Death, Permanent Total Disablement, Permanent Partial Disablement and Emergency Ambulance Cover arising from Hernia.
11. 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.
12. 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, misdemeanour or civil commotion with criminal intent.

13. 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.
14. Death or disablement resulting directly or indirectly contributed or aggravated or prolonged by childbirth or from pregnancy or a consequence thereof;
15. 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.
16. 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.
17. 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.
18. 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.
19. 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.
20. 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.
21. Any physical, medical condition or treatment or service that is specifically excluded in the Policy.

Section 5: General Terms And Conditions

5.1 Standard General Terms and Conditions

5.1.1 Disclosure of Information

The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

"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 Material Change

The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

5.1.4 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 thePolicy

5.1.5 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.

5.1.6 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.

5.1.7 Territorial Limit

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

5.1.8 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, 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.

5.1.9 Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy shall be forfeited.

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.

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.

5.1.10 Cancellation

1. The Insured may cancel this Policy by giving 15 days' written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below.

Cancellation Period	% of Premium
Within 25% of the Coverage Period	60%

25%-50% of the Coverage Period	40%
50%-75% of the Coverage Period	20%
Exceeding 75% of the Coverage Period	0%

For instalment premium, We will refund the paid premium on pro rata basis, after deducting Our expenses.

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 mis-representation, non-disclosure of material facts , fraud by the Insured Person, by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of mis-representation ,non-disclosure of material facts or fraud.

5.1.11 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.

5.1.12 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.

5.1.13 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.

5.1.14 Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person. The Company is not bound to give notice that it is due 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 to maintain continuity of benefits without Break in Policy. Coverage is not available during the grace period.
4. If not renewed within Grace Period after due renewal date, the Policy shall terminate.

5.1.15 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/Certificate of Insurance, 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 instalment premium due for the Policy.
2. During such grace period, Coverage will not 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

5.1.16 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.

5.1.17 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 fifteen 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;

5.1.18 Endorsements (Changes in Policy)

1. This policy constitutes the complete contract of insurance. This Policy cannot bemodified 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 andstamped.
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.

5.1.19 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.

5.1.20 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.

5.1.21 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/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

5.2 Specific Terms and Conditions

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 authorised official. Payment of premium instalments under this Policy will be allowed on a monthly/quarterly/half yearly or yearly basis.

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 favour of Acko General Insurance Limited.

Any change in benefits or premium (other than due to change in Age) will be done with the approval of the Insurance Regulatory and Development Authority of India and will be intimated atleast 3 months in advance.

In the event of this policy being withdrawn in future, We will intimate you about the same 3 months prior to expiry of the Policy. You will have the option to migrate to similar indemnity health insurance policy available with Us at the time of Renewal with all the accrued continuity benefits such as waiver of waiting periods provided that the Policy has been maintained without a break as per Portability guidelines.

We will not apply any additional loading on your policy premium at Renewal based on claim experience.

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 dependants.

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 the following 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.

a) Non-Financial Endorsements – which do not affect the premium.
    - Rectification in name of the proposer / Insured Person.
    - Rectification in gender of the proposer / Insured Person.
    - Rectification in relationship of the Insured Person with the proposer.
    - Rectification of date of birth of the Insured Person (if this does not impact the premium). Change in the correspondence address of the proposer.
    - Change / Update in the contact details viz., phone number, E-mail ID, etc. Update of alternate contact address of the proposer.
    - Change in Nominee details.

b) Financial Endorsements – which result in alteration in premium
- Deletion of Insured Person on death or upon separation or You/Insured Person leaving the country only if no claims are paid / outstanding.
- Change in Age/date of birth.
- Addition of member (including New Born Baby or newly wedded Spouse).
- Change in address (resulting in change in zone).

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 from the expiry of the Policy. We shall not be bound to give notice that such Renewal premium is due. 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. 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 30 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 30 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 an Employee or member or dependant 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

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 Dependants (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 Dependant;

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.

Upon the Insured Person ceasing to be an employee/member of the group administrator/master policyholder, such Insured Person shall have the option to migrate to an approved retail health insurance policy available with Us, provided that:

a. We have discontinued or withdrawn this product or the Insured Person will not be eligible to Renew as he/she ceases to be a member of the group, such Insured Person will have the option to migrate to the nearest substitute policy being issued by Us with continuity of Benefits and in accordance with the Portability guidelines issued by the IRDAI (to the extent applicable).
b. Continuity of Benefits will be provided for the period based on the number of years of continuous coverage under this Policy with Us.

c. The application for Portability should have been received by Us at least 30 days before ceasing to be a member of the group/Employee of Your Organization.
d. 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.
e. 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.
f. Subject to board approved Underwriting Policy.
g. 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.

5.2.14 Underwriting Loadings

We may apply a risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the person proposed for insurance). The maximum risk loading applicable for an individual will not exceed above 100% per diagnosis / medical condition and an overall risk loading of over 150% per person. These loadings are applied from Commencement date of the Policy including subsequent Renewal(s) with Us or on the receipt of the request for increase in Sum Insured (for increased Sum Insured).

We will inform you about the applicable risk loading through a counter offer letter. You need to revert to Us with consent and additional premium (if any), within 7 days of the issuance of such counter offer letter. In case, You neither accept the counter offer nor revert to Us within 7 days, We will cancel Your application and refund the premium paid within next 7 days.

Please note that We will issue Policy only after receiving Your consent and additional premium (If any).

The application of loading does not mean that the illness / condition, for which loading has been applied, would be covered from inception. Any waiting period as mentioned on the Schedule shall be applied on the illness/ condition, as applicable.

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/or the Certificate of Insurance 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 centres, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, in respect of this Policy, or Our other products and services, shall constitute legally binding when done in compliance with Our terms for such facilities.

5.2.17 Communications & Notices

Any communication or notice or instruction under this Policy shall be in writing and will be sent to:
You/ any Insured Person, at the address as specified in the Schedule
To Us, at Our address as specified in the Schedule.

No insurance agents, brokers, other person or entity is authorised to receive any notice on behalf of Us unless explicitly stated in writing by Us.
Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

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

Note:

- Our network hospital list occasionally changes, so ACKO recommends you check our network hospital link 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.

6.1.1 Claims conditions

- For claims, we require you to submit any requested claims document within a set timelines 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 was 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.

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 centre 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, ACKO can choose to deny your claim.

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 claims 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-Authorisation 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 authorisation letter for Hospitalization in the pre authorisation form.
c) The Network Provider shall send the pre-authorisation form along with all the relevant details to the 24 hour authorisation/ cashless department along with contact details of the treating Medical Practitioner and the Insured Person.
d) Upon receiving the pre-authorisation 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 authorisation and the claim is admissible, We shall issue the authorisation 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 authorisation will be issued.
g) The authorisation letter will include details of sanctioned amount, diagnosis, and date of approval.
h) The authorisation letter shall be valid only for a period of 15 days from the date of issuance of authorisation.

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 authorisation to 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-authorisation is issued.

Enhancement to Pre-Authorised Amount:

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

- The Network Provider shall request Us for an enhancement of authorisation 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 pre authorized 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 authorisation letter from Us in accordance with the process described under 6.1.3 1 above.

Discharge Process:
At the time of discharge -

- The Network Provider may forward a final request for authorisation 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 authorisation letter from Us, the Insured Person may be discharged by the Network Provider.

Note:

- Applicable to Section 6.1.3 1and 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 authorisations, 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-authorisation request
  - Copy of pre-authorisation approval letter (s)
  - Documents listed under Section 6.1.4 (Reimbursement Claim Process).
- We may call for any additional documents as required based on the circumstances of the claim.

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 obtain a claim form from any of Our branch offices or download a copy from Our website www.acko.com.

List of necessary claim documents to be submitted for reimbursement are as following:

Claim related to Hospitalization

- Claim form duly filled and signed by the insured
- Original Discharge summary
- Original Death Summary (in case of death)
- 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
- First consultation paper from doctor stating the origin duration and progress of illness
- Copy of FIR/ MLC certificate (Accident claims)
- Copy of medical prescription
- 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
- Other documents as may be required by Acko General Insurance to determine the admissibility of claim
- Certificate from the treating doctor stating the circumstances due to which domiciliary treatment was administered (for domiciliary hospitalization claims only)

Domestic Emergency Evacuation:

- Claim form duly filled and signed by the insured
- 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
- 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
- Other documents as may be required by Acko General Insurance to determine the admissibility of claim

Second Opinion:

- A duly completed claim form signed by the insured person.
- 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)
- 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.
- Other documents as may be required by Acko General Insurance to determine the admissibility of claim

Daily Hospital Cash:

- Claim form duly filled and signed by the insured with date & time of admission/ discharge.
- A copy of the hospital discharge card
- A copy of the hospital bill, money receipt, duly signed with a revenue stamp card
- Copy of laboratory and diagnostic test reports
- 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
- Other documents as may be required by Acko General Insurance to process the claim

Accidental Death or Disability Cover:

- A duly completed claim form signed by the Claimant
- A copy of address proof (Aadhaar/Driving license)
- Attested copy of the death certificate
- Attested copy of the FIR/Panchanama/Inquest Panchnama
- 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
- 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

- Other documents may be required by Acko General Insurance to determine the admissibility of claim.

We may call for any additional documents/information as required based on the circumstances of the claim wherever the claim is under further investigation or available documents do not provide clarity.

In case there is a delay in notification of a claim or submission of claim documents as specified above, then in addition to the documents mentioned above, the Insured Person will also be required to provide Us the reason for such delay in writing.

We will condone the delay on merit for delayed claims where the delay has been proved to be for reasons beyond the claimant's control.

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-authorisation letter has been issued, before approving such a claim, a check will be made with the Network Provider whether the pre-authorisation 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.
- The Pre and Post-Hospitalization 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).

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 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 30 days of submission of all necessary documents and information and any other additional information required for the settlement of the claim.

All claims which in Our view require an investigation, will be investigated and settled in accordance with the applicable regulatory guidelines, including the IRDAI (Protection of Policyholders Interests) Regulations, 2017, 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 30 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 30 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, We shall settle the claim within 30 days from the date of receipt of the last necessary document in accordance with the provisions of the IRDAI (Health Insurance) Regulations, 2016, as amended from time to time.

In the case of delay in the payment of a claim We shall be liable to pay interest from the date of receipt of the last necessary document to the date of payment of claim at a rate 2% above the bank rate.

However, where the circumstances of a claim warrant an investigation in Our opinion, We shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of the last necessary document. In such cases, We shall settle the claim within 45 days from the date of receipt of the last necessary document. In such cases, if there

is a delay beyond stipulated 45 days We shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of the last necessary document to the date of payment of claim.

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.

6.2 Discounts

6.2.1 First Notification of Claim Discount

The insured person is eligible for discount on premium if have agreed to notify Us about any claim under Basic Benefit within 48 hours of Hospitalization or before discharge of the Insured person from the Hospital, whichever is earlier.

If You fail to notify Us as specified above, You will bear a compulsory Co-payment percentage, of the final claim amount assessed by Us, in addition to any other Co-payment applicable.

Co-pay	Discount
10%	5.0%
15%	7.5%

Co-pay	Discount
20%	10.0%

6.2.2 Preferred Provider Network Discount

The Insured person is eligible for discount on premium if have agreed to use the services of Hospitals in Our Preferred provider Network, as specified in the Schedule or Our website, for availing cover under Basic Benefit.

If You make a claim in Hospital outside of the specified Preferred provider Network, You will bear a compulsory Co-payment percentage, of the final claim amount assessed by Us, in addition to any other Co-payment applicable.

Co-pay	Discount
10%	5.0%
15%	7.5%
20%	10.0%

6.2.3 Voluntary Co-Payment Discount:

The insured person is eligible for discount on the premium if you opt for a Voluntary Co-payment as per below table:

Co-pay	Discount
5%	5%
10%	10%
15%	15%
20%	20%
25%	25%
30%	30%

6.2.4 Policy Tenure Discount

If Policy Period is more than one year, the Insured Person will be entitled to receive a discount as per below table, If you pay premium in advance as a single premium.

Policy Tenure (In Years)	Discount
2	7.5%
3	12.5%

6.2.5 Existing Customer Discount

We may provide discount on the policy premium to existing Acko customers i.e. customers who have purchased a policy with Acko. Discount offered is in the range of 0% to 10%.

6.3 Pre-policy health check-up (PPHC)

- 100% PPHC costs will be absorbed by Us.
- Reports to be issued to the Insured for Accepted Cases only.
- Based on the Age, Sum Insured, Plan, Medical History or disclosures made by the customer either in proposal form or during the tele underwriting, we will ask only proposed to be insured customers to undergo certain medical tests and based upon the tests results we may ask certain higher level medical tests as well.

Section 7: Grievance Redressal

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

Our website: www.acko.com

Email: grievance@acko.com

Toll Free : 1860 266 2256

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

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

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

Grievance Redressal Officer

Acko General Insurance Limited

2nd Floor, #36/5, Hustlehub One East, Somasandrapalya,

27th Main Rd, Sector 2, HSR Layout,

Bengaluru, Karnataka - 560102

grievance@acko.com

In the event of 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,

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

BENGALURU - Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-

27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049, Email: bimalokpal.bengaluru@ecoi.co.in

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

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

BHUBANESHWAR - Office of the Insurance Ombudsman, 62, Forest Park, Bhubaneshwar-751 009. Tel.: 0674 - 2596461 /2596455Fax: 0674-2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in (State of Orissa.)

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

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

DELHI - Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi-110 002. Tel.: 011 - 23232481/23213504 Fax: 011-23230858 Email: bimalokpal.delhi@ecoi.co.in (States of Delhi.)

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

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

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

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

KOLKATA - Office of the Insurance Ombudsman, Hindustan Building. Annexe, 4th Floor, C.R. Avenue, Kolkata-700 072. Tel.: 033 - 22124339 / 22124340Fax: 033-22124341 Email: bimalokpal.kolkata@ecoi.co.in (States of West Bengal, Bihar, Sikkim, Jharkhand and Union Territories of Andaman and Nicobar Islands.)

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

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

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

NOIDA - Office of the Insurance Ombudsman, 4th Floor, Bhagwan Sahai Palace,Main Road, Naya Bans, Sector-15, Distt: Gautam Buddh Nagar – 201301. Tel: 0120- 2514250/52/53 Email: bimalokpal.noida@ecoi.co.in (State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.)

PATNA - Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna – 800006. Tel No: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in (Bihar, Jharkhand.)

The updated details of Insurance Ombudsman offices are also available at the IRDAI website www.irdai.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

Section 8: Schedule of Benefits

Sum Insured mentioned below for

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

b) In case of Floater basis, our maximum, total, and cumulative liability for any and all claims made with respect to all the Insured Persons under the Policy, will be up to the Sum Insured specified for the Benefit.

Benefit Type	Product Features	Coverage Details
Basic Benefit	Base Sum Insured	3lacs / 5lacs / 10lacs / 15lacs / 20lacs / 25lacs / 50lacs / 1cr / 1.5cr / 2.5cr / 5cr / 10cr / Unlimited
	In-Patient Hospitalization	Covered up to Sum Insured
	Room Rent/ ICU	Room Category: General Ward / Shared Room / Single AC Room / Upto SI
	Day Care Treatment	Covered up to Sum Insured
	Pre or Post Hospitalization Medical Expenses	Pre: 30, 60, 90 Days Post: 60, 90, 120, 180 Days
	Road Ambulance Limit	1k / 2k / 3k / 4k / 5k / 6k / 7k / 8k / 9k / 10k / Upto Sum Insured
	Domestic Emergency Evacuation Limit	1lac / 2lacs / 3 lacs / 4 lacs / 5 lacs / 6 lacs / 7 lacs / 8 lacs / 9 lacs / 10 lacs / Upto Sum Insured
	Domiciliary Treatment Cover	Covered up to Sum Insured
	Organ Donor Expenses	Covered up to Sum Insured
	Second Opinion	Covered
Basic Benefit Options	Worldwide In-patient Hospitalization	Yes / No
	Restore Sum Insured	Once/ Unlimited
	No Claim Bonus Sum Insured	
	First Notification of Claim	Compulsory Co-pay: 10% / 15% / 20%
	Preferred Providers Network	Compulsory Co-pay: 10% / 15% / 20%
	Co-pay	Compulsory Co-pay: 5% / 10% / 15% / 20% / 25% / 30%
	Super Top-up	In the range: 0.5lacs to 25lacs
	Waiver of Non-payable Medical Expenses	Yes / No
	All Medically Necessary Hospitalization	Yes / No
	Reduction in Specific Illness Waiting Period	Yes / No
	Preventive Health Check-up	Once in a year/ Once in two year/ Once in three year
	Inflation Protect Sum Insured	5%/10%/15%/20%/25%/50%
	Initial 30 days waiting period waiver	Yes/No
Add-on Benefits	Doctor on Call*	No. of consultations allowed: 1/ 2/3/4/5/6/7/8/9/10/ Unlimited
	Family Physician*	No. of consultations allowed: 1/ 2/3/4/5/6/7/8/9/10/ Unlimited
	Out-Patient Department (OPD) Medical Services*	1. Consultations: 1/ 2/3/4/5/6/7/8/9/10/ Unlimited
		Per consultation limit: Rs 250 / 500 / 750 / 1000 / 1500/ Unlimited
		2. Prescribed Diagnostic Tests: 1/ 2/3/4/5/ Unlimited
		Per diagnostic test limit: Per pharmacy limit: Rs 500 / 750 / 1000 / 1500 / 2500/ Unlimited
		3. Prescribed Pharmacy: 1/3/4/6/7/9/10/12/13/15/ Unlimited
		Per pharmacy limit: Rs 500 / 750 / 1000 / 1500 / 2000 / 2500 / 3000 / Unlimited
		4. OPD Treatment: 1/ 2/3/4/5/6/7/8/9/10/ Unlimited
		Limit: 5k/10k/15k/20k/25k/30k/40k/50k/75k/100k / Unlimited
	Access to Our Put-Patient Medical Services Network	Discount: 10% / 20% / 30% / 40% /50%
	Monthly No Claim Bonus OPD Sum Insured	Rs 100 / 150 / 200 / 250 / 300 / 350 / 400 / 450 / 500 per month
	Daily Hospital Cash	Rs 500 / 1000 / 1500 / 2000 / 2500 / 3000 / 4000 / 5000 / 7000 / 8000 / 9000 / 10000 per Day
		Maximum no of days of Hospitalization: Days
	Accidental Death or Disability Cover	
	Accidental Disability Cover	
	Value Added Services	1. e-Consultation
		2. Wellness Coach
		3. Lab Services (Home Collection)
		4. Pharmacy (Home Delivery)
		5. Vital/Physical Activity Monitoring Services
		6. Reminder Notifications
		7. Medical Wallet
		8. Report Aggregation
		9. Home Care Services
		10. Ambulance Arrangement Services
		11. Pick-up and Drop Services for Consultation
		12. Prioritizing Appointments

Annexure

Annexure 1: List of excluded expenses (non-medical)

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

Sr. No.	Item
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 WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE TABLETS
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT

Sr. No.	Item
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

Annexure 2: Benefit Illustration

Illustration 1:

Age of the Members Insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on floater basis with overall Sum Insured (Only one sum insured is available for the entire family)			
	Premium (₹)	Sum Insured (₹)	Premium (₹)	Discount (if any)	Premium after discount (₹)	Sum Insured (₹)	Premium or consolidated premium for all members of the family (₹)	Floater discount (if any)	Premium after discount (₹)	Sum Insured (₹)
0 – 15	2,789	3,00,000	2,789	0	2,789	3,00,000	72,421	7,603	64,818	3,00,000
21 - 25	4,614	3,00,000	4,614	0	4,614	3,00,000				
31 - 35	4,614	3,00,000	4,614	0	4,614	3,00,000				
36 – 40	5,318	3,00,000	5,318	0	5,318	3,00,000				
51 – 55	9,760	3,00,000	9,760	0	9,760	3,00,000				
56 – 60	12,286	3,00,000	12,286	0	12,286	3,00,000				
61 – 65	14,817	3,00,000	14,817	0	14,817	3,00,000				
66 – 70	18,223	3,00,000	18,223	0	18,223	3,00,000				
Total Premium for all members of the family is ₹ 72,421 when each member is covered separately. Sum Insured available for each member separately is ₹ 3,00,000			Total Premium for all members of the family is ₹ 72,421 when they are covered under a single policy. Sum Insured available for each family member is ₹ 3,00,000				Total Premium when policy is opted on a floater basis is ₹ 64,818. Sum Insured ₹ 3,00,000 is available for the entire family			

Coverage assumptions:
1. The family of the proposer comprises spouse, one daughter and one son.
2. Parents and parent-in-laws are covered additionally
3. Age band of family members:

Relationship	Age Band
Self	36 – 40
Spouse	31 – 35
Father	56 – 60
Father-in-Law	66 – 70
Mother	51 - 55
Mother-in-Law	61 – 65
Son	0 -15

Daughter	21 – 25

4. Coverage is standard for Zone 2.

Illustration 2:

Age of the Members Insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on floater basis with overall Sum Insured (Only one sum insured is available for the entire family)			
	Premium (₹)	Sum Insured (₹)	Premium (₹)	Discount (if any)	Premium after discount (₹)	Sum Insured (₹)	Premium or consolidated premium for all members of the family (₹)	Floater discount (if any)	Premium after discount (₹)	Sum Insured (₹)
16 – 20	5,075	3,00,000	5,075	0	5,075	3,00,000	66,192	1,518	64,674	3,00,000
21 – 25	5,075	3,00,000	5,075	0	5,075	3,00,000				
41 - 45	6,559	3,00,000	6,559	0	6,559	3,00,000				
46 – 50	9,390	3,00,000	9,390	0	9,390	3,00,000				
71- 75	20,046	3,00,000	20,046	0	20,046	3,00,000				
76 +	20,046	3,00,000	20,046	0	20,046	3,00,000				
Total Premium for all members of the family is ₹ 66,192 when each member is covered separately. Sum Insured available for each member separately is ₹ 3,00,000			Total Premium for all members of the family is ₹ 66,192 when they are covered under a single policy. Sum Insured available for each family member is ₹ 3,00,000				Total Premium when policy is opted on a floater basis is ₹ 64,674. Sum Insured ₹ 3,00,000 is available for the entire family			

Coverage assumptions:

1. The family of the proposer comprises spouse, one daughter and one son.
2. Parents are covered additionally
3. Age band of family members:

Relationship	Age Band
Self	46 – 50
Spouse	41 – 45
Son	16 – 20
Daughter	21 – 25
Mother	71 – 75
Father	76 +

4. Coverage is standard for Zone 1.