

ACKO SPECIALLY ABLED HEALTH COVER PROSPECTUS

Section 1: Introduction

A unique and innovative product which covers **People with Disabilities** for expenses incurred on hospitalization due to illness or accident in India. 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

Eligibility Criteria	Minimum	Maximum
Age at Entry	91 Days	65 Years
Premium	Rs 3,202	Rs 3,65,876
Premium Payment Term	Single Pay	
Premium Mode	Annually	
Policy Period	1 Year	
Basic Sum Insured	Rs 4,00,000	Rs 5,00,000

2.2 Policy Period

This policy will be issued for a period of 1 Year

2.3 Sum Insured

Sum Insured options are 4 Lacs & 5 Lacs

2.4 Premium Payment Option

Mode of payment: Any, as per the allowed IRDAI options

Section 3: Benefits

3.1 Basic Benefits

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

3.2.1 Inpatient Hospitalization:

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy Year, up to the Sum insured as specified in the Policy Schedule (other than any sub-limits, co-pay as specified in the policy), for:

- i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to maximum of 1% of the Sum Insured per day.
- ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up maximum of 2% of Sum Insured per day.
- iii. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating Medical Practitioner/ surgeon or to the hospital
- iv. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

Other expenses

- i. Expenses incurred on treatment of cataract subject to the sub limits.
- ii. Dental treatment necessitated due to disease or injury (for inpatient care only).
- iii. Plastic surgery necessitated due to disease or injury.
- iv. All day care treatments

Note:

1. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment.
2. The above-mentioned Medical Expenses shall be payable only after the first commencement of the Policy with the Company.

3.2.2 AYUSH Treatment

The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to 50% of sum insured as specified in the policy schedule in any AYUSH Hospital.

3.2.3 Pre-Hospitalization Medical Expenses:

The Company shall indemnify Pre-Hospitalization Medical Expenses incurred, related to an admissible Hospitalization requiring Inpatient care, up to a period of 30 days prior to the date of admissible Hospitalization covered under the Policy during the policy period.

Conditions:

- i. The claim is accepted under Section 3.2.1 (Inpatient Care) or Section 3.2.2 (AYUSH Treatment) or Section 3.2.7 (Modern Treatments) in respect of that Insured Person.
- ii. Pre-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.

3.2.4 Post-Hospitalization Medical Expenses:

The Company shall indemnify Post Hospitalization Medical Expenses incurred, related to an admissible Hospitalization requiring Inpatient Care, up to a period of 60 days from the date of discharge from the Hospital, following an admissible hospitalization covered under the Policy during the policy period.

Conditions:

- i. The claim is accepted under Section 3.2.1 (Inpatient Care) or Section 3.2.2 (AYUSH Treatment) or Section 3.2.7 (Modern Treatments) in respect of that Insured Person.
- ii. Post-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.

3.2.5 Emergency Ground Ambulance

The Company will reimburse Reasonable and Customary Charges for expenses incurred towards ambulance charges for transportation of an Insured person, per hospitalization as per the limit mentioned in Policy Schedule.

Specific Conditions:

The Company will reimburse payments under this Benefit provided that.

- i. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is Injured or is suffering from an Illness to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital as advised by the treating Medical Practitioner in writing for management of the current Hospitalization.
- ii. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalisation.
- iii. The ambulance service is offered by a healthcare or Registered Ambulance Service Provider.
- iv. The original Ambulance bills and payment receipt is submitted to the Company.
- v. The Company has accepted a claim under Section 3.2.1 (Inpatient Care) above in respect of the same period of Hospitalization or Section 3.2.2 (AYUSH Treatment) or Section 3.2.7 (Modern Treatments).
- vi. Any payment under this Benefit will be excluded if the Insured Person is transferred to any Hospital or diagnostic centre for evaluation purposes only.

3.2.6 Cataract Treatment

The company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of Rs.40,000/-, per each eye in one policy year.

3.2.7 Modern Treatment

The following procedures will be covered (wherever medically indicated) either as Inpatient or as part of Day Care Treatment in a Hospital up to 50% of Sum Insured, specified in the Policy Schedule, during the Policy Period.

- a. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
- b. Balloon Sinuplasty
- c. Deep Brain stimulation
- d. Oral chemotherapy
- e. Immunotherapy- Monoclonal Antibody to be given as injection.
- f. Intravitreal injections
- g. Robotic surgeries
- h. Stereotactic radio Surgeries
- i. Bronchial Thermoplasty
- j. Vaporisation of the prostate (Green laser treatment or holmium laser treatment)
- k. IONM- (Intra-Operative Neuro Monitoring)
- l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

3.2.8 Co-Payment

Every claim under the Policy shall be subject to a Co-payment of 20% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co-payment.

This co-payment can be waived off by paying an additional premium(optional).

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 24 months for pre-existing disability/ 48 months for all pre-existing conditions other than HIV/AIDS and Disability (as mentioned in 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 a number of months (as mentioned in Policy Schedule) for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

4.1.2 Specified disease/procedure waiting period- Code- Excl02

- e. Expenses related to the treatment of the listed Conditions; surgeries/treatments shall be excluded until the expiry of 24 months as (mentioned in 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.

- f. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- g. 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.
- h. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- i. 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.

j. List of Specific Diseases/Procedures:

- 1. Benign ENT disorders
- 2. Tonsillectomy
- 3. Adenoidectomy
- 4. Mastoidectomy
- 5. Tympanoplasty
- 6. Hysterectomy
- 7. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps.
- 8. Benign prostate hypertrophy
- 9. Cataract and age-related eye ailments
- 10. Gastric/ Duodenal Ulcer
- 11. Gout and Rheumatism
- 12. Hernia of all types
- 13. Hydrocele
- 14. Non-Infective Arthritis
- 15. Piles, Fissures and Fistula in anus
- 16. Pilonidal sinus, Sinusitis, and related disorders
- 17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident.
- 18. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
- 19. Varicose Veins and Varicose Ulcers

4.1.3 30-day waiting period- Code- Excl03

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

4.1.4 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.

4.1.5 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.

4.1.6 Excluded Providers: Code- Excl09

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep – sea diving.

4.1.7 Breach of law: Code- Excl10

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

4.1.8 Excluded Providers: Code- Excl11

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

4.1.9 Code- Excl12

Treatment for, Alcoholism, drug, or substance abuse or any addictive condition and consequences thereof.

4.1.10 Code- Excl13

Treatments received in health hydro's, 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 less than 7.5 dioptries.

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 Unproven Treatments: Code- Excl16

Expenses related to any unproven treatment, services, and supplies for or in connection with any treatment. Unproven treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

4.1.15 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.

4.1.16 Investigation & Evaluation- Code- Excl04

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

4.1.17 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.

4.1.18 Obesity/ Weight Control: Code- Excl06

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

- 1) Surgery to be conducted is upon the advice of the Doctor
- 2) The surgery/Procedure conducted should be supported by clinical protocols
- 3) The member must 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 Apnoea
 - iv. Uncontrolled Type2 Diabetes

4.2 Specific Exclusions

- 4.2.1 Any medical treatment taken outside India.
- 4.2.2 Hospitalization for donation of any body organs by an Insured including complications arising from the donation of organs.
- 4.2.3 Nuclear damage caused by, contributed to, by or arising from ionising radiation or contamination by radioactivity from:
- a. any nuclear fuel or from any nuclear waste; or
 - b. from the combustion of nuclear fuel (including any self-sustaining process of nuclear fission);
 - c. nuclear weapons material.
 - d. nuclear equipment or any part of that equipment.
- 4.2.4 War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority.
- 4.2.5 Injury or Disease caused by or contributed to by nuclear weapons/materials.
- 4.2.6 Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder, or as may be necessitated due to an accident.
- 4.2.7 Treatment with alternative medicines or Treatment, experimental or any other treatment such as acupuncture, acupressure, magnetic, osteopath, naturopathy, chiropractic, reflexology and aromatherapy.
- 4.2.8 Suicide, Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol) and any violation of law or participation in an event/activity that is against law with a criminal intent.
- 4.2.9 Vaccination or inoculation except as post bite treatment for animal bite.
- 4.2.10 Convalescence, general debility, "Run-down" condition, rest cure, Congenital external illness/disease/defect.
- 4.2.11 Outpatient diagnostic, medical and surgical procedures or treatments, non-prescribed drugs and medical supplies, hormone replacement therapy and expenses related to Domiciliary hospitalization shall not be covered.
- 4.2.12 Dental treatment or Surgery of any kind unless requiring Hospitalisation as a result of accidental Bodily Injury.
- 4.2.13 Venereal/ Sexually Transmitted disease
- 4.2.14 Stem cell storage.
- 4.2.15 Any kind of service charge, surcharge levied by the hospital.

4.2.16 Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.

4.2.17 Non-Payable items: The expenses that are not covered in this Policy are placed under List-I of Annexure-II

4.2.18 Any medical procedure or treatment, which is not medically necessary or not performed by a Medical Practitioner.

4.2.19 This cover will exclude the cost of any Anti-Retroviral Treatment.

Section 5: General Terms And Conditions

5.1 Standard General Terms and Clauses

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 the Policy

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.

5.1.7 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	75%
25%-50% of the Coverage Period	50%
50%-75% of the Coverage Period	25%
Exceeding 75% of the Coverage Period	0%

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, 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.

5.1.14 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 3.2.1, 3.2.2 & 3.2.3 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
2. Migration benefit will be offered to the extent of sum of previous sum insured and accrued bonus/multiplier benefit (as part of the base sum insured), migration benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Migration, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987&flag=1

5.1.15 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.

5.1.16 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 be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.
2. The policyholder may be changed only at the time of renewal. The new policyholder must be the legal heir/immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

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

5.1.19 Terms and conditions of the Policy

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

5.1.20 Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. For Claim settlement under reimbursement, the Company will pay the policyholder. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/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.

Conditions Precedent to the contract -

5.2.1 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.

5.2.2 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.

5.2.3 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.

5.2.4 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 the Policy.

5.2.5 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.

5.2.6 Eligibility Criteria

All Persons with Disability who have at least one of the disabilities as defined under Specified Disability under The Rights Of Persons With Disabilities Act, 2016 with valid disability certificate are eligible to enrol this product. Or Individuals with HIV/AIDS as defined under the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017.

Conditions applicable during the contract -

5.2.7 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.

5.2.8 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.

5.2.9 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.

5.2.10 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 under this Policy will only be allowed 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.

5.2.11 Parties to the Policy

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

5.2.12 Currency

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

5.2.13 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.

5.2.14 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.

5.2.15 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.

5.2.16 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.

5.2.17 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.

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;

5.2.18 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 3.2.1, 3.2.2 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.

For Detailed Guidelines on Portability, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987&flag=1

5.2.19 Underwriting Loadings

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

5.2.20 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..

5.2.21 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.

5.2.22 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 1 and Section 6.1.3 2 Cashless Facility for Hospitalization expenses shall be limited exclusively to Medical Expenses incurred for Treatment undertaken in a Network Provider for Illness or Injury, as the case may be which are specified to be covered under the applicable Benefits under the Policy.
- For all cashless 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:

The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

- i. Duly Completed claim form.
- ii. Photo Identity proof of the patient
- iii. Medical practitioner's prescription advising admission.
- iv. Original bills with itemized break-up

- v. Payment receipts
 - vi. Discharge summary including complete medical history of the patient along with other details.
 - vii. Investigation/ Diagnostic test reports etc. supported by the prescription from attending medical practitioner
 - viii. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).
 - ix. Sticker/invoices of the Implants, wherever applicable.
 - x. MLR (Medico Legal Report copy if carried out and FIR (First information report) if registered, wherever applicable.
 - xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque.
 - xii. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines
 - xiii. Legal heir/succession certificate, wherever applicable
 - xiv. Any other relevant document required by Company/TPA for assessment of the claim.
- a) The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted.
 - b) In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company.
 - c) Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person
 - d) In case of lumpsum payment for HIV/AIDS, Insured will need to submit the below mentioned documents for the processing of Claim:
 - a. Identity proof of the claimant
 - b. Dully filled Claim form
 - c. Copy of Hospital summary/Discharge card/treatment advise / medical reference
 - d. Copy of Medical reports/records
 - e. Copy of Investigation reports
 - f. Medical Practitioner's certificate
 - g. Any other relevant document as requested by the Insurer.
 - h. On receipt of claim documents from Insured

Insurer shall assess the admissibility of claim as per Policy terms and conditions. Upon satisfactory completion of assessment and admission of claim, the Insurer will make the payment of benefit as per the contract. In case if the claim is repudiated Insurer will inform the Insured about the same in writing with reason for repudiation.

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 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 following address:

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, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049, Email: bimalokpal.bengaluru@ecoi.co.in

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

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

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

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

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

DELHI - Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi-110 002. Tel.: 011 - 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 / 22124340 Fax: 033-22124341 Email: bimalokpal.kolkata@ecoi.co.in (States of West Bengal, Bihar, Sikkim, Jharkhand and Union Territories of Andaman and Nicobar Islands.)

LUCKNOW - Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-2, Nawal Kishore Road, Hazratganj, 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.)