Acko Health Insurance Policy

Policy Wordings

1 Preamble

This Policy Wording, together with the Schedule of Benefits, is an insurance contract between You and Us. On receipt of premium as specified in the Schedule, We promise to provide You insurance for the covers specified in the Schedule, subject to terms and conditions explained in this document.

We promise to cover You basis the statements made in the proposal form, by You or on Your behalf and on behalf of all Insured Persons, which is incorporated into the Policy as a copy of the duly completed proposal form. In case such statements and/or information are incorrect, in complete or inaccurate in any way, We shall have the right to re-evaluate the terms of the Benefits for the remainder of the Policy Period. Please do review these details for accuracy completeness and reach out to Us for any amendments required.

Some keywords related to and used in the Policy have been defined in Section 2 (Definitions). Such words appear in Initial Capital letters in the document.

This document explains the following details related to Your Policy:

Definitions

Basic Benefits

Basic Benefit Options

Add on Benefits

Exclusions

General conditions applicable to Benefits

Other terms and conditions

Claim process

2 Definitions

Standard definitions

1. **Accident** means sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Any One Illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/nursing home where treatment was taken.
3. **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorisation is approved.
4. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
5. **Congenital Anomaly** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
    - **Internal Congenital Anomaly** – Congenital anomaly which is not in the visible and accessible parts of the body.

- **External Congenital Anomaly** – Congenital anomaly which is in the visible and accessible parts of the body.
- **Co-Payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder / insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured

6. **Day Care Centre** means any institution established for day care treatment of illness and / or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under-
   - has qualified nursing staff under its employment;
   - has qualified medical practitioner/s in charge;
   - has fully equipped operation theatre of its own where surgical procedures are carried out;
   - maintains daily records of patients and will make these accessible to the insurance company's authorised personnel.
7. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:
   - undertaken under General or Local Anaesthesia in a hospital / day care centre in less than 24 hrs because of technological advancement, and
   - which would have otherwise required a Hospitalization of more than 24 hours.
   - Treatment normally taken on an out-patient basis is not included in the scope of this definition.
8. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any Benefits are payable by the insurer. A deductible does not reduce the Sum Insured.
9. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
10. **Disclosure to information norm:** The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.
11. **Domiciliary Hospitalization:** means medical treatment for an illness/ disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
    - the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
    - the patient takes treatment at home on account of non-availability of room in a hospital.
12. **Emergency Care** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long-term impairment of the insured person's health.
13. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity Benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.
14. **Hospital** means any institution established for in- patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical

Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under:

- has qualified nursing staff under its employment round the clock;
- has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
- has qualified medical practitioner(s) in charge round the clock;
- has a fully equipped operation theatre of its own where surgical procedures are carried out;
- maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

15. **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'In- patient Care' hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

16. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

    Acute condition- Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery

    Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

    I. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
    II. It needs ongoing or long-term control or relief of symptoms
    III. It requires rehabilitation for the patient or for the patient to be specially trained to cope with it
    IV. It continues indefinitely
    V. It recurs or is likely to recur

17. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

18. **Inpatient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

19. **Intensive Care Unit** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

20. **ICU Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensive charges.

21. **Pre-Existing Disease**: Pre-Existing Disease means any condition, ailment, injury or disease**:**

    a. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer **or**
    b. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.

22. **Portability** means the right accorded to an individual health insurance policyholder (including family cover) to transfer the credit gained for Pre-Existing Diseases and time bound exclusions if the

policyholder chooses to switch from one insurer to another insurer or from one plan to another plan of the same insurer.

23. **Pre-Hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days preceding the Hospitalization of the Insured Person, provided that:
    - Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
    - The in-patient hospitalization claim for such Hospitalization is admissible by the Insurance Company.
24. **Post-Hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:
    - Such Medical Expenses are for the same condition for which the insured person's Hospitalization was required, and
    - The inpatient hospitalization claim for such hospitalization is admissible by the insurance company
25. **Maternity expenses mean:**
    - medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization);
    - expenses towards lawful medical termination of pregnancy during the policy period.
26. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
27. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.
28. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.
29. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
    - is required for the medical management of the illness or injury suffered by the insured;
    - must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    - must have been prescribed by a medical practitioner;
    - must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
30. **Network Provider** means hospitals enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.
31. **Non-Network Provider** means any hospital, day care centre or other provider that is not part of the network.
32. **New Born Baby** means baby born during the Policy Year and is aged up to 90 days.

33. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
34. **OPD treatment** means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.
35. **Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
36. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.
37. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.
38. **Subrogation** shall mean the right of the insurer to assume the rights of the insured person to recover expenses paid out under the Policy that may be recovered from any other source.
39. **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.
40. **Unproven/Experimental Treatment** means the treatment, including drug experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.
41. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.

Specific definitions

1. **Age or Aged** means the age as on last birthday.
2. **Admission** means Your admission in a Hospital as an in-patient for the purpose of medical treatment of an Injury and/ or Illness.
3. **Ambulance** means a road vehicle operated by a licenced/authorised service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.
4. **Annexure** means a document attached and marked as Annexure to this Policy.
5. **Annual Renewal Date** means the anniversary of the Commencement Date each Policy Year or any other date which We and You may agree in writing.
6. **AYUSH Treatment** refers to the medical and /or Hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy Systems.
7. **Benefit** means any Benefit shown in the Schedule.
8. **Base Sum Insured** referred herein means the specified amount of Sum Insured against a Benefit or set of Benefits, as specified in the Schedule or/and Certificate of Insurance.
9. **Break in Policy** occurs at the end of the existing Policy term, when the premium due for renewal on a given Policy is not paid on or before the premium renewal date or within 30 days thereof.
10. **Certificate of Insurance** means the certificate We issue to the Insured Person confirming the Insured Person's cover under the Policy.

11. **Claim** means a demand by You or on Your behalf, for payment of Medical Expenses or any other Benefits as covered under the Policy.
12. **Commencement Date:** Commencement Date means the start date of the Policy as specified in the Schedule.
13. **Covered In-patient Medical Expenses** shall include Room Rent, ICU/CCU/HDU charges, nursing charges, operation theatre charges, Surgical Appliance and/or Medical Appliance cost, fees of Medical Practitioner/ surgeon / anaesthetist / Specialist / radiologist / pathologist and diagnostic tests conducted within the same Hospital where the Insured Person has been admitted.
14. **Coverage Period:** Coverage Period means the period specified in the Schedule which commences on the Risk Commencement Date specified in the Schedule and ends on the coverage expiry date specified in the Schedule.
15. **Date of Admission** means the date of the Insured Person's first admission to a Hospital or Day Care Centre in relation to Any One Illness or the Injury sustained in any single Accident.
16. **Dependent** means the Employee's / Member's parents, Spouse or child who have been enrolled in the Policy.
17. **Employee:** means any member of Your staff who is proposed and/or sponsored by You and who becomes an Insured Person under this Policy
18. **Emergency** shall mean a serious medical condition or symptom resulting from Injury or Illness which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long-term impairment of the Insured Person's health, until stabilisation at which time this medical condition or symptom is not considered an Emergency anymore.
19. **Empanelled Service Provider**: Empanelled Service Provider means the service provider specified in the Schedule/Certificate of Insurance, appointed by Us from time to time.
20. **Exclusions** mean specified coverage, hazards, services, conditions, and the like that are not provided for (covered) under this Policy, or set of Benefits under this Policy.
21. **In-patient** means an Insured Person who is admitted to a Hospital and stays for at least 24 hours for the sole purpose of receiving Treatment.
22. **First Diagnosis** means the point in time at which the requirements of any Critical Illness under this Policy were first satisfied with respect to the Insured Person, including the availability of all the test reports and medical reports evidencing such diagnosis.
23. **Family Type** means the amount of Sum Insured mentioned in the Schedule which is common to the whole family covered under the Policy which will be the maximum amount payable under this Policy for all the covered family members put together, during the Policy Period if opted to be a Floater policy.
24. **Floater Benefit** means the amount of Sum Insured mentioned in the Schedule which is common to the whole family covered under the Policy which will be the maximum amount payable under this Policy for all the covered family members put together, during the Policy Period if opted to be a Floater policy.
25. **HDU** - High Dependency Unit is an area in a Hospital, usually located closely to the Intensive Care Unit where patients can be cared for more extensively than in a normal ward but not to the point of care provided in the Intensive Care Unit.
26. **Insured Person** means the Primary Insured and/or the Dependents of the Primary Insured named in the Schedule for whom the insurance is proposed and the appropriate premium is paid, and who is covered under this Policy.

27. **IRDAI** means the Insurance Regulatory and Development Authority of India.
28. **Loss of Independent Living:** Loss of Independent Living means inability to perform one or more of the following activities of daily living:
    - Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;
    - Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
    - Transferring: The ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa;
    - Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
    - Feeding: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available;
    - Mobility: The ability to move indoors from room to room on level surfaces at the normal place of residence.
29. **Nominee** means the person named in the Schedule (as applicable) who is nominated to receive the Benefits due in respect of an Insured Person or Dependent covered under the Policy in accordance with the terms and conditions of the Policy, if such person is deceased when the Benefit becomes payable.
30. **Out-Patient** means a person who undergoes an OPD treatment or a temporary Hospitalization for a stay of less than 24 hours.
31. **Primary Insured:** Primary Insured means the person named in the Certificate of Insurance who is employed by or is a member of Your organization.
32. **Private Room** means a single occupancy accommodation in a private Hospital.
33. **Policy** means the statements in the proposal form/personal statement, these terms and conditions, Certificates of Insurance issued to the Insured Persons, group proposal form and the Schedule including any Annexures and endorsements, as amended from time to time which form part of the Policy contract and shall be read together.
34. **Policy Anniversary Date** means the day of the calendar year on which the Coverage Period under the current Policy commenced.
35. **Policy Period** means the period between the Commencement Date and the expiry date of the Policy as specified in the Schedule or the date of cancellation of this Policy, whichever is earlier.
36. **Policy Year** means a period of 12 consecutive months within the Coverage Period commencing from the Policy Anniversary Date.
37. **Risk Commencement Date**: Risk Commencement Date means the date specified in the Schedule on which the Coverage Period and Our coverage under the Policy in respect of the Insured Person commences.
38. **Room Category** means the type of room accommodation and associated boarding expenses at a Hospital and may be in the nature of a Deluxe AC room, Private/Single AC room, Twin sharing AC room, Non-AC sharing room, or a general ward in a Hospital etc.
39. **Schedule** means the schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the Policy Period, special conditions, and the limits to which

Benefits under the Policy are subject to, and as may be amended from time by way of endorsements made to or on it, and where more than one, then the latest in time.

40. **Spouse** means the Employee's legal husband or wife, who is proposed to be covered under the Policy.

41. **Specialist Medical Practitioner** is a Medical Practitioner who:

    - Has received advanced specialist training;
    - Practices a particular branch of medicine or Surgery;
    - Is or has been appointed as a consultant in a Hospital or is or has been appointed to a position in a Hospital which is deemed by Us or the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government as being of equivalent status.

    It is clarified that a physiotherapist who is registered or licensed as such under the laws of the country, state or other regulated area in which the Treatment is provided is only a Specialist Medical Practitioner for the purpose of physiotherapy as described in the list of Benefits.

42. **Sum Insured** means, subject to the terms, conditions and exclusions of this Policy, the amount specified in the Schedule against a Benefit, or set of Benefits, that represents Our maximum, total liability for any or all claims arising under this Policy for the respective Benefit(s) in respect of an Insured Person or all Insured Persons constituting the Floater Unit, if applicable, and is as specified in the Policy Schedule and/or Certificate of Insurance against the particular Benefit(s).

43. **Surgical Appliance and/or Medical Appliance** means:

    - An artificial limb, prosthesis or device which is required for the purpose of or in connection with a Surgery;
    - An artificial device or prosthesis which is a necessary part of the Treatment immediately following Surgery for as long as such device or prosthesis is required by medical necessity.
    - A prosthesis or appliance which is medically necessary and is part of the recuperation process for a reasonably short period of time.

44. **Sub Limit** means the limitation on the amount of coverage available to cover a specific type of claim. A Sub limit is part of, rather than an addition to, the limit that would otherwise apply to the admissible claim amount.

45. **TPA** means any person who is licensed under the IRDAI (Third Party Administrators – Health Services) Regulations 2016 (as may be amended, replaced or modified by the IRDAI) and is engaged for a fee or remuneration by Us for the purposes of providing health services. The list and details of TPA are set out on Our website.

46. **Treatment** means any relevant treatment controlled or administered by a Medical Practitioner to cure or substantially relieve an Illness or an Injury.

47. **Valuables:** Valuables means and includes photographic, audio, video, computer and any other electronic and electrical equipment, cellular phones, data, business goods, telecommunications and electrical equipment, motor vehicles and any accessories, telescopes, lenses, binoculars, antiques, art, watches, jewellery and gems, furs and articles made of precious stones and metals.

48. **Waiting Period** means a time bound exclusion period related to condition(s) specified in the Schedule or Policy which shall be served before a claim related to such condition(s) becomes admissible.

49. **We/Our/Ours/Us** means the Acko General Insurance Company Limited.

50. You/Your/Yours/Yourself/Policyholder means the person named in the Schedule who has concluded this Policy with Us.

Definitions of Critical Illnesses:

Standard definitions

1. Cancer of Specified Severity:

A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded:

- All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.
- Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
- Malignant melanoma that has not caused invasion beyond the epidermis;
- All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
- All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
- Chronic lymphocytic leukaemia less than RAI stage 3
- Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
- All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
- All tumors in the presence of HIV infection.

2. Myocardial Infarction (First Heart Attack of specific severity):

The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

- A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
- New characteristic electrocardiogram changes
- Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

- Other acute Coronary Syndromes
- Any type of angina pectoris
- A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. Open Chest CABG

The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The

diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

The following are excluded:

Angioplasty and/or any other intra-arterial procedures

4. Open Heart Replacement or Repair of Heart Valves

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

5. Coma of specified severity

A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

- no response to external stimuli continuously for at least 96 hours;
- life support measures are necessary to sustain life; and
- Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

6. Kidney failure requiring regular dialysis

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

7. Stroke resulting in permanent symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

The following are excluded:

- Transient ischemic attacks (TIA)
- Traumatic injury of the brain
- Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. Major organ/bone marrow transplant

The actual undergoing of a transplant of:

- One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
- Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:

- Other stem-cell transplants
- Where only islets of langerhans are transplanted

9. Permanent Paralysis of Limbs

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

10. Motor neuron disease with permanent symptoms

Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

11. Multiple Sclerosis with persisting symptoms

The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

- investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
- there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

Other causes of neurological damage such as SLE and HIV are excluded.

12. Angioplasty

Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

13. Benign Brain Tumor

Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

- Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
- Undergone surgical resection or radiation therapy to treat the brain tumor.

The following conditions are excluded:

Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

14. Blindness

Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

The Blindness is evidenced by:

i. corrected visual acuity being 3/60 or less in both eyes or;
ii. the field of vision being less than 10 degrees in both eyes.

The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

15. Deafness

Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90 decibels across all frequencies of hearing" in both ears.

16. End Stage Lung Failure

End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart;
ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia;
iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and
iv. Dyspnea at rest.

17. End Stage Liver Failure

Permanent and irreversible failure of liver function that has resulted in all three of the following:

- Permanent jaundice; and
- Ascites; and
- Hepatic encephalopathy.

Liver failure secondary to drug or alcohol abuse is excluded.

18. Loss of Speech

Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.

All psychiatric related causes are excluded.

19. Loss of Limbs

The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

20. Major Head Trauma

Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

The Activities of Daily Living are:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
iv. Mobility: the ability to move indoors from room to room on level surfaces;
v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
vi. Feeding: the ability to feed oneself once food has been prepared and made available.

The following are excluded:

i. Spinal cord injury;

21. Primary (Idiopathic) Pulmonary Hypertension

An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

The NYHA Classification of Cardiac Impairment are as follows:

- Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
- Class IV: Unable to engage in any physical activity without discomfort. Symptoms maybe present even at rest.

Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

22. Third Degree Burns

There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

Specific definitions

23. Alzheimer's Disease

Clinically established diagnosis of Alzheimer's Disease (presenile dementia) resulting in a permanent inability to perform independently three or more activities of daily living – bathing, dressing/undressing, getting to and using the toilet, transferring from bed to chair or chair to bed, continence, eating/drinking and taking medication – or resulting in need of supervision and permanent presence of care staff due to the disease. These conditions have to be medically documented for at least 3 months.

24. Surgery of Aorta

The actual undergoing of medically necessary surgery for a disease of the aorta needing excision and surgical replacement of the diseased aorta with a graft. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches. Traumatic injury of the aorta is excluded.

25. Medullary Cystic Disease

The occurrence of Parkinson's Disease where there is an associated Neurological Deficit that results in Permanent Inability to perform independently atleast three of the activities of daily living as defined below.

i. Transfer: Getting in and out of bed without requiring external physical assistance
ii. Mobility: The ability to move from one room to another without requiring any external physical assistance
iii. Dressing: Putting on and taking of all necessary items of clothing without requiring any external physical assistance
iv. Bathing/Washing: The ability to wash in the bath or shower (including getting in and out of the bath or shower) or wash by other means
v. Eating: All tasks of getting food into the body once it has been prepared. Parkinson's disease secondary to drug and/or alcohol abuse is excluded.

26. Medullary Cystic Disease

Medullary Cystic Disease where the following criteria are met:

i. the presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis;
ii. clinical manifestations of anaemia, polyuria, and progressive deterioration in kidney function; and
iii. the Diagnosis of Medullary Cystic Disease is confirmed by renal biopsy. Isolated or

benign kidney cysts are specifically excluded from this benefit.

27. Muscular Dystrophy

A group of hereditary degenerative diseases of muscle characterised by weakness and atrophy of muscle. The diagnosis of muscular dystrophy must be unequivocal and made by a Registered Doctor who is a consultant neurologist. The condition must result in the inability of

the Life Insured to perform (whether aided or unaided) at least 3 of the 6 "Activities of Daily Living" for a continuous period of at least 6 months.

Activities of daily living:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;
ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
iii. Transferring: The ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa;
iv. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
v. Feeding: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available.
vi. Mobility: The ability to move indoors from room to room on level surfaces at the normal place of residence

28. Infective Endocarditis

Inflammation of the inner lining of the heart caused by infectious organisms, where all of the following criteria are met:

i. Positive result of the blood culture proving presence of the infectious organism(s);
ii. Presence of at least moderate heart valve incompetence (meaning regurgitant fraction of 20% or above) or moderate heart valve stenosis (resulting in heart valve area of 30% or less of normal value) attributable to Infective Endocarditis; and
iii. The Diagnosis of Infective Endocarditis and the severity of valvular impairment are confirmed by a Registered Doctor who is a cardiologist.

29. Dissecting Aortic Aneurysm

A condition where the inner lining of the aorta (intima layer) is interrupted so that blood enters the wall of the aorta and separates its layers. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches. The diagnosis must be made by a Registered Doctor who is a specialist with computed tomography (CT) scan, magnetic resonance imaging (MRI), magnetic resonance angiograph (MRA) or angiogram. Emergency surgical repair is required.

30. Systemic Lupus Erythematosus with Lupus Nephritis

A multi-system autoimmune disorder characterised by the development of autoantibodies directed against various self-antigens. In respect of this Policy, systemic lupus erythematosus will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Class III to Class V Lupus Nephritis, established by renal biopsy, and in accordance with the WHO Classification). The final diagnosis must be confirmed by a Registered Doctor specialising in Rheumatology and Immunology.

The WHO Classification of Lupus Nephritis:

- Class I Minimal Change Lupus Glomerulonephritis
- Class II Messangial Lupus Glomerulonephritis
- Class III Focal Segmental Proliferative Lupus Glomerulonephritis
- Class IV Diffuse Proliferative Lupus Glomerulonephritis
- Class V Membranous Lupus Glomerulonephritis

31. Apallic Syndrome

Universal necrosis of the brain cortex with the brainstem remaining intact. The diagnosis must be confirmed by a Neurologist acceptable to Us and the condition must be documented for at least one month.

32. Aplastic Anaemia

I. Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:
   i. Blood product transfusion;
   ii. Marrow stimulating agents;
   iii. Immunosuppressive agents; or
   iv. Bone marrow transplantation.

II. The diagnosis must be confirmed by a haematologist using relevant laboratory investigations including Bone Marrow Biopsy resulting in bone marrow cellularity of less than 25% which is evidenced by any two of the following:
   i. Absolute neutrophil count of less than 500/mm³ or less
   ii. Platelets count less than 20,000/mm³ or less
   iii. Reticulocyte count of less than 20,000/mm³ or less

III. Temporary or reversible Aplastic Anaemia is excluded.

33. Bacterial Meningitis

I. Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal chord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks. This diagnosis must be confirmed by:
   i. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
   ii. A consultant neurologist.

II. Bacterial Meningitis in the presence of HIV infection is excluded.

34. Cardiomyopathy

I. An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a Registered Doctor who is a cardiologist, and which results in permanent physical impairment to the degree of New York Heart Association Classification Class IV, or its equivalent, for at least six (6) months based on the following classification criteria:
Class IV – inability to carry out an activity without discomfort. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced.

II. The Diagnosis of Cardiomyopathy has to be supported by echographic findings of compromised ventricular performance.

III. Irrespective of the above, Cardiomyopathy directly related to alcohol or drug abuse is excluded.

35. Other Serious Coronary Artery Disease

I. Severe coronary artery disease in which at least three (3) major coronary arteries are individually occluded by a minimum of sixty percent (60%) or more, as proven by coronary angiogram only (non-invasive diagnostic procedures excluded).

II. For purposes of this definition, “major coronary artery” refers to any of the left main stem artery, left anterior descending artery, circumflex artery and right coronary artery (but not including their branches).

36. Creutzfeldt-Jacob Disease (CJD)

I. Creutzfeldt-Jacob disease is an incurable brain infection that causes rapidly progressive deterioration of mental function and movement. A Registered Doctor who is a neurologist must make a definite diagnosis of Creutzfeldt-Jacob disease based on clinical assessment, EEG and imaging. There must be objective neurological abnormalities on exam along with severe progressive dementia.

37. Encephalitis

I. Severe inflammation of brain substance (cerebral hemisphere, brainstem or cerebellum) caused by viral infection and resulting in permanent neurological deficit. This diagnosis must be certified by a Registered Doctor who is a consultant neurologist and the permanent neurological deficit must be documented for at least 6 weeks.

II. Encephalitis caused by HIV infection is excluded.

38. Fulminant Hepatitis

I. A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:

i. Rapid decreasing of liver size;
ii. Necrosis involving entire lobules, leaving only a collapsed reticular framework;
iii. Rapid deterioration of liver function tests;
iv. Deepening jaundice; and
v. Hepatic encephalopathy.

II. Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria.

39. Eisenmenger's Syndrome

I. Development of severe pulmonary hypertension and shunt reversal resulting from heart condition. The diagnosis must be made by a Registered Doctor who is a specialist with echocardiography and cardiac catheterisation and supported by the following criteria:

i. Mean pulmonary artery pressure > 40 mm Hg;
ii. Pulmonary vascular resistance > 3mm/L/min (Wood units); and
iii. Normal pulmonary wedge pressure < 15 mm Hg.

40. Chronic Adrenal Insufficiency (Addison's Disease)

I. An autoimmune disorder causing a gradual destruction of the adrenal gland resulting in the need for life long glucocorticoid and mineral corticoid replacement therapy. The disorder must be confirmed by a Registered Doctor who is a specialist in endocrinology through one of the following:

i. ACTH simulation tests;
ii. insulin-induced hypoglycemia test;
iii. plasma ACTH level measurement;
iv. Plasma Renin Activity (PRA) level measurement.

II. Only autoimmune cause of primary adrenal insufficiency is included. All other causes of adrenal insufficiency are excluded.

41. Progressive Scleroderma

I. A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. This diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.

II. The following are excluded:

i. Localised scleroderma (linear scleroderma or morphea);

ii. Eosinophilic fasciitis; and

iii. CREST syndrome.

42. Progressive Supranuclear Palsy

I. Confirmed by a Registered Doctor who is a specialist in neurology of a definite diagnosis of progressive supranuclear palsy. There must be permanent clinical impairment of motor function, eye movement disorder and postural instability.

43. Chronic Relapsing Pancreatitis

I. An unequivocal diagnosis of Chronic Relapsing Pancreatitis, made by a Registered Doctor who is a specialist in gastroenterology and confirmed as a continuing inflammatory disease of the pancreas characterised by irreversible morphological change and typically causing pain and/or permanent impairment of function. The condition must be confirmed by pancreatic function tests and radiographic and imaging evidence.

II. Relapsing Pancreatitis caused directly or indirectly, wholly or partly, by alcohol is excluded.

44. Elephantiasis

I. Massive swelling in the tissues of the body as a result of destroyed regional lymphatic circulation by chronic filariasis infection. The unequivocal diagnosis of elephantiasis must be confirmed by a Registered Doctor who is a specialist physician. There must be clinical evidence of permanent massive swelling of legs, arms, scrotum, vulva, or breasts. There must also be laboratory confirmation of microfilariae infection.

II. Swelling or lymphedema caused by infection with a sexually transmitted disease, trauma, post-operative scarring, congestive heart failure, or congenital lymphatic system abnormalities is excluded.

45. Brain Surgery

I. The actual undergoing of surgery to the brain under general anaesthesia during which a craniotomy is performed. Keyhole surgery is included however, minimally invasive treatment where no surgical incision is performed to expose the target, such as irradiation by gamma knife or endovascular neuroradiological interventions such as embolizations, thrombolysis and stereotactic biopsy are all excluded. Brain surgery as a result of an Accident is also excluded. The procedure must be considered medically necessary by a Registered Doctor who is a qualified specialist.

46. HIV Due to Blood Transfusion and Occupationally Acquired HIV

I. Infection with the Human Immunodeficiency Virus (HIV) through a blood transfusion, provided that all of the following conditions are met:

i. The blood transfusion was medically necessary or given as part of a medical treatment;
ii. The blood transfusion was received in India after the Policy Date, Date of endorsement or Date of reinstatement, whichever is the later;
iii. The source of the infection is established to be from the Institution that provided the blood transfusion and the Institution is able to trace the origin of the HIV tainted blood; and
iv. The Life Insured does not suffer from Thalassaemia Major or Haemophilia.

II. Infection with the Human Immunodeficiency Virus (HIV) which resulted from an Accident occurring after the Policy Date, date of endorsement or date of reinstatement, whichever is the later whilst the Life Insured was carrying out the normal professional duties of his or her occupation in India, provided that all of the following are proven to the Company's satisfaction:

i. Proof that the Accident involved a definite source of the HIV infected fluids;
ii. Proof of sero-conversion from HIV negative to HIV positive occurring during the 180 days after the documented Accident. This proof must include a negative HIV antibody test conducted within 5 days of the Accident; and
iii. HIV infection resulting from any other means including sexual activity and the use of intravenous drugs is excluded.

III. This benefit is only payable when the occupation of the Life Insured is a Registered Doctor, housemen, medical student, registered nurse, medical laboratory technician, dentist (surgeon and nurse) or paramedical worker, working in medical centre or clinic in India. This benefit will not apply under either section A or B where a cure has become available prior to the infection. "Cure" means any treatment that renders the HIV inactive or non-infectious.

47. Terminal illness

I. The conclusive diagnosis of an illness, which in the opinion of a Registered Doctor who is an attending Consultant and agreed by our appointed Registered Doctor, life expectancy is no greater than twelve (12) months from the date of notification of claim, regardless of any treatment that might be undertaken.

48. Myelofibrosis

I. A disorder which can cause fibrous tissue to replace the normal bone marrow and results in anaemia, low levels of white blood cells and platelets and enlargement of the spleen. The condition must have progressed to the point that it is permanent and the severity is such that the Life Insured requires a blood transfusion at least monthly. The diagnosis of myelofibrosis must be supported by bone marrow biopsy and confirmed by a Registered Doctor who is a specialist.

49. Pheochromocytoma

I. Presence of a neuroendocrine tumour of the adrenal or extra-chromaffin tissue that secretes excess catecholamines requiring the actual undergoing of surgery to remove the tumour.

II. The Diagnosis of Pheochromocytoma must be confirmed by a Registered Doctor who

is an endocrinologist.

50. Crohn's Disease

I. Crohn's Disease is a chronic, transmural inflammatory disorder of the bowel. To be considered as severe, there must be evidence of continued inflammation in spite of optimal therapy, with all of the following having occurred:

i. Stricture formation causing intestinal obstruction requiring admission to hospital, and
ii. Fistula formation between loops of bowel, and
iii. At least one bowel segment resection.

II. The diagnosis must be made by a Registered Doctor who is a specialist Gastroenterologist and be proven histologically on a pathology report and/or the results of sigmoidoscopy or colonoscopy.

51. Severe Rheumatoid Arthritis

I. Unequivocal Diagnosis of systemic immune disorder of rheumatoid arthritis where all of the following criteria are met:

i. Diagnostic criteria of the American College of Rheumatology for Rheumatoid Arthritis;
ii. Permanent inability to perform at least two (2) "Activities of Daily Living";
iii. Widespread joint destruction and major clinical deformity of three (3) or more of the following joint areas: hands, wrists, elbows, knees, hips, ankle, cervical spine or feet; and
iv. The foregoing conditions have been present for at least six (6) months.

52. Severe Ulcerative Colitis

I. Acute fulminant ulcerative colitis with life threatening electrolyte disturbances.

II. All of the following criteria must be met:

i. the entire colon is affected, with severe bloody diarrhoea; and
ii. the necessary treatment is total colectomy and ileostomy; and
iii. the diagnosis must be based on histopathological features and confirmed by a Registered Doctor who is a specialist in gastroenterology.

53. Pneumonectomy

The undergoing of surgery on the advice of an appropriate Medical Specialist to remove an entire lung for disease or traumatic injury suffered by the life assured.

The following conditions are excluded:

- Removal of a lobe of the lungs (lobectomy)
- Lung resection or incision

54. Multiple System Atrophy

A diagnosis of multiple system atrophy by a Specialist Medical Practitioner (Neurologist). There must be evidence of permanent clinical impairment for a minimum period of 30 days of either:

- motor function with associated rigidity of movement; or
- The ability to coordinate muscle movement; or

- Bladder control and postural hypotension.

55. Ebola

Infection with the Ebola virus where the following conditions are met:

- presence of the Ebola virus has been confirmed by laboratory testing;
- there are ongoing complications of the infection persisting beyond thirty (30) days from the onset of symptoms; and
- the infection does not result in death.

56. Hemiplegia

The total and permanent loss of the use of one side of the body through paralysis caused by illness or injury, except when such injury is self-inflicted.

57. Loss of Independent Existence

Inability to perform at least three (3) of the "Activities of Daily Living" as defined below (either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons) for a continuous period of at least six (6) months and leading to a permanent inability to perform the same. For the purpose of this definition, the word "permanent" shall mean beyond the hope of recovery with current medical knowledge and technology. The Diagnosis of Loss of Independent Existence must be confirmed by a Registered Doctor.

Only Life Insured with Insurance Age between 18 and 74 on first diagnosis is eligible to receive a benefit under this illness.

All psychiatric related causes are excluded.

The Activities of Daily Living are:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
iv. Mobility: the ability to move indoors from room to room on level surfaces;
v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
vi. Feeding: the ability

3 Basic Benefits

All the Benefits under this Section are available to the Insured Person(s). The Sum Insured limits, Exclusions including Waiting Periods and Basic Benefit Options applicable are as opted by You in the proposal form and as specified in the Schedule.

Claims under the Basic Benefit 3.1 (In-patient Hospitalization) and Basic Benefit 3.2 (Day-care treatment) will be admissible subject to the fulfilment of the following conditions with respect to the Insured Person's Hospitalization:

a. 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 Medically Necessary Treatment of that Illness or Injury, and commences and continues on the written advice of the treating Medical Practitioner.

3.1 In-patient Hospitalization

We will indemnify the Medical Expenses incurred towards the Insured Person's Hospitalization as an in-patient, provided that the Medical Expenses are incurred towards one or more of the following:

(i) Room Rent;

(ii) ICU/CCU/HDU charges;

(iii) Operation theatre charges;

(iv) Medical Practitioners' fees;

(v) Medicines prescribed by the treating Medical Practitioner;

(vi) Diagnostic tests directly related to the current Hospitalization; and,

(vii) Surgical Appliance and/or Medical Appliance(s) prescribed by the treating Medical Practitioner.

Some expenses as specified in Section 11.1 (Annexure I) are not covered in the Policy, unless specified otherwise in the Schedule.

Room Rent / Room Category / ICU Charges

The Schedule will specify the eligibility of Room Rent or Room Category or ICU Charges applicable for the Insured Person(s) under the Policy.

If the availed Room Rent / Room Category / ICU Charges are higher than that specified in the Schedule, then the Insured Person shall bear a rateable proportion of the total Covered In-patient Medical Expenses (including surcharge or taxes thereon) in the proportion of the difference between the Room Rent of the entitled Room Category to the Room Rent actually incurred.

The Room Category (or eligible Room Rent) will be specified in the Schedule for the Insured Person. The nomenclature of Room Category may vary from one Hospital to the other, and the specification and description of the Room Category, as specified in the Policy Schedule/ shall be used to determine the applicable Room Category.

3.2 Day Care Treatment

We will indemnify the Medical Expenses incurred towards Day Care Treatment undertaken by an Insured Person in a Hospital / nursing home / Day Care Centre.

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

3.3 Pre & Post Hospitalization Medical Expenses

We will indemnify the relevant Medical Expenses incurred towards an Insured Person in relation to:

a. Pre-hospitalization Medical Expenses of an Insured Person incurred up to the number of days specified in the Schedule, immediately prior to the Date of Admission or date of commencement of the Day Care Treatment; and

b. Post-Hospitalization Medical Expenses of an Insured Person incurred up to the number of days specified in the Schedule, immediately post the date of discharge from the Hospital or date of completion of the Day Care Treatment.

The above Medical Expenses shall be payable provided that a claim has been admitted for the same Hospitalization under Basic Benefit 3.1 (In-patient Hospitalization) or Basic Benefit 3.2 (Day Care Treatment) above.

3.4 Road Ambulance

We will indemnify the reasonable costs incurred towards transportation of an Insured Person to a Hospital or a Day Care Centre by an Ambulance or public transport, in case of the Insured Person requiring Emergency Care. This Basic Benefit is payable provided that:

a. We have accepted a claim under Basic Benefit 3.1 (In-patient Hospitalization) or Basic Benefit 3.2 (Day Care Treatment) for the same Illness or Injury;

It is medically necessary to transport the Insured Person using an Ambulance.

We shall not be liable to pay any expenses in relation to transportation of the Insured Person from Hospital to the Insured Person's residence unless medically necessary and pre-approved by Us.

3.5 Domestic Emergency Evacuation

In case of a medical Emergency during the Coverage Period in respect to an Insured Person, if adequate medical facilities are not available locally, We will indemnify the reasonable costs towards emergency evacuation of the Insured Person to the nearest medical facility capable of providing adequate care, provided that:

a. The emergency evacuation must be certified in writing by the attending Medical Practitioner for the evacuation to be medically necessary to prevent the immediate and significant effects of an Illness/Injury which if left untreated could result in a significant deterioration of health.

The emergency evacuation is pre-authorised by Us. Only where it can be demonstrated to Our satisfaction that it was not reasonably possible for pre-authorisation to be sought before the evacuation takes place, authorisation should be sought as soon as possible after the emergency evacuation has occurred.

In considering such requests, We will consider the nature of the Insured Person's Illness or Injury, the Insured Person's condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions and distance to be covered.

The Insured Person's medical condition must require the accompaniment of a qualified Medical Practitioner during the entire course of the transportation to be considered as requiring emergency evacuation.

Transportation will be provided by medically equipped specialty aircraft, commercial airline, train, Ambulance or air ambulance depending upon the medical needs and available transportation specific to each case, and within the geographical territory of India only.

3.6 Domiciliary Treatment Cover

We will indemnify the Medical Expenses incurred on the Domiciliary Hospitalization of an Insured Person during the Coverage Period following an Illness or Injury that occurs during the Coverage Period, provided that:

a. The Domiciliary Hospitalization continues for at least 3 consecutive days in which case We shall make payment under this Benefit in respect of Medical Expenses incurred from the first day of Domiciliary Hospitalization;

The treating Medical Practitioner confirms in writing that Domiciliary Hospitalization was medically necessary.

Medical Expenses can be claimed under this Basic Benefit on a reimbursement basis only.

3.7 Organ Donor Expenses

We will indemnify the Hospitalization expenses specified in Section 3.1 (In-patient Hospitalization) incurred by an Insured Person's organ donor as an in-patient towards harvesting of the organ, provided that:

a. We have admitted a claim under Section 3.1 (In-patient Hospitalization) for the Insured Person under this Policy and it is related to the same Illness or Injury.

The organ donation is in accordance with the Transplantation of Human Organs Act 1994 (as amended from time to time) and other applicable laws and rules.

The organ donated is for the use of the Insured Person who has been advised to undergo an organ transplant in writing by the treating Medical Practitioner.

We shall not be liable to indemnify any expenses under this Benefit for the following:

a. Any Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the organ donor;

b. Any costs incurred towards donor screening;

c. Any costs directly or indirectly associated to the acquisition of the organ;

d. Any other medical treatment undergone, or complications suffered by the donor consequent to the harvesting of the organ:

e. Expenses related to organ transportation or preservation;

f. Transplant of any organ/tissue where the transplant is experimental or investigational.

3.8 Second Opinion

We will indemnify the expenses incurred towards seeking a second opinion for an alternate evaluation of the diagnosis or Treatment from a Specialist Medical Practitioner, on an out-patient consultation basis, if an Insured Person is advised for Hospitalization or Day Care Treatment by a Medical Practitioner during the Coverage Period.

The option to avail a second opinion is at the Insured Person's sole discretion, and the Insured Person is 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.

3.9 New Born Baby

We will indemnify the Medical Expenses under Basic Benefit 3.1 (In-patient Hospitalization) or Basic Benefit 3.2 (Day Care Treatment) incurred towards the Hospitalization of an Insured Person's New Born Baby who is born during the Coverage Period, provided that:

a. The New Born Baby is born at least 10 months after the first Policy Commencement Date.

You have paid the additional premium for the New Born Baby as per the applicable premium rates based on the new Family Type.

None of the parents is suffering from any Pre-Existing Disease/Condition which has not been disclosed to Us at the time of the first Policy inception date and which medically has a high probability of getting transmitted to the New Born Baby.

3.10 Annual Preventive Health Check-up

We will facilitate and provide the following preventive health check-ups, to all Insured Persons above 18 years of Age, once in each Policy Year:

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)

All the Insured Persons must undergo the preventive health check-ups as specified in the Schedule, annually, provided that:

a. The Network Provider / Empanelled Service Provider shall be assigned by Us within 90 days of expiry of the Policy Year;

We shall arrange and pay for the test(s) at Our Network Providers/ Empanelled Service Providers only;

Any test undergone by the Insured person(s) outside of Our Network Providers/ Empanelled Service Providers within three months from the expiry of the current Policy Year may be considered under this Basic Benefit, at Our sole discretion, if the report of such tests is submitted to Us;

Section 6.6 (Exclusion 9), is not applicable in respect of coverage under this Basic Benefit.

3.11 Inflation Protect Sum Insured

We will provide You an additional Sum Insured, called 'Inflation Protect Sum Insured', in a subsequent Policy Year, if the Policy is active or is Renewed with Us. The Inflation Protect Sum Insured in the subsequent Policy Year will be a fixed percentage, as specified in the Schedule, of the Base Sum Insured of the last completed Policy Year. This Inflation Protect Sum Insured will be added for each of the ten (10) completed and continuous Policy Years.

a. If the Base Sum Insured has been reduced at the time of Renewal, the applicable Inflation Protect Sum Insured shall be calculated on the revised Base Sum Insured on pro-rata basis.

b. If the Base Sum Insured is increased at the time of Renewal, the Inflation Protect Sum Insured will be calculated on the Base Sum Insured of the last completed Policy Year.

3.12 Restore Sum Insured

We will restore Your Sum Insured up to 100% of the Base Sum Insured once in a Policy Year, in case the sum total of Base Sum Insured, Inflation Protect Sum Insured, and any NCB Sum Insured under Basic Benefit Option 4.3, earned under the Policy is insufficient to pay for Medical Expenses as a result of previous claims admitted during the Policy Year, provided that:

a. A claim will be admissible for utilization of the Restore Sum Insured only if the claim is admissible under Basic Benefit 3.1 (In-patient Hospitalization) or Basic Benefit 3.2 (Day Care Treatment);

b. Restoration of Sum Insured will not trigger for the first claim made in the Policy Year;

c. For individual policies, Restore Sum Insured will be available on individual basis whereas for floater policies, it will be available on floater basis;

d. If the Restore Sum Insured is not utilised in a Policy Year, it will not be carried forward to the subsequent Policy Year;

e. For Treatment of Any One Illness during a Policy Year, the maximum claim amount payable shall not exceed the sum of

- Base Sum Insured;
- Inflation Protect Sum Insured; and
- NCB Sum Insured (if available).

4 Basic Benefit Options

4.1 Worldwide In-patient Hospitalization

If this Basic Benefit Option is in force, We will indemnify the Covered In-patient Medical Expenses, to the extent specified in Basic Benefit 3.1, incurred during Hospitalization of an Insured Person anywhere outside India for the Illness or Injury, as specified in the Schedule, provided that:

a. Intimation of such Hospitalization has been made to Us within 48 hours of such admission;

The Hospitalization is for Medically Necessary Treatment, and commences and continues on the written advice of the treating Medical Practitioner;

The payment of any claim under this Benefit will be based on the rate of exchange, published by Reserve Bank of India (RBI), from the currency of the country of treatment to Indian Rupees as on the date of payment (or the next available date for which exchange rate is available) to the Hospital;

Any claim made under this Benefit will be as per the claims procedure provided under Section 13 of this Policy.

Permanent Exclusion under Exclusion 7 of Section 6.5 will be waived off for the purpose of this Benefit in respect of that Insured Person.

4.2 Unlimited Restore

Notwithstanding the terms of the Basic Benefit 3.12 (Restore Sum Insured), If this Basic Benefit Option is in force, We will restore the Sum Insured for unlimited number of times in a Policy Year, in case the sum total of Base Sum Insured, Inflation Protect Sum Insured and any NCB Sum Insured under Basic Benefit Option 4.3, earned under the Policy is insufficient to pay for Medical Expenses as a result of previous claims admitted during the Policy Year, provided that:

a. A claim will be admissible for utilization of the Restore Sum Insured only if the claim is admissible under Basic Benefit 3.1 (In-patient Hospitalization) or Basic Benefit 3.2 (Day care Treatment);

b. Restoration of Sum Insured will not trigger for the first claim made in the Policy Year;

c. For individual policies, Restore Sum Insured will be available on individual basis whereas for floater policies, it will be available on floater basis;

d. If the Restore Sum Insured is not utilised in a Policy Year, it will not be carried forward to the subsequent Policy Year.

e. For treatment of Any One Illness during a Policy Year, the maximum claim amount payable shall not exceed the sum of

- Base Sum Insured;
- Inflation Protect Sum Insured; and
- NCB Sum Insured (if available)

If this Basic Benefit Option is in force, it supersedes the Basic Benefit 3.12 (Restore Sum Insured).

4.3 No Claim Bonus Sum Insured

If this Basic Benefit Option is in force, We will provide You an additional Sum Insured, called No Claim Bonus (NCB) Sum Insured, in the subsequent Policy Year, if the Policy is active or is Renewed with Us. The additional NCB Sum Insured in the subsequent Policy Year will be a fixed percentage, specified in the Schedule, of the Base Sum Insured of the last completed Policy Year.

a. Any NCB Sum Insured that has accrued will be available for any claims made in the subsequent Policy Year.

b. At the time of Renewal of this Policy, if the Policyholder chooses not to renew this Basic Benefit Option, then the NCB Sum Insured under the Policy shall be forfeited.

c. In case a claim is made under Basic Benefit 3.1 (In-patient Hospitalization) or Basic Benefit 3.2 (Day Care Treatment) during a Policy Year, the NCB Sum Insured in the subsequent Policy Year will be zero (0).

d. During any Policy Year, the NCB Sum Insured cannot be more than the Base Sum Insured.

e. If the Base Sum Insured has been reduced at the time of Renewal, the applicable NCB Sum Insured shall be calculated on the revised Base Sum Insured on pro-rata basis.

f. If the Base Sum Insured under the Policy has been increased at the time of Renewal, the NCB Sum Insured shall be calculated on the Base Sum Insured of the last completed Policy Year.

4.4 First Notification of Claim

If this Basic Benefit Option is in force, in return of a discount in premium offered by Us, You have agreed to notify Us about any claim under Basic Benefit 3.1 (In-patient Hospitalization) or Basic Benefit 3.2 (Day Care Treatment) 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, as specified in the Schedule, of the final claim amount assessed by Us, in addition to any other Co-payment applicable.

4.5 Preferred Providers Network

If this Basic Benefit Option is in force, in return of a discount in premium offered by Us, You have agreed to use the services of Hospitals in Our Preferred Provider Network, as specified in the Schedule or Our website www.acko.com, for availing cover under Basic Benefit 3.1 (In-patient Hospitalization) or Basic Benefit 3.2 (Day Care Treatment).

If You make a claim under Basic Benefit 3.1 (In-patient Hospitalization) or Basic Benefit 3.2 (Day Care Treatment) for Hospitalization in a Hospital outside of the specified Preferred Provider Network, You will bear a compulsory Co-payment percentage, as specified in the Schedule, of the final claim amount assessed by Us, in addition to any other Co-payment that may be applicable.

4.6 Co-Pay

If this Basic Benefit Option is in force, in return of a discount in premium offered by Us, You have agreed to bear a compulsory Co-payment percentage of the final claim amount assessed by Us, as specified in the Schedule, for all claims under Basic Benefits and Basic Benefit Options.

4.7 Super Top-up

If this Basic Benefit Option is in force, We will indemnify the Insured Persons for claims only when the total admissible claim amount for all Insured Persons covered under the Policy, during the Policy Year exceeds the Annual Aggregate Deductible amount specified in the Schedule, and subject to any other conditions specified against this Basic Benefit Option in the Schedule. However, no Deductible under

this Basic Benefit Option shall be applicable for the claims under Basic Benefit 3.10 (Annual Preventive Health Check-ups).

Note that:

a. For the purpose of calculating the Annual Aggregate Deductible and assessment of admissibility, all claims must be submitted in accordance with the claims process specified under Section 7 and terms and conditions under Section 8 of the Policy, as applicable.

The consumption of the Annual Aggregate Deductible amount will be on the basis of the admissible claim amount after applying the Sub-limits as per of the Schedule.

4.8 Waiver of Non-payable Medical Expenses Exclusion

If this Basic Benefit Option is in force, We shall indemnify the reasonable and customary expenses towards Non-payable Medical Expenses as specified in the Section 11.1 (Annexure I) "List of excluded expenses (non-medical)" and on Our website acko.com, provided that the claim is admitted under Basic Benefit 3.1 (In-patient Hospitalization), or Basic Benefit 3.2 (Day Care Treatment) or Basic Benefit 3.6 (Domiciliary Treatment Cover).

4.9 All Medically Necessary Hospitalization

If this Basic Benefit Option is in force, We shall indemnify the reasonable and customary expenses towards Permanent Exclusions as specified in Section 6.5, provided that the claim is admitted under Basic Benefit 3.1 (In-patient Hospitalization), or Basic Benefit 3.2 (Day Care Treatment) or Basic Benefit 3.6 (Domiciliary Treatment Cover).

4.10 Reduction in Specific Disease/Procedure Waiting Period

If You have opted for this Basic Benefit Option at the time of inception of the first policy with Us and We have accepted the same, then We shall reduce the applicable specific waiting period for claims related to Specific Diseases/Procedures specified under Section 6.2 (Specific Disease/Procedure Waiting Period) to the period as specified in the Schedule.

This Basic Benefit Option will be available only at the time of inception of the first policy with Us and only for the Sum Insured opted at such inception.

5 Add-on Benefits

5.1 Doctor-on-Call

If this Add-on Benefit is in force, We will provide the Insured Person with access to a general Medical Practitioner, either directly or facilitated through Our Empanelled Service Provider, for round-the-clock medical consultation through an online portal as a chat service, a call back service or a voice call service.

This Add-on Benefit will be available provided that:

a. Consultation shall be requested by the Insured Person at his or her sole direction, either to Us or Our Empanelled Service Provider.

b. Consultation will be arranged based solely on the information and documentation provided by the Insured Person.

c. Consultation must not be considered a substitute to medical opinion or Medical Advice nor shall the same be pursued over a medical opinion or a Medical Advice given by a treating physician or doctor.

d. By seeking consultation under this Add-on Benefit, the Insured Person is not prohibited or advised against visiting or consulting with any other independent Medical Practitioner or commencing or continuing any treatment advised by such Medical Practitioner.

e. The Insured Person is free to choose whether or not to obtain the consultation, and if obtained then whether or not to act on it in whole or in part.

f. Consultation under this Add-on Benefit shall not be valid for any medico-legal purposes.

g. We do not make any warranties or representations as to the correctness of the medical consultation and shall not assume or deem to assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the general Medical Practitioner.

5.2 Family Physician

If this Add-on Benefit is in force, We will assign a qualified Medical Practitioner who is a general physician as a 'Family Physician' to the Insured Person in the locality of his/her place of residence whom the Insured Person or any of the Dependents covered under the Policy may visit for general physician consultations, provided that:

a. The Family Physician assigned to the Insured Person will be a general physician and not a Specialist Medical Practitioner for any disease;

b. We will provide a choice of at least one Family Physician within 5 kilometre from the Insured Person's current address on a best efforts basis. In case no such Family Physician is available, We will assign the Insured Person a Family Physician outside such radius, or assign a general physician of his/her choice;

In case of the Insured Person's movement from the current address, We will reassign a different Family Physician for the new address.

5.3 Out-Patient Department (OPD) Medical Services

If this Add-on Benefit is in force, We will indemnify the Medical Expenses incurred by an Insured Person in respect of any Medically Necessary Treatment availed, in a Hospital or Day Care Centre or by any service provider in an out-patient facility, of the following nature:

a. **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 indemnification of the costs of medicines/pharmacy duly supported by the prescriptions of the Medical Practitioner attending to the Insured Person;

OPD Treatment: Any OPD treatment undertaken.

The above services will be available only at a network of service providers as specified in the Schedule and on Our website.

We shall not be liable to indemnify any Medical Expenses under this Add-on Benefit of treatment and consultation for the following unless specified in the Schedule:

a. Facilities and services availed for pleasure or rejuvenation or as a preventive aid, such as beauty treatments, Panchakarma, purification or detoxification.

b. Cost of spectacles, hearing aids, braces, implants, prosthetic devices, and lenses etc as medical aid and physiotherapy.

c. Any OPD treatment taken outside India.

d. All routine examinations and preventive health check-ups.

e. Preventive care, vaccination including inoculation and immunizations (except in case of post-bite treatment).

f. Cost incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose.

g. Sterility, infertility, sub-fertility or other related conditions and complications arising out of the same, assisted conception, surrogate, vicarious pregnancy or Pregnancy, birth control, and similar procedures; contraceptive supplies or services including complications arising due to supplying services.

h. Complications arising out of pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness), maternity or birth (including caesarean section) except in the case of ectopic pregnancy for in-patient only.

i. Investigational treatments, Unproven / Experimental treatment, or drugs yet under trial, including experimental devices and pharmacological regimens.

j. Correction of eyesight due to refractive error including routine examination.

k. Weight management programs or treatment in relation to the same including vitamins and tonics, treatment of obesity (including morbid obesity).

m. Dentures, implants and artificial teeth, Dental Treatment and Surgery of any kind, unless requiring due to an Accident.

5.4 Access to Our Out-Patient Medical Services Network

If this Add-on Benefit is in force, You are entitled to avail of a physical consultation or prescribed diagnostics, as specified in the Schedule, at a discount on their retail rates as specified in the Schedule.

For each service, You will be able to see the original retail rates for Our Empanelled Service Providers, which You would have paid if this Add-on Benefit was not in force.

5.5 Monthly No Claim Bonus OPD Sum Insured

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

a. Such NCB OPD Sum Insured will be solely available for OPD Medical Services mentioned in Add-on Benefit 5.3 (Out-Patient Medical Services)

b. The Sum Insured accrued at the end of a Policy Month, will expire after 12 months in case the Sum Insured is not utilized.

c. In case a claim is admitted under Basic Benefit 3.1 (In-patient Hospitalization) or Basic Benefit 3.2 (Day Care Treatment) in a Policy Month, the No Claim Bonus Sum Insured will not accrue for 12 subsequent Policy Months.

5.6 Daily Hospital Cash

If this Add-on Benefit is in force, in case a claim is admitted under Basic Benefit 3.1 (In-patient Hospitalization), We will pay the daily allowance amount specified against this Add-on Benefit in the Schedule, for each continuous and completed period of 24 hours of Hospitalisation for a maximum of 45 days as specified in the Schedule against this Add-on Benefit.

If Basic Benefit Options 4.4 (First Notification of Claim) or 4.5 (Preferred Provider Network) are in force, a Co-payment of the percentage specified in the Schedule, will be deducted from the daily allowance amount as per the conditions specified in Basic Benefit Options 4.4 and 4.5.

5.7 Critical Illness Benefit

If this Add-on Benefit is in force, We will pay the Sum Insured as is specified against such Critical Illness under this Add-on Benefit in the Schedule, in case the Insured Person is First Diagnosed as suffering from any of the Critical Illnesses or required to undergo covered Surgical Procedures as specified in the Schedule, Critical Illness Benefit covers the following conditions/ surgeries as below:

Sr no.	Conditions	22 CIs	37 CIs	57 CIs
1.	Cancer of specified severity	✓	✓	✓
2.	Myocardial Infarction (First Heart Attack of specified severity)	✓	✓	✓
3.	Open Chest CABG	✓	✓	✓
4.	Open Heart Replacement or Repair of Heart Valves	✓	✓	✓
5.	Coma of specified severity	✓	✓	✓
6.	Kidney failure requiring regular dialysis	✓	✓	✓
7.	Stroke resulting in permanent symptoms	✓	✓	✓
8.	Major Organ/Bone Marrow Transplantation	✓	✓	✓
9.	Permanent Paralysis of Limbs	✓	✓	✓
10.	Motor Neuron Disease with permanent symptoms	✓	✓	✓
11.	Multiple Sclerosis with persisting symptoms	✓	✓	✓
12.	Angioplasty	✓	✓	✓
13.	Benign Brain Tumor	✓	✓	✓
14.	Blindness	✓	✓	✓
15.	Deafness	✓	✓	✓
16.	End Stage Lung Failure	✓	✓	✓
17.	End Stage Liver Failure	✓	✓	✓
18.	Loss of Speech	✓	✓	✓
19.	Loss of Limbs	✓	✓	✓
20.	Major Head Trauma	✓	✓	✓
21.	Primary (Idiopathic) Pulmonary Hypertension	✓	✓	✓
22.	Third Degree Burns	✓	✓	✓
23.	Alzheimer's Disease		✓	✓
24.	Surgery of Aorta		✓	✓
25.	Parkinson’s Disease		✓	✓
26.	Medullary Cystic Disease		✓	✓
27.	Muscular Dystrophy		✓	✓
28.	Infective Endocarditis		✓	✓
29.	Dissecting Aortic Aneurysm		✓	✓
30.	Systemic Lupus Erythematous with Lupus Nephritis		✓	✓
31.	Apallic Syndrome		✓	✓
32.	Aplastic Anemia		✓	✓
33.	Bacterial Meningitis		✓	✓
34.	Cardiomyopathy		✓	✓
35.	Other serious coronary artery disease		✓	✓
36.	Creutzfeldt-Jakob Disease (CJD)		✓	✓
37.	Encephalitis		✓	✓
38.	Fulminant Hepatitis			✓
39.	Eisenmenger's Syndrome			✓
40.	Chronic Adrenal Insufficiency (Addison's Disease)			✓
41.	Progressive Scleroderma			✓
42.	Progressive Supranuclear Palsy			✓
43.	Chronic Relapsing Pancreatitis			✓
44.	Elephantiasis			✓
45.	Brain Surgery			✓
46.	HIV due to blood transfusion and occupationally acquired HIV			✓
47.	Terminal Illness			✓
48.	Myelofibrosis			✓
49.	Pheochromocytoma			✓
50.	Crohn's Disease			✓
51.	Severe Rheumatoid Arthritis			✓
52.	Severe Ulcerative Colitis			✓
53.	Pneumonectomy			✓
54.	Multiple System Atrophy			✓
55.	Ebola			✓
56.	Hemiplegia			✓
57.	Loss of Independent Existence			✓

For this add on benefit:

a. The Critical Illness or covered Surgical Procedure has been First Diagnosed/contracted or required for the Insured Person for the first time in his/her life during the Coverage Period;

The Critical Illness contracted has not been diagnosed within the applicable Waiting Period specified in the Schedule against this Add-on Benefit (or against any Critical Illness), from the date of inception of first Policy with Us;

The Insured Person survives the applicable number of days of 'Survival Period' as specified in the Schedule following the First Diagnosis of the Critical Illness or undergoing the Surgical Procedure for the first time, whichever is earlier;

The Critical Illness or the Surgical Procedure claim is not a consequence of or arising out of any Pre-Existing Disease or condition;

Once a claim has been paid under Critical Illness and / or Surgical Procedure, cover under this Add-on Benefit shall cease and no further payment will be made for any consequent disease or any dependent disease;

First Diagnosis of the Critical Illness should have occurred during the Insured Person's life-time, i.e., no payment under any Benefit shall be made if such First Diagnosis of the Critical Illness is made post-mortem.

As an illustration, in case an Insured Person is diagnosed with a Critical Illness during the Waiting Period, he/she will not get paid if it is a Critical Illness as set out in the Policy, because the First Diagnosis of the Critical Illness has occurred within the opted number of days. However, if an Insured Person is diagnosed with heart blockage during the Waiting Period but undergoes the specified Surgical Procedure of "Coronary Artery Bypass Graft" after the completion of the Waiting Period, the claim under this Add-on Benefit will be paid for Coronary Artery Bypass Graft as the Surgical Procedure was carried out after the completion of the Waiting Period.

5.8 Accidental Death or Disability Cover

If this Add-on Benefit is in force, in case an Insured Person suffers an Injury due to an Accident that occurs during the Coverage Period and that Injury solely and directly results in the Insured Person's Death or Disability which is of the nature specified in the table below, within 365 days from the date of the Accident, We will pay the percentage specified in the table below of the Sum Insured specified against the Add-on Benefit in the 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%

Insured Event	Percentage of the Sum Insured payable
10. Total and irrecoverable loss of sight in one eye	50%
11. Loss of one hand or one foot	50%
12. Loss of all toes - any one foot	10%
13. Loss of toe great - any one foot	5%
14. Loss of toes other than great, if more than one toe lost, each	2%
15. Total and irrecoverable loss of hearing in both ears	50%
16. Total and irrecoverable loss of hearing in one ear	15%
17. Total and irrecoverable loss of speech	50%
18. Loss of four fingers and thumb of one hand	40%
19. Loss of four fingers	35%
20. Loss of thumb- both phalanges	25%
21. Loss of thumb- one phalanx	10%
22. Loss of index finger-three phalanges	10%
23. Loss of index finger-two phalanges	8%
24. Loss of index finger-one phalanx	4%
25. Loss of middle/ring/little finger-three phalanges	6%
26. Loss of middle/ring/little finger-two phalanges	4%
27. Loss of middle/ring/little finger-one phalanx	2%

For the purpose of this Add-on Benefit:

a. **Limb** means a hand at or above the wrist or a foot above the ankle;

Physical separation of one hand or **foot** means separation at or above wrist and/or at or above ankle, respectively.

This Add-on Benefit will be payable provided that:

a. The Disability, of the nature specified in the foregoing table, continues for a period of at least 180 days from the commencement of the Disability, and the Disability Certificate issued by the treating Medical Practitioner at the expiry of the 180 days confirms that there is no reasonable medical hope of improvement. It is clarified that this condition is not application for any Disability in the nature of a physical separation;

If the Insured Person suffers a loss that is not of the nature of a Disability specified in the table above, then Our independent medical advisors will determine the degree and percentage of such disability;

If a claim is accepted under this Add-on Benefit in respect of an Insured Person, and the amount due under this Add-on Benefit and claims already admitted under the Policy in respect of the Insured Person will cumulatively exceed the Sum Insured specified against this Add-on Benefit under the Schedule, then Our maximum, total and cumulative liability under any and all such claims in a Policy Year will be limited to the Sum Insured under this Add-on Benefit.

Once the total claim paid under this Add-on Benefit reaches 100% of Sum Insured for an Insured Person, the cover under this Add-on Benefit will cease for the remainder of the Coverage Period and the Insured Person will not be eligible for this Add-on Benefit in subsequent Policy Years.

5.9 Permanent Total Disability Cover

If this Add-on Benefit is in force, in case an Insured Person suffers an Injury due to an Accident that occurs during the Coverage Period and that Injury solely and directly results in the Permanent Total Disability of the Insured Person which is of the nature specified in the table below, within 365 days from the date of the Accident, We will pay the Sum Insured specified against this Add-on Benefit in the Schedule:

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

For the purpose of this Add-on Benefit:

a. Limb means a hand at or above the wrist or a foot above the ankle;

Physical separation of one hand or foot means separation at or above wrist and/or at or above ankle, respectively.

This Add-on Benefit will be payable provided that:

a. The Permanent Total Disability continues for a period of at least 180 days from the commencement of the Permanent Total Disability, and the Disability Certificate issued by the treating Medical Practitioner at the expiry of the 180 days confirms that there is no reasonable medical hope of improvement. It is clarified that this condition is not application for any Disability in the nature of a physical separation;

b. If the Insured Person suffers Injuries resulting in more than one of the Permanent Total Disabilities specified in the table above, then Our maximum, total and cumulative liability under this Add-on Benefit shall be limited to the Sum Insured specified against this Add-on Benefit in the Schedule.

c. On the acceptance of a claim under this Add-on Benefit, all cover under this Policy shall immediately and automatically cease in respect of that Insured Person.

5.10 Value Added Services

If this Add-on Benefit is in force, some or all of the below mentioned Value Added Services may be available to the Insured Person, if specified in the 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.

The cost of utilizing the below services will be borne by You or the Insured Person unless specifically covered under any of the Basic Benefits or Add-on Benefits of the Policy. Our role is to facilitate the below services for Your/Insured Person's ease of use, and We will not assume any liability for the services or advice provided by Our Empanelled Service Providers under this Add-on Benefit. All the below services will be provided upon Your/Insured Person's request through Our Empanelled Service Providers.

Sr No.	Name of Service	Description
1	e-Consultation	We will facilitate a digital appointment with a qualified Medical Practitioner who can help Insured Person by providing round-the-

Sr No.	Name of Service	Description
		clock medical helpline services through an online portal as a chat service, a call back service or a voice call service.
2	Wellness Coach	In order to educate, empower and engage the Insured Person to become more aware of the Insured Person's health and proactively manage it, We will, through periodic communications like e-mailers, blogs and online platform provide the Insured Person information on wellness coaching in areas such as: ○ Weight management ○ Activity and fitness ○ Nutrition ○ Tobacco cessation ○ Alcohol abuse de-addiction program ○ Information on various diseases ○ Dietary plans
3	Lab Services (Home Collection)	We will facilitate collection of test samples such as blood, urine, stool etc from the Insured Person's home address for further testing and analysis. 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 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,

Sr No.	Name of Service	Description
		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: ○ Home Care Nursing ○ Patient Assistant ○ Physiotherapy ○ Yoga Trainer ○ Psychologist ○ Palliative Care ○ 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.

Terms and Conditions applicable to Wellness Program:

a. Any Information provided by the Insured Person shall be kept confidential by Us and Our Network Providers/Empanelled Service Provider.

b. For services which are provided through Our Network Providers/Empanelled Service Provider/, We act solely as a facilitator, and We would not be liable for any incidental, consequential or incremental costs of the services incurred by the Insured Person, of any nature.

c. Any advice or recommendations provided under this Add-on Benefit should not be construed to constitute medical advice and/or substitute the Insured Person's visit/ consultation to an independent Medical Practitioner.

d. We shall not be liable for any discrepancy in the information provided under this Add-on Benefit.

e. All medical services are being provided by Network Providers/Empanelled Service Provider who are empanelled after proper due diligence. The Insured Person is free to consult their personal/ family doctor/Medical Practitioner before availing the medical services. The decisions to utilise the services will solely be at the discretion of the Insured Person.

f. Availing the services under this Add-on Benefit is purely upon the customer's own discretion and at own risk. We shall have no liability and shall not be deemed to have any liability if the Insured Person fails to follow the advice of his or her Medical Practitioner or avails any of these services against the advice of his or her Medical Practitioner.

g. We do not assume any liability and shall not be deemed to assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by any Medical Practitioner or the Network Providers/Empanelled Service Provider.

6 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.

Standard Exclusions

6.1 Pre-Existing Diseases-Code-Excl01

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of number of months, as specified in the Schedule, of continuous coverage after the date of inception of the first policy with insurer.

b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

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

6.2 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 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 Gastro Intestinal 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.

6.3 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.

6.4 Excluded Medical Expenses

We shall not be liable to pay the expenses towards Non-Medical Expenses as listed in Section 11.1 (Annexure I) for any claim under Basic Benefit 3.1 (In-patient Hospitalization), Basic Benefit 3.2 (Day Care Treatment) or Basic Benefit 3.6 (Domiciliary Treatment Cover).

6.5 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 and Critical illness 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 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.
6. **Unproven and Experimental Treatment**:
    a. **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.
    b. **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 4.1
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 (excluding hairline fractures) and dislocations of the mandible and extremities;
    c. Treatment for Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (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:
    a. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code-Excl12

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 (In-patient Hospitalization) or Basic Benefit 3.2 (Day care Treatment).

6.6 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 and Critical illness Add-on Benefits):

1. **Birth control, Sterility and Infertility**: Code – Excl17: Expenses related to Birth Control, sterility and infertility. This includes:
   a. Any type of contraception, sterilization
   b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
   c. Gestational Surrogacy
   d. Reversal of sterilization
2. **Maternity: Code- Excl18**
   a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
   b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.
3. **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. **Suicide**
5. **Treatment for Cosmetic Purposes:**
   a. **Refractive Error: Code-Excl15** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

   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.

   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.
6. **Medically unnecessary Treatment:**
   a. **Obesity/ Weight Control: Code- Excl06 :** Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

      1) Surgery to be conducted is upon the advice of the Doctor
      2) The surgery/Procedure conducted should be supported by clinical protocols
      3) The member has to be 18 years of age or older and
      4) Body Mass Index (BMI);
         a) greater than or equal to 40 or

b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
   i. Obesity-related cardiomyopathy
   ii. Coronary heart disease
   iii. Severe Sleep Apnoea
   iv. Uncontrolled Type2 Diabetes

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.

7. **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.

8. **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.

9. **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.

10. **Excluded Providers: Code-Excl11:** Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life-threatening situations following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

11. **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.

12. Treatments received in heath 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.**Code-Excl13**

13. 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. **Code-Excl14**

14. **Hormonal Therapies:** Growth hormone therapy and/or any form of hormone replacement therapy (HRT) and/or administration of other hormonal medication.

6.7 Permanent Exclusions for Critical Illness Add-on Benefit

We shall not be liable to make any payment under this Policy towards a covered Critical Illness, directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following

1. Any Illness, sickness or disease other than those specified as Critical Illnesses under this Policy;
2. Any claim with respect to any Critical Illness diagnosed or which manifested prior to Policy Inception Date
3. Any Pre-existing Disease; injury or any complication arising therefrom.
4. Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis, whether or not arising out of conditions listed under 3 above.
5. Any Critical Illness arising out of use, abuse or consequence or influence of any substance, intoxicant, drug, alcohol or hallucinogen;
6. Narcotics used by the Insured Person unless taken as prescribed by a registered Medical Practitioner,
7. Any Critical Illness directly or indirectly caused due to intentional self-injury, suicide or attempted suicide;
8. Any Critical Illness directly or indirectly, caused by or arising from or attributable to a 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), civil war, public defence, rebellion, revolution, insurrection, military or usurped power;
9. Any Critical Illness caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.
10. Working in underground mines, tunnelling or involving electrical installations with high tension supply, or as jockeys or circus personnel;
11. Congenital Anomalies or any complications or conditions arising therefrom including any developmental conditions of the Insured;
12. 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;
13. Participation by 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.
14. Any loss resulting directly or indirectly, contributed or aggravated or prolonged by childbirth or from pregnancy;
15. Any Critical Illness based on certification/diagnosis/treatment from persons not registered as Medical Practitioners, or from a Medical Practitioner who is practicing outside the discipline that he is licensed for, or any diagnosis or treatment that is not scientifically recognized or Unproven/Experimental Treatment, or is not Medically Necessary or any kind of self-medication and its complications;
16. Any treatment/surgery for change of sex, cosmetic or plastic surgery or any elective surgery or cosmetic procedure that improve physical appearance, surgical and non- surgical treatment of obesity, including morbid obesity (unless certified to be life threatening) and weight control

programs, or treatment of an optional nature including complications/illness arising as a consequence thereof;

17. Any Critical Illness 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;

18. In the event of the death of the Insured Person within the stipulated survival period as set out above.

19. Failure to seek or follow Medical Advice.

20. Birth control procedures and hormone replacement therapy.

21. Any loss or treatment arising from or traceable to pregnancy (including voluntary termination), miscarriage (unless due to an accident), childbirth, maternity (including Caesarean section), abortion or complications of any of these. This exclusion will not apply to ectopic pregnancy.

6.8 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
17. sea diving using hard helmet and breathing apparatus, polo, snow and ice sports in so far as they involve the training for or participation in competitions or professional sports, or involving a naval, military or air force operation and is specifically specified in the Policy Schedule.
18. Working in underground mines, tunnelling or explosives, or involving electrical installation with high tension supply, or as jockeys or circus personnel, or engaged in Hazardous Activities.
19. Death or disablement arising from or caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.
20. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
21. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) microorganisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.
22. Any physical, medical condition or treatment or service that is specifically excluded in the Policy.

7 General Conditions Applicable to Benefits

1. **Schedule**: The Schedule specifies which Benefits are in force for the Insured Person(s) under the Policy together with the cover conditions applicable to the Benefits.
2. **Limitations on the Benefits covered**: Claims made in respect of an Insured Person for any of the Benefits applicable to the Insured Person shall be subject to the availability of the applicable Sum Insured as well as applicable Sub-limits/ Co-Payment /Deductibles/other conditions specified for the Benefits, applicable Waiting Periods (if any), as specified in the Schedule and the terms, conditions and exclusions of this Policy.

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

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

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

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

   a. The claim amount payable will always be subject to availability of Sum Insured for the particular Benefit, as specified in the Schedule. Where the Coverage Period is for a period of more than one year, the Sum Insured will be applicable for each Policy Year, unless specified otherwise in the Schedule.

   b. The type of Sum Insured available for the Basic Benefit, are as follows:

      i. Base Sum Insured

      ii. Inflation Protect Sum Insured

      iii. Restore Sum Insured

      iv. No Claim Bonus (NCB) Sum Insured (if opted for)

   c. Our total, cumulative and maximum liability for a Basic Benefit in a Policy Year is the sum of the Base Sum Insured, Inflation Protect Sum Insured, Restore Sum Insured, and NCB Sum Insured (if opted).

   d. Our total, cumulative and maximum liability for Any One Illness in a Policy Year is the sum of Base Sum Insured and Inflation Protect Sum Insured.

   e. Each Add-on Benefit has its own Sum Insured which is in addition to the Sum Insured applicable to the Basic Benefit.

   f. Any Sum Insured which is not availed in any particular Policy Year, shall not be carried forward to any subsequent Policy Year, unless explicitly specified in the Schedule/Certificate of Insurance.

5. **Consequential losses not covered**: We do not assume any liability and shall not be deemed to assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations made by the Network Provider / Empanelled Service Providers in relation to the services availed under this Policy.

6. **Reasonable and Customary**: We will indemnify only those costs and expenses whether medical or non-medical related, that are Reasonable and Customary Charges.

7. **Claim Process**: All claims must be made in accordance with the procedure set out in Section 7.

8 Terms and conditions

8.1 Duty of Disclosure

In the event of untrue or incorrect statements, misrepresentation, mis-description or non- disclosure of any material particulars/ in the proposal form, personal statements, declarations, medical history and connected documents, or any material information having been withheld by You / Insured Person or

any one acting on Your behalf, under this Policy, We may at Our sole discretion can take consent from You or the Insured Person and permanently exclude the Pre-Existing Disease or can incorporate additional Waiting Period or levying extra premium or loading based on the objective criteria laid down by Us and continue with the Policy or We may cancel the Policy as per Our internal underwriting guidelines.

8.2 Observance of Terms and Conditions

The due observance and fulfilment of the terms and conditions of the Policy (including the realisation of premium by their respective due dates and compliance with the specified procedure on all claims) in so far as they relate to anything to be done or complied with by You or any of the Insured Persons, shall be the Condition Precedent to Our liability under this Policy.

8.3 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.

8.4 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.

8.5 Material Change

It is Condition Precedent to Our liability under the Policy that You shall at Your own expense immediately notify Us in writing of any material change in the risk on account of change in nature of occupation or business of any Insured Person. We may, in Our discretion, adjust the scope of cover and / or the premium paid or payable, accordingly.

8.6 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), State of Gujarat

Zone B: Rest of India

Zone opted by You is mentioned in Your Schedule.

8.7 Dispute Resolution & Applicable Law

Any and all disputes or differences under or in relation to this Policy shall be determined by the Indian Courts and subject to Indian law.

8.8 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.

8.9 Free Look period

A period of 15 days (30 days if the Policy is sold through distance marketing) from the date of receipt of the Policy document is available to You to review the terms and conditions of this Policy irrespective of the Policy tenure and to return if the same is not acceptable. You have the option of cancelling the Policy stating the reasons for cancellation. In such an event, if there are no claims reported (paid/outstanding) under the Policy, then We shall refund the premium after deducting the risk premium on pro rata basis, stamp-duty charges and after retaining percentage of costs for any medical tests as specified in the Schedule if conducted. All rights under this Policy shall immediately stand extinguished on the free look cancellation of the Policy.

Free look period shall not be available on Renewal of this Policy.

8.10 Parties to the Policy

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

8.11 Currency

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

8.12 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.

8.13 Changes to the terms and conditions of the Policy

We can end the Policy or change any of the terms and conditions relating to the Policy subject to IRDAI approval. If the Policy is revised in accordance with any change in applicable law, We will inform You in writing. In all circumstances, We will give the following notice:

a. For changes to the list of Benefits, at least 90 days' notice in writing if allowed as per IRDAI;

For changes to the Policy terms and conditions, or discontinuance of the Policy, at least 90 days' notice in writing. The change will take place, failing which, the Policy will end on the next Annual Renewal Date.

8.14 Nominee

You can, on the Risk Commencement Date or at any time before the expiry of the Policy nominate any person(s) within the allowed relationships for the purpose of payment of claims, in accordance with applicable law.

Any change of nomination shall be communicated to Us in writing and such change shall be effective only when an endorsement to the Policy is made by Us.

In case of death of any Dependent of an Insured Person where such Dependent is covered under this Policy, for the purpose of payment of claims, the Nominee would be treated as the Insured Person.

8.15 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.

8.16 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.

8.17 Multiple Policies

a. In case of multiple policies covering the Insured Person, which provides fixed benefits on occurrence of the insured event in accordance with the terms and conditions of the Policy, We shall make the claim payments independent of payments received under similar policies.

b. If two or more policies cover the Insured Person during a period from one or more insurers to indemnify treatment costs, You/Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her policies.

- In all such cases where We have issued the chosen policy, We 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.
- Claims under any other policy/ies may be made after exhaustion of the sum insured in the policy / policies chosen earlier for indemnification.
- If the amount to be claimed exceeds the Sum Insured under a single policy after considering the Deductibles or Co-pay, You/Insured Person shall have the right to choose the insurers from whom he/she wants to claim the balance amount.
- Where an Insured Person has policies from more than one insurer to cover the same risk on indemnity basis, the Insured Person shall only be indemnified the such costs in accordance with the terms and conditions of the chosen policy.

8.18 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.

8.19 Records to be maintained

You or the Insured Person, as the case may be, shall keep an accurate record containing all relevant medical records and shall allow Us or Our representative(s) to inspect such records. You or the Insured Person, as the case may be, shall furnish such information as may be required by Us under this Policy at any time during the Policy Year and up to three years after the Policy expiration, or until final adjustment (if any) and resolution of all claims under this Policy.

8.20 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.

Revival Period

Where premium is payable on an instalment basis, the instalment should be paid to Us during the revival period of 15 days from the date of the instalment due date. Wherever premiums are not received within the revival period, the Policy will be terminated and all claims that fall beyond such instalment due date shall not be covered as part of the Policy. However, We will be liable to pay in respect of all claims where the treatment/admission/Accident has commenced/ occurred prior to the date of termination of such Policy, if notified to Us in accordance with the applicable claim notification requirements under the Policy.

Change in Sum Insured

The Sum Insured can be enhanced only at the time of Renewal subject to the underwriting norms and acceptability criteria of the Policy. If Insured Person increases the Sum Insured, the case may be subject to medicals, in case of increase in the Sum Insured, the Waiting Periods will apply afresh in relation to the amount by which the Sum Insured has been enhanced. The quantum of increase shall be at our discretion and subject to our underwriting guidelines.

Additional premium if any, shall be charged as per term and conditions of the Policy.

8.21 Cancellation of the Policy by You

Request for cancellation of the Policy shall be intimated to Us by You by giving 15 days' written notice, in which case We shall refund the percentage of premium for the unexpired Policy Period/ Coverage Period if no claim has been made under the Policy as per the short period scale mentioned below, after deducting Our expenses.

Premium shall be refunded as per the short period scale provided below. The short period scale below is applicable only for single premium Policy.

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.

8.22 Our Right of Termination

8.22.1 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.

8.22.2 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;

8.23 Dishonest & Fraudulent Claims

If any claim is in any manner dishonest or fraudulent, or is supported by any dishonest or fraudulent means or devices, whether by You or any Insured Person or anyone acting on behalf of You or an Insured Person, then this Schedule will be void and all Benefits otherwise payable under it will be forfeited.

8.24 Portability

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 45 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.

8.25 Underwriting Loadings & Discounts

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.

8.26 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..

8.27 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.

8.28 Communications & Notices

Any communication or notice or instruction under this Policy shall be in writing and will be sent to:

a. 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.

8.29 Complete Discharge

We will not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy. The payment made by Us to You/ the Insured Person(s) or to their Nominee/legal representative/legal heirs or to the Hospital, as the case may be, of any Medical Expenses, compensation, or Benefit under the Policy shall in all cases be complete, valid and construed as an effectual discharge of Our duties and obligations under the Policy.

9 Claims Procedure

Processing of claims for Cashless Facility and/or for reimbursement and providing access to the Network Provider will be through Our TPA. Details of the TPA will be available on the health card issued by Us to the Insured Persons and on Our website.

A TPA will be used for accessing Network Providers and for facilitating claim processing.

The updated applicable list of Network Providers will also be available on the TPA's website. Details of applicable Network Providers may also be obtained from the TPA's call centre. In advance of availing Cashless Facility from a Network Provider, the updated list may be checked to ensure that the Network Provider can provide Cashless Facility in respect of the Treatment or facilities required by the Insured Person.

We, in Our sole discretion, reserve the right to modify, add or restrict any Network Provider for providing Cashless facilities under the Policy. Before availing a Cashless facility, the Policyholder / Insured Person is required to check the applicable/latest list of Network Providers on the TPA's or Our website or by calling the TPA's or Our call centre.

9.1 Condition Precedent

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

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

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

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

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

a. Forthwith intimate, file and submit the claim form and documents as prescribed in accordance with the procedure set out below.

If so, requested by Us, the Insured Person must submit himself / herself for a medical examination by Our nominated Medical Practitioner as often as deemed reasonable and necessary. The cost of such examination will be borne by Us.

Allow the Medical Practitioner or any of Our representatives to inspect the medical and Hospitalization records, investigate the facts and examine the Insured Person.

Assist and not hinder or prevent Our representatives in pursuance of their duties for ascertaining the admissibility of the claim, its circumstances and its quantum under the provisions of the Policy.

9.3 Claim Intimation

Upon the discovery or occurrence of an Illness /Injury or any other contingency that may give rise to a claim under this Policy, then as a Condition Precedent to Our liability under the Policy, the Insured Person or the Nominee as the case may be must notify Us / Our TPA either at the call centre or in writing and shall undertake the following.

a. In the case of Planned Hospitalization - The Insured Person will intimate such admission at least 3 days prior to the planned Date of Admission.

In the case of Emergency Hospitalization - The Insured Person will intimate such admission within 48 hours of such admission but not later than discharge from the Hospital.

Following details are to be provided to TPA/Us at the time of intimation of claim:

a. Policy Number
b. Name of the Policyholder
c. Name of the Insured Person in whose relation the claim is being lodged
d. Nature of Illness / Injury / Critical Illness
e. Name and address of the attending Medical Practitioner and Hospital
f. Date of Admission
g. Any other information that may be reasonably required by Us

If any claim is not notified/ made within the timelines set out above then we will condone such delay on merits only where the delay has been proved to be for reasons behind the claimant's control.

9.4 Cashless Process

Cashless facility for Hospitalization expenses shall be limited exclusively to Medical Expenses incurred for Treatment undertaken in a Network Provider/Empanelled Service Providers.

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

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).

(i) For Planned Hospitalization:

a. The Insured Person 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. 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.

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. 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.

The authorisation letter will include details of sanctioned amount, diagnosis, and date of approval.

The authorisation letter shall be valid only for a period of 15 days from the date of issuance of authorisation.

(ii) In case of Emergency Hospitalization

a. The Insured Person may approach the Network Provider for Hospitalization for medical Treatment.

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 9.4 (i) (c) above.

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 finalised.

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.

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 authorised limit as mentioned in the authorisation letter:

a. 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 authorised 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-authorised 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 Section 9.4 (i) above.

Discharge Process:

At the time of discharge:

a. 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 Section 9.4 (i) above.

b. Upon receipt of the final authorisation letter from Us, the Insured Person may be discharged by the Network Provider.

Note: (Applicable to Section 9.4 (i) and Section 9.4 (ii): 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:

i. Original pre-authorisation request

ii. Copy of pre-authorisation approval letter (s)

iii. Documents listed under Section 9.5 (Reimbursement Claim Process).

We may call for any additional documents as required based on the circumstances of the claim.

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 9.5, which will be considered subject to the Policy terms and conditions.

9.5 Claim Reimbursement Process

Wherever the Insured Person has opted for a reimbursement of Medical Expenses, he/she may submit the following documents for reimbursement of the claim to Our branch or head office at his/her own expense not later than 15 days from the date of discharge from the Hospital. The Insured Person 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 dully 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 dully 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 dully 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

Critical Illness Benefit:

- Critical Illness Insurance claim form duly signed by the insured
- Photocopy of the discharge summary/discharge certificate
- Photocopy of the final hospital bill
- First consultation paper from doctor stating the origin duration and progress of illness
- A copy of all the required investigation reports as per the illness
- 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 Panchanama
- Attested copy of the post-mortem report
- Attested copy of the viscera report (Only if it is preserved and sent for further analysis that is mentioned on the post-mortem report)
- Attested copy of the disability certificate from a civil surgeon of a government hospital stating percentage and type of disability
- All X-ray/investigation reports and films supporting the disability
- Photograph of the patient before and after the accident to support the disability
- 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.

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 in 3.5.(a) above, then in addition to the documents mentioned in 3.5.(a) 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.

9.6 Scrutiny of Claim Documents

a. We shall scrutinise the claim form and the accompanying documents. Any deficiency in the documents shall be intimated to the Insured Person / Network Provider as the case may be.

b. 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.

c. We will send a maximum of 3 (three) reminders.

d. 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.

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

f. The Pre and Post-Hospitalization Medical Expenses Cover claim per Basic Benefit 3.3 (Pre and Post-Hospitalization Medical Expenses) 3.3 shall be processed only after the Hospitalization claim has been admitted under Basic Benefit 3.1 (In-patient Hospitalization).

9.7 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 –

a. 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.

9.8 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 last necessary document. In such cases, We shall settle or reject the claim, as may be the case, within 30 days from the date of receipt of last necessary document.

9.9 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 Post-Hospitalization period of cover.

We shall receive Pre and Post- Hospitalization Medical Expenses Cover claim documents either along with papers for Basic Benefit 3.1 (In-patient Hospitalization)or separately and process the same based on merit of the claim derived on the basis of the documents received.

9.10 Settlement and Repudiation of a claim

We shall settle the claim within 30 days from the date of receipt of last necessary document in accordance with the provisions of the IRDAI (Health Insurance) Regulations, 2016, as amended from time to time.

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

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

9.11 Representation against Rejection

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

9.12 Claim Payment Terms

a. 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.

b. All claims will be payable in India and in Indian rupees.

c. 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.

d. 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.

10 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

#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.

11 Annexure

11.1 Annexure I: 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
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
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