Policy Wordings

Acko Group Total Protect

Section 1. Preamble

This Policy is a contract of insurance between You and Us which is subject to the receipt of premium in full in respect of the Insured Persons and the terms, conditions and exclusions of this Policy.

This Policy is valid for the period as specified in the Schedule or the Certificate of Insurance.

The terms listed in Section 2 (Definitions) and which have been used elsewhere in the Policy in Initial Capital letters shall have the meaning set out against them in Section 2, wherever they appear in the Policy.

Section 2. Definitions

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

2.1 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. **AYUSH Day Care** Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:
    a. Having qualified registered AYUSH Medical Practitioner(s) in charge;
    b. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
    c. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
4. **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
    a. Central or State Government AYUSH Hospital; or
    b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
    c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
        i. Having at least 5 in-patient beds;
        ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
        iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
        iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
5. **AYUSH Treatment:** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
6. **Cashless facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions,

are directly made to the Network Provider by the insurer to the extent pre-authorization is approved.

7. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
8. **Congenital Anomaly** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
    a. **Internal Congenital Anomaly-** Congenital anomaly which is not in the visible and accessible parts of the body.
    b. **External Congenital Anomaly-** Congenital anomaly which is in the visible and accessible parts of the body
9. **Co-Payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured**.**
10. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium
11. **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under –
    a. Has qualified nursing staff under its employment;
    b. Has qualified medical practitioner/s in charge;
    c. Has fully equipped operation theatre of its own where surgical procedures are carried out;
    d. Maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
12. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:
    a. Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
    b. Which would have otherwise required hospitalization of more than 24 hours.

    Treatment normally taken on an out-patient basis is not included in the scope of this definition.
13. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.
14. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and Surgery.
15. **Disclosure to information norm** means that 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.
16. **Domiciliary Hospitalization** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
    a. The condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
    b. The patient takes treatment at home on account of non-availability of room in a hospital.
17. **Emergency Care** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a medical practitioner to prevent death or serious long-term impairment of the insured person's health.
18. **Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received.

    The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.
19. **Hospital** means any institution established for in-patient care and day care treatment of illness

and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said act Or complies with all minimum criteria as under:

i) Has qualified nursing staff under its employment round the clock;

ii) Has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

iii) Has qualified medical practitioner(s) in charge round the clock;

iv) Has a fully equipped operation theatre of its own where surgical procedures are carried out;

v) Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

20. **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**.**

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

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

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

i. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests

ii. It needs ongoing or long-term control or relief of symptoms

iii. It requires rehabilitation for the patient or for the patient to be specially trained to cope with it

iv. It continues indefinitely

v. It recurs or is likely to recur

22. **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.

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

24. **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.

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

26. **Maternity expenses** means –

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);

b. Expenses towards lawful medical termination of pregnancy during the policy period.

27. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription**.**

28. **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.

29. **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.

30. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
    i. Is required for the medical management of the illness or injury suffered by the insured;
    ii. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    iii. Must have been prescribed by a medical practitioner;
    iv. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
31. **Migration** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer**.**
32. **Network Provider** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.
33. **New Born Baby** means baby born during the Policy Period and is aged upto 90 days**.**
34. **Non-Network** provider means any hospital, day care centre or other provider that is not part of the network.
35. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
36. **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.
37. **Pre-Existing Disease** means any condition, ailment, injury or disease:
    i. That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or
    ii. For which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.
38. **Pre-hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days preceding the Hospitalization of the Insured Person, provided that:
    i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
39. **Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer .
40. **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:
    i. Such Medical Expenses are for the same condition for which the insured person's Hospitalization was required, and
    ii. The inpatient hospitalization claim for such Hospitalization is admissible by the insurance company.
41. **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.
42. **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.
43. **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.
44. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and

shall include the associated medical expenses**.**

45. **Specific Waiting Period:** means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.
46. **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.
47. **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.

2.2 Specific Definitions

1. **Age or Aged** means the age as on last birthday.
2. **Ambulance** means a road vehicle operated by a licensed/authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.
3. **Annexure** means a document attached and marked as Annexure to this Policy.
4. **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.
5. **Bank** means a bank or any financial institution
6. **Base Sum Insured** referred herein means the Sum Insured for the Base Cover as specified in the Policy Schedule or/and Certificate of Insurance.
7. **Benefit** means any Benefit shown in the Policy Schedule / Certificate of Insurance.
8. **Carpet Area** means
   a. for the main building unit of Your Home, it is the net usable floor area, excluding the area covered by the external walls, areas under services shafts, exclusive balcony or verandah area and exclusive open terrace area, but including the area covered by the internal partition walls of the residential unit;
   b. for any enclosed structure on the same site, it is the net usable floor area of such structure; and
   c. For the main building unit of Your Home, it is the net usable floor area, excluding the area covered by/ the external walls, areas under services shafts, exclusive balcony or verandah area and exclusive open terrace area, but including the area covered by the internal partition walls of the residential unit; for any enclosed structure on the same site, it is the net usable floor area of such structure; and for any balcony, verandah area, terrace area, parking area, or any enclosed structure that is part of Your Home, it is 25% of its net usable floor area.
9. **Certificate of Insurance** means the certificate We issue to the Insured Person confirming the Insured Person's cover under the Policy.
10. **Commencement Date** means Commencement Date means the start date of the Policy as specified in the Schedule.
11. **Common Death or Disability Sum Insured** means the amount specified in the Certificate of Insurance cumulatively against
    - Benefit 3.2.1.1 (Accidental Death Benefit),
    - Benefit 3.2.1.2 (Permanent and Total Disability),
    - Benefit 3.2.1.3 (Permanent Partial Disability) and
    - Benefit 3.2.1.4 (Temporary Total Disability)

    that represents Our maximum, total and cumulative liability for any and all claims made in respect of that Insured Person under such Benefits during the Coverage Period.
12. **Cost of Construction** means the amount required to construct Your Home Building at the Commencement Date. This amount is calculated as follows:

    a. **For residential structure of Your Home including Fittings and Fixtures:**Carpet Area of the structure in square metres X Rate of Cost of Construction at the Commencement Date. The Rate

of Cost of Construction is the prevailing rate of cost of construction of Your Home Building at the Commencement Date as declared by You and accepted by Us and shown in the Policy schedule.

b. **For additional structures:** the amount that is based on the prevailing rate of Cost of Construction at the Commencement Date as declared by You and accepted by Us.

13. **Covered In-patient Medical Expenses** shall include Room Rent, ICU/CCU/HDU charges, nursing charges, operation theatre charges, Surgical Appliances or Medical Appliances 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 Policy Schedule / Certificate of Insurance which commences on the Risk Commencement Date specified in the Policy Schedule / Certificate of Insurance and ends on the coverage expiry date specified in the Policy Schedule / Certificate of Insurance.
15. **Critical Illness** Critical Illness means any Illness, medical event or Surgical Procedure as specifically defined in Annexure I of this Policy.
16. **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.
17. **Defence Costs** Defence Costs are reasonable costs necessarily incurred in defending the Insured Person against any civil proceeding initiated against him/her during the Travel Period.
18. **Dentist** means a dentist, dental surgeon or dental practitioner who is registered or licensed as such under the laws of the country, state or other regulated area in which the Treatment is provided.
19. **Dependent** means the Employee's / Member's parents, Spouse or child who have been enrolled in the Policy.
20. **Dependent Child** refers to a child (natural or legally adopted), who is under Age 25, either in fulltime education or residing at the same residence as the Employee / Member at the commencement of any Treatment and is financially dependent on the Employee / Member. For the purpose of coverage under this Policy the Age limit for a dependent child shall be 25 years. However, with respect to coverage under specific Sections, separate Age limits may be defined under each Benefit and applicable for the purpose of such Benefit
21. **Eligibility** means the provisions of the Policy that state the requirements to be satisfied with for an person to be enrolled in this Policy as an Insured Person.
22. **Emergency** shall mean a serious medical condition or symptom resulting from Injury or sickness 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.
23. **EMI(s) or EMI Amount(s)** EMI(s) or EMI Amount(s) means and includes the amount of monthly payment required to repay the Principal Outstanding Amount and any applicable interest by the Insured Person, as set forth in the amortization chart referred to in the relevant Loan agreement (or any amendments thereto) between the bank/financial institution and the Insured Person as on the date of any occurrence or event which gives rise to a claim under this Policy.
24. **Employee:** means any member of Your staff who is proposed and/or sponsored by You and who becomes an Insured Person under this Policy.
25. **Endorsement** means A written amendment to the Policy that We make (additions, deletions, modifications, exclusions or conditions of an insurance Policy) which may change the terms or scope of the original policy
26. **Event** means any official sporting occasion, music concert, exhibition, educational / cultural tour, cinema, theatre, theme park or military display, or a visit to any other tourist attraction where admission is only by way of tickets sold in advance.
27. **Exclusions** mean specified coverage, hazards, services, conditions, and the like that are not provided for (covered) under this Policy, or a coverage category or set of Benefits under this Policy.
28. **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.
29. **General Contents** are all the contents of household use in Your Home, e.g., furniture, electronic items and goods, antennae, solar panels, water storage equipment, kitchen equipment, electrical

equipment (including those fitted on walls), clothing and apparel and items of similar nature.

30. **Home Contents** means Those articles or things in Your Home that are not permanently attached or fixed to the structure of Your Home. Home Contents may consist of General Contents and/or Valuable Contents.
31. **Home Nursing** is arranged by the Hospital for a Qualified Nurse to visit the patient's home to give expert nursing services immediately after undergoing Treatment in a Hospital for as long as is required by medical necessity, for Medically Necessary Treatment which would normally be provided in a Hospital. In either case, the Medical Practitioner and Specialist who treated the patient must have recommended these services.
32. **HDU** means 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.
33. **Hazardous Activities** means any sport or activity, which is potentially dangerous to the Insured Person whether he is trained in such sport or activity or not. Such sport/activity includes stunt activities of any kind, adventure racing, base jumping, biathlon, big game hunting, black water rafting, BMX stunt/obstacle riding, bobsleighing/using skeletons, bouldering, boxing, canyoning, cavin/pot holing, cave tubing, rock climbing/trekking/mountaineering, cycle racing, cyclo cross, drag racing, endurance testing, hand gliding, harness racing, hell skiing, high diving (above 5 meters), hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, lugging, risky manual labour, marathon running, martial arts, micro-lighting, modern pentathlon, motor cycle racing, motor rallying, parachuting, paragliding/parapenting, piloting aircraft, polo, power lifting, power boat racing, quad biking, river boarding, scuba diving, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo riding, ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting or wrestling any type and other activities of similar kind.
34. **Immediate Relative** means the Insured Person's spouse, children, siblings, parents or in-laws.
35. **Income:** Income means and includes the amount that the Insured Person earns each month from his/her primary occupation.

    For Salaried Individuals, this would mean salary including regular bonuses, regular commissions, superannuation contributions or any other allowances, any benefits explicitly mentioned in CTC (Cost to Company) or any compensation structure provided to the Insured Person by his/her employer for the financial year, or as declared in the previous ITR (Income Tax Return) filed by the Insured Person.
36. **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.
37. **Insured Person** means the Primary Insured and/or the Dependents of the Primary Insured named in the Policy Schedule / Certificate of Insurance for whom the insurance is proposed and the appropriate premium is paid, and who is covered under this Policy.
38. **Insured Property** means Your Home Building and Home Contents, or any item of property covered by this Policy.
39. **Involuntary Unemployment:** Involuntary Unemployment means a termination, lay off, retrenchment or permanent dismissal of an Insured Person who is a Salaried Individual from his/her primary occupation due to Injury sustained or Illness contracted.. For the purpose of this Policy, Involuntary Unemployment does not include any unemployment caused due to or arising from poor performance, dismissal due to a fraudulent act, non-compliance of any company or organization's internal rules/guidelines, or any disciplinary action.
40. **IRDAI** means the Insurance Regulatory and Development Authority of India.
41. **Kutcha Construction** means Building(s) having walls and/or roofs of wooden planks/thatched leaves and/or grass/hay of any kind/bamboo/plastic cloth/asphalt/canvas/tarpaulin and the like.
42. **Loan:** Loan means the sum of money lent at an interest or otherwise to the Insured Person by any bank/financial institution as identified by the Loan Account Number specified in the Certificate of Insurance or certified in writing and provided to Us by the bank/financial institution.
43. **Loss of Independent Living:** Loss of Independent Living means inability to perform one or more of the following 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.

44. **Money:** Money means cash, bank drafts, current coins, bank and currency notes, treasury notes, cheques, traveller's cheques, postal orders and current postage stamps not forming part of a collection.

45. **Nominee** means the person named in the Policy Schedule / Certificate of Insurance (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.

46. **Operation** means any procedure performed on a living body usually with instruments for the repair of damage or the restoration of health and especially one that involves incision, excision, or suturing.

47. **Out-Patient** means a person who undergoes an OPD treatment or a temporary Hospitalization for a stay of less than 24 hours.

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

49. **Policy Anniversary Date** means the day of the calendar year on which the Coverage Period under the current Policy commenced.

50. **Policy Period** means the period between the Commencement Date and the expiry date of the Policy as specified in the Policy Schedule / Certificate of Insurance or the date of cancellation of this Policy, whichever is earlier.

51. **Policy Year** means a period of 12 consecutive months within the Coverage Period commencing from the Policy Anniversary Date.

52. **Policy Schedule** means the schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the Policy Period, special conditions, and the limits to which Benefits under the Policy are subject to, and as may be amended from time by way of endorsements made to or on it, and where more than one, then the latest in time.

53. **Premium** means the premium is the amount You pay Us for this insurance. The Policy Schedule shows the amount of premium for the Policy Period and all other taxes and levies.

54. **Primary Insured:** Primary Insured means the person named in the Certificate of Insurance who is employed by or is a member of Your organization.

55. **Principal Outstanding Amount:** Principal Outstanding Amount means the principal amount of the Loan outstanding as on the date of any occurrence or event which gives rise to a claim under the Policy, less the portion of principal component included in the EMIs, payable but not paid, from the date of the loan agreement till the date of such occurrence or event.

    For the purpose of avoidance of doubt, it is clarified that any:

    i. EMIs that are overdue and unpaid to the financial institution prior to such occurrence or event,

    ii. Any additional amounts imposed by a financial institution, or otherwise falling due as a penalty or by way of a default in repayment, will not be considered for the purpose of this Policy and shall be payable by the Insured Person.

56. **Private Room** means a single occupancy accommodation in a private Hospital.

57. **Pucca Construction** means Construction other than Kutcha Construction.
58. **Risk Commencement Date**: Risk Commencement Date means the date specified in the Policy Schedule / Certificate of Insurance on which the Coverage Period and Our coverage under the Policy in respect of the Insured Person commences.
59. **Salaried Individuals:** Salaried Individuals means those Insured Persons who work for an employer as an Employee or a worker, whether confirmed or on probation, as on the Risk Commencement Date, and earn a fixed amount of compensation at a fixed frequency as salary. Such fixed amount of compensation should be evidenced by such Salaried Individual's ITR (Income Tax Return) for the preceding year(s).
60. **Spouse** means the Employee's legal husband or wife, who is proposed to be covered under the Policy.
61. **Specialist** 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 for the purpose of physiotherapy as described in the list of Benefits.
62. **Sum Insured** means, subject to the terms, conditions and exclusions of this Policy, the amount specified in the Policy Schedule / Certificate of Insurance against a Benefit, coverage category 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.
63. **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.
64. **Survival Period:** Survival Period means the period that the Insured Person has to survive before a claim becomes valid, commencing from the date of First Diagnosis.
65. **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.
66. **Temporary or Seasonal Job:** Temporary or Seasonal Job means any occupation or job where the employee is expected to remain employed in a position only for a certain period of time.
67. **TPA** means any person who is licensed under the IRDAI (Third Party Administrators – Health Services) Regulation (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.
68. **Total Loss** means A situation where the Insured Property or item is completely destroyed, lost or damaged beyond retrieval or repair or the cost of repairing it is more than the Sum Insured for that item or in total.
69. **Treatment** means any relevant treatment controlled or administered by a Medical Practitioner to cure or substantially relieve an Illness or an Injury.
70. **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.

    (For 4.2. Griha Raksha) Valuable content means Your Home consist of items such as jewellery,

silverware, paintings, works of art, antique items, curios and items of similar nature.

71. **Waiting Period** means a time bound exclusion period related to condition(s) specified in the Policy Schedule / Certificate of Insurance or Policy which shall be served before a claim related to such condition(s) becomes admissible.
72. **Your Home Building** is a building consisting of a residential unit, having an enclosed structure and a roof, basement (if any) and used as a dwelling place (**For 4.2. Griha Raksha**) of this Policy.
73. **We/Our/Ours/Us** means the Acko General Insurance Company Limited.
74. **You/Your/Yours/Yourself/Policyholder** means the person named in the Policy Schedule / Certificate of Insurance who has concluded this Policy with Us

Section 3. Base Benefits

The base benefit can be opted by the insured as Any/ All or Cross Combination of the below:

3.1 In-Patient Hospitalization ("IPD") Indemnity Category

3.2 Personal Accident Category

3.3 Out-patient ("OPD") and Wellness Benefit Category

3.4 Critical Illness Category

The benefits listed below are available to all Insured Persons. The Schedule or the Certificate of Insurance will specify which of the benefits are in force and available for the Insured Persons under the Policy.

Claims made in respect of an Insured Person for the benefits listed below shall be subject to the availability of the Sum Insured specified against such benefit, applicable sub-limits/Deductibles for the benefits claimed and the terms, conditions and exclusions of this Policy.

All claims must be made in accordance with the procedure set out in Section 6 General Terms and Condition (Claims Procedure and Requirements).

3.1 In-Patient Hospitalization ("IPD") Indemnity Category

3.1.1 Benefits

The Section defines the Benefits under this coverage category. The following Benefits shall trigger in the event related to Hospitalization of the Insured Person on an in-patient basis. Claims under this coverage category will be admissible subject to the fulfilment of the following conditions with respect to the Insured Person's Hospitalization:

i. 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 Policy Schedule / Certificate of Insurance.
ii. The Date of Admission is within the Coverage Period.

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

3.1.1.1 In-patient Hospitalization Cover

We will indemnify the following Covered In-patient Medical Expenses of an Insured Person incurred during Hospitalization for the Illness or Injury, as specified in the Policy Schedule / Certificate of Insurance:

i. Room Rent
ii. ICU/CCU/HDU charges,
iii. Operation theatre cost,
iv. Medical Practitioner fees,
v. Specialist fee,
vi. Surgeon's fee,
vii. Anaesthetist fee,
viii. Radiologist fee,

ix. Pathologist fee,
x. Assistant Surgeon fee,
xi. Qualified Nurses fee,
xii. Medication,
xiii. Cost of diagnostic tests as an in-patient such as but not limited to radiology, pathology, X-rays, MRI and CT Scans, physiotherapy and drugs, consumables, blood, oxygen, and
xiv. Surgical Appliances and/or Medical Appliances, required as a direct consequence of the Illness or Injury.
xv. Ayush Treatment

3.1.1.2 Daily Hospital Cash

If an Insured Person requires Hospitalization due to an Illness or Injury, as specified in the Policy Schedule / Certificate of Insurance, suffered or contracted during the Coverage Period, then We will pay the daily allowance amount specified against this Benefit in the Policy Schedule / Certificate of Insurance, for each continuous and completed period of 24 hours of Hospitalisation.

This benefit will be payable provided that:

a. Our liability to make any payment under this benefit shall commence only after a continuous and completed 24 hours of Hospitalization of the Insured Person for each claim.
b. This Benefit shall not be payable in respect of the Insured Person for more than the maximum number of days specified in the Policy Schedule / Certificate of Insurance for each Coverage Period.
c. Only one daily allowance amount is payable for each day of Hospitalization, regardless of number of the Illnesses contracted/Injuries sustained.

3.1.1.3 Day Care Treatment Cover

We will indemnify the Medical Expenses incurred towards the Day Care Treatment or Surgery undertaken that requires less than 24 hours Hospitalization due to advancement in technology and which is undertaken by an Insured Person in a Hospital / Nursing Home / Day Care Centre for the Illness or Injury, as specified in the Policy Schedule / Certificate of Insurance. Any treatment in Out-Patient department is not covered under this Benefit.

3.1.1.4 In-patient Hospitalization Fixed Benefit

We will pay a fixed benefit amount, in the event of a Hospitalization solely and directly due to the Illness or Injury, as specified in the Policy Schedule / Certificate of Insurance.

3.1.1.5 Road Ambulance

We will indemnify the reasonable costs incurred towards transportation of an Insured Person to a Hospital or Day Care Centre by an Ambulance for treatment of the Illness or Injury, as specified in the Policy Schedule / Certificate of Insurance, in case of the Insured Person requiring Emergency Care.

3.1.1.6 EMI Protection

If an Insured Person is unable to pay the EMI Amounts payable under his/her Loan due to an Illness or Injury, as specified in the Policy Schedule / Certificate of Insurance, suffered or contracted during the Coverage Period , then We will pay an amount equal to the EMI Amount which is due on the Insured's outstanding Loan in the number of months immediately following the date of such occurrence, as is specified in the Policy Schedule / Certificate of Insurance, subject to this amount not exceeding the amount specified in the Policy Schedule / Certificate of Insurance.

Amortization Chart means a complete table of periodic loan payments, showing the amount of principal loan amount and the amount of interest that comprise each payment or EMI, as the case may be, until the Loan is paid off at the end of its term.

This Insuring Clause will be payable provided that:

a. Any payments that are overdue and unpaid by the Insured prior to the occurrence of the event giving rise to a claim under this Insuring Clause will not be considered for the purpose of this Policy

and shall be deemed as paid by the Insured.

b. The Benefit will not apply to any voluntary and uninsurable events, which are caused by or with the knowledge of the Insured Person, or which are against public policy, criminal or fraudulent under applicable law.

c. The treatment required by the Insured Person is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

d. For the purpose of claim settlement against any cover under this Policy, the Amortization Chart prepared by the bank/financial institution as on the date of Loan disbursement or commencement of the Coverage Period (whichever is later) shall be considered wherever applicable.

e. Any additional amounts falling due as a penalty or charge by way of a default in repayment will not be considered for the purpose of this Policy and shall be deemed as paid by the Insured.

3.1.1.7 Income Protection Cover

We will pay the daily allowance amount specified against this Benefit in the Policy Schedule / Certificate of Insurance, for each continuous and completed day, on which the Insured Person is unable to do his/her regular employment, business or professional activity due to an Illness or Injury, as specified in the Policy Schedule / Certificate of Insurance, suffered or contracted during the Coverage Period.

This benefit will be payable provided that:

a. Our liability to make any payment under this benefit shall commence only after a continuous and completed minimum number of days of inability of carrying out employment or business or professional activity as specified in the Certificate of Insurance for each claim.

b. Our liability to make any payment under this benefit shall be in excess of the Deductible of the number of days specified in the Certificate of Insurance for each claim.

c. This Benefit shall not be payable in respect of the Insured Person for more than the maximum number of days specified in the Certificate of Insurance for each Coverage Period.

d. We shall not be liable to make any payment under this benefit if the loss is explicitly paid/covered by the employer or any other business partner.

e. The treatment required by the Insured Person is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

3.1.1.8 Repatriation of Mortal Remains

We will reimburse the expenses incurred up to the limit specified in the Policy Schedule / Certificate of Insurance for transportation of mortal remains from the place of death to the residence of the Insured Person, in case of death due to illness or injury, as specified in the Policy Schedule / Certificate of Insurance.

This Benefit will be payable provided that:

a. The death of the Insured Person occurred in a location that is not the city/place of residence of the Insured Person.

b. In case of Death due to illness, we have accepted a claim under the Benefit Section 3.1.1

c. In case of Death due to injury, we have accepted a claim under Benefit Section 3.2.1

3.1.1.9 Funeral Expenses

We will reimburse the expenses incurred up to the limit specified in the Policy Schedule / Certificate of Insurance towards expenses on the funeral, cremation/ or burial and transportation of the body to the place of the funeral ceremony for the Insured Person, in case of death due to illness or injury, as specified in the Policy Schedule / Certificate of Insurance, provided that:

a. In case of Death due to illness, we have accepted a claim under the Benefit Section 3.1.1

b. In case of Death due to injury, we have accepted a claim under Benefit Section 3.2.1

3.1.1.10 Missed Bill Payment

If an Insured Person defaults on payment of a credit card bill or an essential utility bill such as water, electricity or gas, on or before the due date for making such payment due to an Illness or Injury, as specified in the Policy Schedule / Certificate of Insurance, suffered or contracted during the Coverage Period, then We will pay the amount specified in Policy Schedule / Certificate of Insurance towards the penalty levied on the Insured Person for non-payment of such bill amount within the due date.

3.2 Personal Accident Category

3.2.1 Benefits

The Section defines the Benefits under this coverage category. The following Benefits shall trigger in the event of the Insured Person suffering an Injury due to an Accident. Claims under this coverage category will be admissible subject to the fulfilment of the following conditions with respect to the Insured Person's Injury:

i. The date of Accident is within the Coverage Period as specified in the Policy Schedule / Certificate of Insurance
ii. The Hospitalization is certified as Medically Necessary by the treating Medical Practitioner

3.2.1.1 Accidental Death Benefit

If 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 within 365 days from the date of the Accident, We will pay the Sum Insured.

If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this Benefit and claims already admitted under Benefit 3.2.1.1 (Accidental Death Benefit), Benefit 3.2.1.2 (Permanent Total Disability) and Benefit 3.2.1.3 (Permanent Partial Disability) in respect of the Insured Person will cumulatively exceed the Common Death or Disability Sum Insured, then Our maximum, total and cumulative liability under any and all such claims will be limited to the Common Death or Disability Sum Insured.

On the acceptance of a claim under this Benefit and payment being made under any applicable Cover Options, all cover under this Policy shall immediately and automatically cease in respect of that Insured Person.

3.2.1.2 Permanent Total Disability

If 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:

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 Benefit:

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

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

This 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;

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 Benefit shall be limited to the Sum Insured specified against this Benefit in the Policy Schedule / Certificate of Insurance.

c. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this Benefit and claims already admitted under Benefit 3.2.1.1 (Accidental Death Benefit), Benefit 3.2.1.2 (Permanent Total Disability) and Benefit 3.2.1.3 (Permanent Partial Disability) in respect of the Insured Person will cumulatively exceed the Common Death or Disability Sum Insured then Our maximum, total and cumulative liability under any and all such claims will be limited to the Common Death or Disability Sum Insured.

d. If We have admitted a claim for Permanent Total Disability in accordance with this Benefit, then We shall not be liable to make any payment under the Policy on the death of the Insured Person, if the Insured Person subsequently dies;

e. On the acceptance of a claim under this Benefit, all cover under this Policy shall immediately and automatically cease in respect of that Insured Person after the payment of any other applicable Cover Options.

3.2.1.3 Permanent Partial Disability

If 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 Partial 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 amount specified in the table below:

Nature of Permanent Partial Disability	Percentage of the Sum Insured Payable
i. Total and irrecoverable loss of sight in one eye	50%
ii. Loss of one hand or one foot	50%
iii. Loss of all toes - any one foot	10%
iv. Loss of toe great - any one foot	5%
v. Loss of toes other than great, if more than one toe lost, each	2%
vi. Total and irrecoverable loss of hearing in both ears	50%
vii. Total and irrecoverable loss of hearing in one ear	15%
viii. Total and irrecoverable loss of speech	50%
ix. Loss of four fingers and thumb of one hand	40%
x. Loss of four fingers	35%
xi. Loss of thumb- both phalanges	25%
xii. Loss of thumb- one phalanx	10%
xiii. Loss of index finger-three phalanges	10%
xiv. Loss of index finger-two phalanges	8%
xv. Loss of index finger-one phalanx	4%
xvi. Loss of middle/ring/little finger-three phalanges	6%
xvii. Loss of middle/ring/little finger-two phalanges	4%
xviii. Loss of middle/ring/little finger-one phalanx	2%

This Benefit will be payable provided that:

a. The Permanent Partial Disability continues for a period of at least 180 days from the commencement of the Permanent Partial 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;

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

c. We will not make any payment under this Benefit if We have already paid or accepted any claims under the Policy in respect of the Insured Person and the total amount paid or payable under the claims is cumulatively greater than or equal to the Sum Insured for that Insured Person;

d. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this benefit and claims already admitted under Benefit 3.2.1.1 (Accidental Death Benefit), Benefit 3.2.1.2 (Permanent Total Disability) and Benefit 3.2.1.3 (Permanent Partial Disability) in respect of the Insured Person will cumulatively exceed the Common Death or Disability Sum Insured then Our maximum, total and cumulative liability under any and all such claims will be limited to the Common Death or Disability Sum Insured.

e. On the acceptance of a claim under this Benefit, the Insured Person's insurance cover under this Policy shall continue, subject to the availability of the Sum Insured and the Common Death or Disability Sum Insured.

3.2.1.4 Temporary Total Disability

If 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 disability of the Insured Person which prevents the Insured Person from engaging in any employment or occupation on a temporary basis, then We will pay the amount specified in the Policy Schedule / Certificate of Insurance at the frequency specified in the Policy Schedule / Certificate of Insurance for the duration that the Temporary Total Disability continues.

This Benefit will be payable provided that:

a. This Benefit shall be paid only if the Temporary Total Disability continues for a period of at least for the minimum number of days specified in the Policy Schedule / Certificate of Insurance from the date of commencement of Temporary Total Disability.

b. This Benefit shall not be paid in excess of the Insured Person's Income at the time of injury excluding overtime, bonuses, tips, commissions, or any other compensation for the period specified in the Policy Schedule / Certificate of Insurance;

c. Our liability to make any payment under this benefit shall be in excess of the Deductible of the number of days specified in the Certificate of Insurance for each claim.

d. This Benefit shall not be payable in respect of the Insured Person for more than the maximum number of days specified in the Certificate of Insurance for each Coverage Period.

e. We will not make any payment under this Benefit if We have already paid or accepted any claims under this Benefit in respect of the Insured Person and the total amount paid or payable under the claims is cumulatively greater than the Sum Insured specified against this Benefit in the Policy Schedule / Certificate of Insurance.

f. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this Benefit and claims already admitted under Benefit 3.2.1.1 (Accidental Death Benefit), Benefit 3.2.1.2 (Permanent Total Disability), Benefit 3.2.1.3 (Permanent Partial Disability) and Benefit 3.2.1.4 (Temporary Total Disability) in respect of the Insured Person will cumulatively exceed the Common Death or Disability Sum Insured then Our maximum, total and cumulative liability under any and all such claims will be limited to the Common Death or Disability Sum Insured.

3.2.1.5 Child Education Cover

We will pay the amount specified in the Policy Schedule / Certificate of Insurance at the frequency specified in the Policy Schedule / Certificate of Insurance in respect of each surviving Dependent Child, irrespective of whether the child is an Insured Person under this Policy.

For the purpose of this Benefit:

Dependent Child means a child of the Insured Person who is less than Age 25 and does not have any independent source of income.

This Benefit will be payable provided that:

a. We have accepted a claim under the Benefit 3.2.1.1 (Accidental Death Benefit) or Benefit 3.2.1.2 (Permanent Total Disability) in respect of that Insured Person;

b. The amount payable under this Benefit will be in addition to the amount payable under the Benefit 3.2.1.1 (Accidental Death Benefit) or any other applicable Benefits;

We shall not be liable to accept a claim under this Benefit in respect of more than 2 Dependent Children of the Insured Person.

3.3 Out-patient ("OPD") and Wellness Benefit Category

3.3.1 Benefits

This Section defines the Benefits under this coverage category. The following Benefits shall trigger in the event of the Insured Person undergoing any Medically Necessary Treatment as an Out-Patient or incurring Medical Expenses in relation to such Medically Necessary Treatment. Claims under this coverage category will be admissible subject to the fulfilment of the following conditions with respect to the Insured Person's OPD Treatment or Medical Expenses incurred:

i. The Insured Person incurs the Medical Expenses during the Coverage Period.
ii. The date of consultation / diagnostics / Treatment is within the Coverage Period.
iii. The Medically Necessary Treatment is undergone on the written advice of a qualified Medical Practitioner, and the Medical Expenses are certified to be for such Medically Necessary Treatment by the treating Medical Practitioner.

3.3.1.1 Out-Patient Treatment Cover

We will indemnify the Medical Expenses incurred by an Insured Person in respect of any Medically Necessary Treatment availed/provided, in a Hospital or Day Care Centre or by any service provider as an Out-Patient, of the following nature and subject to the limits as specified in the Policy Schedule / Certificate of Insurance:

i. Physical Consultation: Medical advice taken from a general or specialist Medical Practitioner;

ii. Online Consultation: A web-based consultation from a qualified Medical Practitioner

iii. Diagnostics: Any diagnostic procedures undergone by the Insured Person

iv. Pharmacy: Discounts on medicine/pharmacy costs or/and indemnify the cost of medicines/pharmacy duly supported by the prescriptions of the Medical Practitioner attending to the Insured Person

v. Dietician: Advise on wellness coaching from dieticians

vi. Doctor on Call: A telephonic consultation from a general Medical Practitioner

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

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

ii. Cost of spectacles, hearing aids, braces, implants, prosthetic devices, and lenses etc as Medical Aids.

3.4 Critical Illness Category

3.4.1 Benefits

The Section defines the Benefits under this coverage category. The following Benefits shall trigger in the event that the Insured Person is diagnosed to be suffering from a Critical Illness specified in Annexure I of the Policy. Claims under this coverage category will be admissible subject to the fulfilment of the following conditions with respect to the Insured Person's diagnosis:

i. The Insured Person is First Diagnosed to be suffering from the Critical Illness during the Coverage Period
ii. Such Critical Illness also first occurs or first manifests itself during the Coverage Period as a first incidence;
iii. The Insured Person is specified to be covered with respect to such Critical Illness or Surgical Procedure, as stated in the Policy Schedule / Certificate of Insurance
iv. First Diagnosis of the Critical Illness should have occurred during the Insured Person's lifetime, i.e, no payment under any Benefit shall be made if such First Diagnosis of the Critical Illness is made post-mortem.
v. All the test reports and medical reports required to support the diagnosis of the Critical Illness or the Surgical Procedure, the stage and form of such Critical Illness, and for Us to make a claims assessment, including any claim documentation required under Section 3 of the Policy, should be available before the death of the Insured Person and in a form suitable for sharing with Us.

3.4.1.1 Critical Illness Benefit

We will pay the percentage of Sum Insured as is specified against such Critical Illness under this Benefit in the Policy Schedule / Certificate of Insurance, if the Critical Illness or Surgical Procedure is covered under the Policy for the Insured Person, and provided that:

a. The Insured Person survives the applicable Survival Period as specified in the Policy Schedule / Certificate of Insurance.

b. The Critical Illness contracted has not arisen within the applicable Waiting Period specified in the Policy Schedule / Certificate of Insurance against this Benefit (or against any Critical Illness), from the Risk Commencement Date.

3.4.2 Benefit Options

3.4.2.1 Critical Illness Waiting Period

If this Benefit Option is in force for the Insured Person, We shall not be liable to make any payment under this Benefit in respect of any Critical Illness if You are first diagnosed as suffering from a critical Illness within the Waiting Period specified in the Policy Schedule / Certificate of Insurance from the Risk Commencement Date.

The number of days for the purpose of the Waiting Period are calculated from the Risk Commencement Date to the actual final diagnosis which confirms the Critical Illness, or date on which the Surgical Procedure is done, whichever is earlier.

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 as the First Diagnosis of the Critical Illness is within the opted number of days. However, if an Insured Person is diagnosed with heart blockage during the Waiting Period but undergoes "Coronary Artery Bypass Graft" after the completion of the Waiting Period, the claim for Critical Illness will be paid for Coronary Artery Bypass Graft as the Surgical Procedure was carried out after the completion of the Waiting Period.

3.4.2.2 Survival Period for Critical Illness

If this Benefit Option is in force for the Insured Person, any amount payable under Benefit 3.4.1.1 shall be subject to survival of the Insured Person for the period specified in the Policy Schedule / Certificate of Insurance following the First Diagnosis of the Critical Illness or undergoing the Surgical Procedure for

the first time, whichever is earlier.

If an Insured Person is First Diagnosed to be suffering from a Critical Illness of the nature specified in Annexure I of the Policy, during the Coverage Period, then We will pay the Sum Insured under this Benefit as specified in the Certificate of Insurance.

This benefit is payable provided that:

a. The Critical Illness is covered under the Policy for the Insured Person as stated in the Certificate of Insurance;

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

Section 4. Optional Benefit:

Insured can opt from the below give optional benefit in lieu of additional premium.

4.1 Loss of Job

If an Insured Person suffers an Involuntary Unemployment during the Coverage Period resulting in loss of Income, then We will pay the monthly amount specified in the Certificate of Insurance against this Benefit, or the number of EMI Amount(s) as specified in the Certificate of Insurance falling due in respect of the Loan Account Number specified against this benefit in the Certificate of Insurance, as applicable, for each continuous and completed month specified in the Certificate of Insurance from the date of such Involuntary Unemployment.

This benefit shall be payable subject to the following:

a. Salaried Individuals are eligible for cover under this benefit, where such primary occupation is evidenced by their ITR (Income Tax Return) for the number of years specified in the Certificate of Insurance preceding the date of loss of income.

b. The Insured Person is employed on the direct payroll of an organization or entity having a registered office in India for a minimum of six continuous months before the Risk Commencement Date, or of an Indian branch of such organization or entity.

c. Such dismissal/termination/retrenchment of the Insured Person by his/her employer should be affected in compliance with his/her employer's internal rules/regulations/policies, and any laws or any directives issued by a public authority and in force.

d. Our liability to make any payment under this benefit shall be in excess of the Deductible specified in the Certificate of Insurance for each claim and shall be payable for the maximum number of months specified in the Certificate of Insurance against this benefit, until reinstatement of employment with the same or any other employer, whether confirmed or on probation.

e. Where the EMI Option is opted for and specified as such in the Certificate of Insurance, any payments that are overdue and unpaid by the Insured Person prior to the occurrence of the event giving rise to a claim under this benefit will not be considered for the purpose of this benefit and shall be deemed as paid by the Insured Person.

f. Any monthly amounts being paid under an admitted claim under this benefit will be discontinued if We reasonably believe that the Insured Person is demonstrably not taking any measures, deemed reasonable and necessary as advised by Us, that can assist in reinstatement of employment in his/her primary occupation, or any occupation of similar nature.

4.2 Griha Raksha

4.2.1 Insured Events

We give insurance cover for physical loss or damage, or destruction caused to Insured Property by the following unforeseen events occurring during the Policy Period.

The events covered are given in Column A and those not covered in respect of these events are given in Column B.

COLUMN A	COLUMN B
We cover physical loss or damage, or destruction caused to the Insured Property by	**We do not cover** any loss or damage, or destruction caused to the Insured Property
1. Fire	caused by burning of Insured Property by order of any Public Authority.
2. Explosion or Implosion	-
3. Lightning	-
4. Earthquake, volcanic eruption, or other convulsions of nature	-
5. Storm, Cyclone, Typhoon, Tempest, Hurricane, Tornado, Tsunami, Flood and Inundation	-
6. Subsidence of the land on which Your Home Building stands, Landslide, Rockslide	caused by a. normal cracking, settlement or bedding down of new structures, b. the settlement or movement of made up ground, c. coastal or river erosion, d. defective design or workmanship or use of defective materials, or e. demolition, construction, structural alterations or repair of any property, or groundworks or excavations.
7. Bush fire, Forest fire, Jungle fire	-
8. Impact damage of any kind, i.e., damage caused by impact of, or collision caused by any external physical object (e.g. vehicle, falling trees, aircraft, wall etc.)	caused by pressure waves caused by aircraft or other aerial or space devices travelling at sonic or supersonic speeds.
9. Missile testing operations	-
10. Riot, Strikes, Malicious Damages	caused by a. temporary or permanent dispossession, confiscation, commandeering, requisition or destruction by order of the government or any lawful authority, or b. temporary or permanent dispossession of Your Home by unlawful occupation by any person.
11. Acts of terrorism (Coverage as per Terrorism Clause attached)	Exclusions and Excess as per Terrorism Clause attached.
12. Bursting or overflowing of water tanks, apparatus and pipes.	-
13. Leakage from automatic sprinkler installations.	a. Repairs or alterations in Your Home or the building in which Your Home is located, b. Repairs, removal or extension of any sprinkler installation, or c. Defects in the construction known to You.

14. Theft within 7 (seven)days from the occurrence of and proximately caused by any of the above Insured Events.	if it is a. of any article or thing outside Your Home, or b. of any article or thing attached from the outside of the outer walls or the roof of Your Home, unless securely mounted.

4.2.2 Coverage

4.2.2.1 Home Building Cover

1. What We cover

We cover physical loss or damage, or destruction of Your Home Building because of any Insured Event listed in Section 4.2.1 this Policy. We also cover architect's, surveyor's, consulting engineer's fees, cost of removing debris as specified under 4.2.2.1 (5) (f) of this Policy. Further, We pay for Loss of rent and Rent for Alternative Accommodation, which will be paid to the extent declared by You and agreed by Us as specified under 4.2.2.1(6) of this Policy while Your Home Building is not fit for living following loss or damage due to an insured event.

2. Your Home Building

a. Your Home Building is a building consisting of a residential unit, having an enclosed structure and a roof, basement (if any) and used as a dwelling place.
b. Your Home Building includes
   i. fixtures and fittings permanently attached to the floor, walls or roof, like fixed sanitary fittings, electrical wiring and other permanent fittings.
   ii. the following 'additional structures' if they are on the same site, and are used as part of Your Home Building:
      a) garage, domestic out-houses used for residence, parking spaces or areas, if any
      b) compound walls, fences, gates, retaining walls and internal roads,
      c) verandah or porch and the like,
      d) septic tanks, bio-gas plants, fixed water storage units or tanks,
      e) solar panels, wind turbines and air conditioning systems, central heating systems and the like, if not included in Home Contents Cover,
   iii. any other structure shown in the Policy Schedule.
c. Your Home Building does not include Contents of Your Home.

3. Use for residence

a. We will pay only if Your Home Building is used for the purpose of residence of Yourself and Your family, or of Your tenant, licensee or employee.
b. We will not pay if
   i. Your Home Building is used as a holiday home, or for lodging and boarding, or
   ii. Your Home Building or any part of Your Home Building is used for purposes other than residential except where it is used both for Your residence and for the purposes of earning Your livelihood if You are self- employed or You have shifted Your office to Your Home Building for a temporary period due to lockdown or closure of Your office ordered by a public authority.

4. Sum Insured

a. The Sum Insured for the Home Building Cover is the prevailing Cost of Construction of Your Home Building at the Commencement Date as declared by You and accepted by Us and will be the maximum amount payable in the event the Home Building is a Total Loss.
b. If the Policy Period is more than one year, We will automatically increase Your Sum Insured during the Policy Period by 10% per annum on each anniversary of Your Policy without additional premium for a maximum of 100% of the Sum Insured at the Policy Commencement Date.
c. The Sum Insured will be automatically increased each day by an amount representing 1/365th of 10% of Sum Insured at the Policy Commencement Date for annual policies.
d. Restoration of Sum Insured: Except as stated in Section 4.2.4 (3) (b) of this Policy, the insurance cover will at all times be maintained during the Policy Period to the full extent of the respective Sum

Insured. This means that after We have paid for any loss, the policy shall be restored to the full original amount of Sum Insured. You must pay to Us proportionate premium for the unexpired Policy Period from the date of loss. We can also deduct this premium from the net claim that We must pay You.

5. What We pay

a. If You make a claim under the policy for damage to Your Home Building due to any of the insured perils, We reimburse the cost to repair it to a condition substantially the same as its condition at the time of damage. You must spend for repairs, and claim that amount from Us.
b. We will calculate the amount of claim on the basis of the actual Carpet Area subject to the Carpet Area not exceeding that declared by You in the Proposal Form and stated in the Policy Schedule.
c. The maximum We will pay for all items together is the Sum Insured shown in the Policy Schedule for Home Building Cover. If the Policy Schedule shows any limit for any item, such limit is the maximum We will pay for that item.
d. If Your Home Building is a Total Loss, We will pay You the Sum Insured of the Home Building.
e. If only an additional structure is destroyed, We will pay You an amount equal to the Cost of Construction of the additional structure.
f. In addition to what Section 4.2.2.1 (5) (c) of this Policy provides for, We will pay You the following expenses:
    i. up to 5% of the claim amount for reasonable fees of architect, surveyor, consulting engineer;
    ii. up to 2 % of the claim amount for reasonable costs of removing debris from the site.

6. Loss of Rent and Rent for Alternative Accommodation: In addition to what Section 4.2.2.1 (5) (c) of this Policy provides for, We will pay the amount of rent You lose or alternative rent You pay while Your Home Building is not fit for living because of physical loss arising out of an Insured Event as follows:

a. If You are living in Your Home as a tenant, and You are required to pay higher rent for the alternative accommodation, We will pay the difference between the rent for alternative accommodation and the rent of Your Home Building.
b. We will pay the loss under this cover for an accommodation that is not superior to Your Home Building in any way and in the same city as Your Home Building.
c. The amount of lost rent shall be calculated as follows: Sum Insured for Cover for Loss of Rent (as declared by You in the Proposal Form and specified by Us in the Policy Schedule) X Period necessary for repairs ÷ Loss of Rent Period opted for.
d. This cover will be available for the reasonable time required to repair Your Home Building to make it fit for living. The maximum period of this cover is three years from the date Your Home Building becomes unfit for living. You must submit a certificate from an architect or the local authority to show that Your Home Building is not fit for living.
e. Claim for loss of rent will be accepted only if We have accepted Your claim for loss for physical damage to Your Home under the Home Building Cover.

4.2.2.2 Home Contents Cover

1. What We cover:

We cover the physical loss or damage to or destruction of the General Contents of Your Home caused by an Insured Event as listed in Section 4.2.1 of this Policy. Valuable Contents of Your Home are not covered under this Policy unless You have purchased the optional cover for the Valuable Contents.

2. Sum Insured:

a. The Sum Insured for the Home Contents Cover is shown in the Policy Schedule and will be the maximum amount payable in the event the Home Contents are destroyed/lost completely.
b. The policy has a built-in cover for the General Contents of Your home equal to 20% of the Sum Insured for Home Building Cover subject to a maximum of ₹ 10 Lakh (Rupees Ten Lakh) provided You have opted for both Home Building and Home Contents cover. If You choose to have a higher Sum Insured for Home Contents, You have to declare the Sum Insured in the Proposal Form and pay additional premium.

c. If You have purchased only Home Contents Cover, You have to declare the Sum Insured for the General Contents in the Proposal Form.
d. The Sum Insured You have chosen for General Contents must be enough to cover the cost of replacement of the General Contents.
e. If You want to cover the Valuable Contents in Your Home, You must opt for the Optional Cover for Valuable Contents as given in Section 4.2.3.1 (a) of this Policy.
f. Restoration of Sum Insured: Except as stated in Section 4.2.4 (6) (b) of this Clause below, the insurance cover will at all times be maintained during the Policy Period to the full extent of the respective Sum Insured. This means that after We have paid for any loss, the policy shall be restored to the full original amount of Sum Insured. You must pay to Us proportionate premium for the unexpired Policy Period from the date of loss. We can also deduct this premium from the net claim that We must pay You.

3. What We pay

a. If the General Contents of Your Home are physically damaged by any Insured Event, We will at Our option,
   i. reimburse to You the cost of repairs to a condition substantially the same as its condition at the time of damage, or
   ii. pay You the cost of replacing that item with a same or similar item, or
   iii. repair the damaged item to a condition substantially the same as its condition at the time of damage.
b. The maximum We will pay for Home Contents is the Sum Insured shown in the Policy Schedule for Home Contents Cover. If the Policy Schedule shows any limit for any item, or category or groups of items, such limit is the maximum We will pay for that item.

4.2.3 Additional Cover

4.2.3.1 Optional Covers:

a. **Cover for Valuable Contents on Agreed Value Basis (under Home Contents cover):** For Valuable Contents, a value may be agreed upon by You and Us based on a valuation certificate submitted by You and accepted by Us. However, We shall waive the requirement of valuation certificate if the Sum Insured opted for is up to ₹ 5 Lakh (Rupees Five Lakh) and Individual item value does not exceed ₹ 1 Lakh (Rupees One Lakh).

   i. If the Valuable Contents of Your Home are physically damaged by any Insured Event, We will pay the cost of repairing the item/s.
   ii. If the Valuable Contents of Your Home are a Total Loss We will pay the Sum Insured shown in the Policy Schedule for the Valuable item/s. If the Policy Schedule shows any limit for any item, or category or groups of items, such limit is the maximum We will pay for that item. Loss to only one item of a pair or set does not constitute loss or damage to the entire pair or set.

4.2.4 Specific Conditions to Griha Raksha

1. Make true and full disclosure in the proposal and related documents

a. You have a duty of disclosure to tell Us everything You know, or could reasonably be expected to know, that is relevant to Us for deciding whether to give You insurance cover and on what terms. You owe this duty to disclose such relevant material information even if We have not specifically asked for it. This duty extends to any information or declaration given by anyone else on Your behalf.
b. We have agreed to give You insurance cover entirely on the basis of the information You, or anyone on Your behalf, have given Us in the proposal, statements and other declarations and documents (in writing or electronic) about Yourself, Your family, Your Home Building and Home Contents. The correct and complete information You give is the basis of Our contract with You. Our promise to pay is conditional upon the truth of these statements and on the assumption that You, or anyone on Your behalf, has not withheld any material information about Yourself, Your family, Your Home Building and Home Contents.

2. Obligation to take care: You must:

a. keep Your Home Building and Home Contents in good condition and well maintained, You must ensure that the structure of Your Home Building does not have any faults or defects that are visible

and material that will aggravate loss or damage to the Home Building in the event an insured peril occurs.

b. take care to prevent theft, loss or damage to Your Home Building and Home Contents, and
c. ensure that unauthorized persons do not occupy Your Home Building.

3. **Inform change in circumstances:** You must inform Us immediately if

a. You change Your address,
b. You make any addition, alteration, extension to the structure of Your Home Building,
c. You let out Your Home Building, or Your Home Building will no longer be solely occupied by You,
d. You change the use of Your Home Building.

4. **Allow inspection and investigation of claim:** You must allow, and give full cooperation to the survey/investigation of Your claim by Us. You must allow Us, and any surveyor, officer or other representative that We authorise, to inspect Your Home Building and Home Contents including the interior wherever necessary, take photographs and where required, permit the scientific testing and investigation of any insured article affected by the insured peril. You must answer all questions asked regarding Your claim truthfully and completely, and submit all relevant documents that We will require.

5. **Make true statements and full disclosure in the claim and related documents:** You must also give true and full information in Your claim and submit true documents. If You give any false information or document in the claim, or if You withhold any information or document (written or electronic), We have a right to refuse payment of Your claim. We may also cancel Your policy.

6. **Automatic termination of the Policy**

This Policy will automatically end in the following cases:

a. **Destruction of Your Home Building**: This Policy will automatically end 7 (seven) days after Your Home Building collapses or is destroyed by reason other than any Insured Event. If a separable part of Your Home Building, or any additional structure falls down or is destroyed by reason other than any Insured Event, the covers will end for such part or additional structure. You can apply within 7 (seven) days of such fall or destruction for continuing insurance cover. We may agree, but will not be bound, to continue the cover on the same rates, terms and conditions.

b. **Exhaustion of Sum Insured**: If Your Home Building, or any additional structure, or any item of Home Contents, is lost, destroyed or stolen, or is a Total Loss, and We pay You the full Sum Insured for such item, the insurance cover for that item will automatically end unless the subject matter of insurance is reconstructed and the Sum Insured is reinstated by paying additional premium. If We pay the total Sum Insured for any claim, this Policy will end.

c. **Change of use of Your Home Building or Home Contents:** The Policy will end
   i. if You change the use of Your Home Building from personal residence to any other purpose, or
   ii. if You use any item of Home Contents for use that is not personal.

d. **Sale of Your Home Building or Home Contents:** This Policy will end when You sell, surrender or release Your interest in Your Home Building and/or Home Contents, or Your interest in the Home Building and/or Home Contents comes to an end. The Policy will end to the extent any additional structure of Your Home Building or item of Home Contents if You sell, surrender or release Your interest in such additional structure or item of Home Content, or Your interest in these ends.

e. **Effect of death**

In the event of the unfortunate death of the Insured during the Policy Period, the Home Building Cover and the Home Contents Cover that You have purchased will continue for the benefit of Your legal representative/s during the Policy Period subject to all the terms and conditions of this Policy.

16. **Changes to Covers**

a. You can choose to make changes to the covers of this Policy as may be permitted by Us, or increase or reduce any Sum Insured. You must make a proposal or request for any change. It will

be effective only after We have accepted Your proposal, and You have paid the additional premium, where applicable.

b. This Policy (including the Policy Schedule, the proposal, declarations and Endorsements) consists of the entire contract between You and Us.

17. Waiver of Underinsurance

Underinsurance does not apply to this **Section 4.2. Griha Raksha**. Thus, if Your Sum Insured calculated on the basis of the information that You provided, is less than the actual value at risk, the difference will not affect the amount We pay.

Section 5. General Exclusion

(Applicable to Section 3 and Optional cover 4.1)

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.

I. Standard Exclusions

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.

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 diseases fall 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 the Waiting Period for the same would be reduced to the extent of prior coverage.

f. List of specific diseases/procedures:

i. Cataract,

ii. Hysterectomy for Menorrhagia or Fibromyoma or prolapse of Uterus unless necessitated by malignancy myomectomy for fibroids,

iii. Knee Replacement Surgery (other than caused by an Accident), Non-infectious Arthritis, Gout, Rheumatism, Osteoarthritis and Osteoporosis, Joint Replacement Surgery (other than caused by Accident), Prolapse of Intervertebral discs (other than caused by Accident), all Vertebrae Disorders, including but not limited to Spondylitis, Spondylosis, Spondylolisthesis.

iv. Varicose Veins and Varicose Ulcers,

v. Stones in the urinary uro-genital and biliary systems including calculus diseases,

vi. Benign Prostate Hypertrophy, all types of Hydroceles,

vii. Fissure, Fistula in anus, Piles, all types of Hernia, Pilonidal sinus, Hemorrhoids and any abscess related to the anal region.

viii. Chronic Suppurative Otitis Media (CSOM), Deviated Nasal Septum, Sinusitis and related disorders, Surgery on tonsils/Adenoids, Tympanoplasty and any other benign ear, nose and throat disorder or Surgery.

ix. Gastric and duodenal ulcer, any type of Cysts/Nodules/Polyps/internal tumors/skin tumors, and any type of Breast lumps (unless malignant), Polycystic Ovarian Diseases,

x. Any Surgery of the genito-urinary system unless necessitated by malignancy.

Notwithstanding anything contained under this Benefit Option, if any of the foregoing listed Illnesses are Pre-Existing Diseases at the time of proposal or subsequently found to be Pre-Existing Diseases, the Pre-Existing Disease Waiting Periods as specified in the Policy Schedule / Certificate of Insurance shall apply.

3. 30-day waiting period (Code-Excl03)

a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

c. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

4. 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.

5. Rest Cure, rehabilitation and respite care (Code- Excl05)

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

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily life 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.

6. Obesity/ Weight Control (Code- Excl06)

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

1) Surgery to be conducted is upon the advice of the Doctor

2) The Surgery/Procedure conducted should be supported by clinical protocols

3) The member has to be 18 years of age or older and

4) Body Mass Index (BMI);

a) greater than or equal to 40 or

b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

7. Change-of-Gender treatments (Code- Excl07)

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

8. Cosmetic or plastic Surgery (Code- Excl08)

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

9. 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.

10. 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.

11. 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 as disclosed in website www.acko.com/health-insurance / notified to the policyholders are not admissible. However, in case of life-threatening situations or following an Accident, expenses up to the stage of stabilization are payable but not the complete claim.

12. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Code- Excl12).

13. Treatments received in health hydros, nature-cured 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)

14. 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)

15. Refractive Error (Code- Excl15)

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

16. 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.

17. Sterility and Infertility: (Code- Excl17)

Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization

ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

iii. Gestational Surrogacy

iv. Reversal of sterilization

18. Maternity (Code - Excl18):

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization) except ectopic pregnancy;

ii. Expenses towards miscarriage (unless due to an Accident) and lawful medical termination of pregnancy during the policy period.

II. Specific Exclusions

A. Specific Exclusion (Applicable for Section 3)

We shall not be liable to make any payment for any claim under the Policy in respect of an Insured Person, arising from or caused by any of the following:

1. **Stem cell treatment:** Stem cell implantation/Surgery, harvesting, storage or any kind of Treatment using stem cells.
2. **Dental Treatment:** Dental Treatment, dentures or Surgery of any kind unless necessitated due to an Accident and requiring minimum 24 hours Hospitalization. Treatment related to gum disease or tooth disease or damage unless related to irreversible bone disease involving the jaw which cannot be treated in any other way.
3. **Circumcision**: Circumcision unless necessary for Treatment of an Illness or Injury not excluded hereunder or due to an Accident.
4. Birth control procedures, contraceptive supplies or services including complications arising due to supplying services, hormone replacement therapy and voluntary termination of pregnancy, surrogate or vicarious pregnancy.
5. **Eye sight & Optical services/surgeries:** Routine medical, eye examinations, cost of spectacles, laser Surgery for cosmetic purposes or corrective Surgeries or contact lenses.
6. Ear examinations, cost of hearing aids or cochlear implants.
7. Vaccinations except post-bite Treatment.
8. Any physical, psychiatric or psychological examinations or testing, any Treatment and associated expenses for alopecia, baldness, wigs, or toupees and hair fall Treatment and products, issue of medical certificates and examinations as to suitability for employment or travel.
9. **Medical Instrument:** Instrument used in Treatment of Sleep Apnea Syndrome (C.P.A.P.) and Continuous Peritoneal Ambulatory Dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pump or any other external devices used during or after Treatment.
10. **Artificial Life Maintenance**: Artificial life maintenance, including life support machine use, where such Treatment will not result in recovery or restoration of the previous state of health.
11. **Developmental problem treatment:** Treatment for developmental problems including learning

difficulties eg. Dyslexia, behavioural problems including attention deficit hyperactivity disorder (ADHD).

12. Treatment for general debility, ageing, convalescence, sanatorium Treatment, private duty nursing, run down condition or rest cure.
13. **Prosthetics and other devices**: Prostheses, corrective devices and and/or Medical Appliances, which are not required intra-operatively for the Illness / Injury for which the Insured Person was Hospitalised.
14. Treatment received outside India.
15. **External Congenital Anomaly** : External Congenital Anomaly or defects, inherited disorders or any complications or conditions arising therefrom including any developmental conditions of the Insured Person.
16. **Suicide and Self-Injury**:
    a. Suicide or attempted suicide, intentional self-inflicted Injury or acts of self-destruction, whether the Insured Person is medically sane or insane.

    b. Death or disability/ Any illness or Hospitalisation arising from or caused due to use, abuse or a consequence or influence of an abuse of any substance, intoxicant, drug, alcohol or hallucinogen by the Insured Person.
17. **Change in profession:** 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 / Certificate of Insurance
18. **Unlawful Activities:** Death or disability/Any illness or Hospitalisation arising or resulting from the Insured Person committing any breach of law or participating in an actual or attempted felony, riot, crime, misdemeanor or civil commotion with criminal intent.
19. Death, injury, illness or disability 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.
20. **War and hazardous substances**: Death or disability arising out of or attributable to foreign invasion, act of foreign enemies, hostilities, participation in any naval, military or air-force operation, civil war, public defense, rebellion, revolution, insurrection, military or usurped power, 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.
21. **Non-Medical Expenses:** For complete list of non-medical expenses, please refer to the Annexure II “Non-Medical Expenses” and also on Our website. Any opted Deductible (Per claim / Aggregate / Group) amount or percentage of admissible claim under Co-Payment, Sub Limit if applicable and as specified in the Policy Schedule / Certificate of Insurance to this Policy.

    All non-medical expenses including but not limited to convenience items for personal comfort not consistent with or incidental to the diagnosis and Treatment of the Illness/Injury for which the Insured Person was Hospitalised, such as, ambulatory devices, walker, crutches, belts, collars, splints, slings, braces, stockings of any kind, diabetic footwear, glucometer/thermometer and any medical equipment that is subsequently used at home except when they form part of room expenses.
22. **Organ Donor:** Costs of donor screening or costs incurred in an organ transplant Surgery involving organs not harvested from a human body.
23. **Hazardous Activities:** Any Injury caused while engaging in 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 or involving a naval military or air force operation.
24. Any physical, or medical condition or Treatment or service that is specifically excluded in the Policy Schedule / Certificate of Insurance under special conditions.

A.1. Specific exclusion applicable to 3.2. Personal Accident Category

1. Working in underground mines, tunnelling or explosives, or involving electrical installation with hightension supply, or as jockeys or circus personnel, or engaging in Hazardous Activities.
2. Certification of disability by a family member, or a person who stays with the Insured Person, or from persons not registered as Medical Practitioners under the respective Medical Councils, or from a Medical Practitioner who is practicing outside the discipline that he is licensed for.
3. Death or disability caused other than by an Accident.
4. Medical or surgical treatment except as necessary solely and directly as a result of an Accident.
5. Death or disability resulting directly or indirectly, contributed or aggravated or prolonged by childbirth or from pregnancy or a consequence thereof including ectopic pregnancy unless specifically arising due to Accident.
6. **Chemical Attack**: 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 disability or death.
7. **Biological Attack:** 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 disability or death.

A.2. Specific exclusion applicable to 3.3. Out- Patient Treatment Cover

- Inpatient Care and Day Care Treatments will not be covered.

A.3. Specific exclusion applicable to 3.4. Critical Illness Category

1. Certification / diagnosis / Treatment by a family member, or a person who stays with the Insured Person, or from persons not registered as Medical Practitioners under the respective Medical Councils, 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 recognised or Unproven/ Experimental treatment, or any form of clinical trials or any kind of self-medication and its complications.
2. **Chemical Attack:** 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 disability or death.
3. **Biological Attack:** 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 disability or death.

B. Specific Exclusion (Applicable for Section 4.1 Loss of Job.)

We shall not be liable to make any payment for any claim under this benefit in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:

1. Any Involuntary Unemployment of the Insured Person that is attributed to any dishonesty, misconduct or fraud, or any wilful violation by the Insured Person of any internal rules/regulations/policies, or any laws or any directives issued by a public authority and in force, or any disciplinary action initiated against the Insured Person by his/her employer.
2. Unemployment from any occupation or job which is a Temporary or Seasonal Job, or where the Insured Person is not on the direct payroll of the employer.
3. Any voluntary unemployment, self-resignation, or voluntary retirement.
4. Any Involuntary Unemployment or suspension of the Insured Person at his/her primary occupation, which is temporary in nature.

5. Any unemployment from any occupation or job in which no salary was ever provided to the Insured Person.
6. Any unemployment occurring while the Insured Person, who is a Salaried Individual, is still under his/her probation, including any unemployment resulting from non-confirmation of his/her employment by the employer during or after the period on probation.
7. Any suspension of the Insured Person from his/her primary occupation on account of any pending enquiry being conducted by the employer or a public authority.
8. Any unemployment if it arises as a result of the place of employment or part thereof being temporary closed down for a period not exceeding the minimum number of days specified in Certificate of Insurance/Schedule due to lay off, lockout, strike or any other reason.
9. Any unemployment due to non-extension of a maternity/paternity leave, either as per the Maternity Benefit Act 1961, as amended from time to time, or as per the employer's internal regulation/policy in force at the time of any event or occurrence that may give rise to a claim.
10. Any unemployment due to any strike or labour disturbance in which the Insured Person is directly or indirectly involved.
11. Any reasonable belief that the Insured Person was aware that such loss of Income was likely to happen, whether or not any official communication was provided, at the time of Risk Commencement Date.
12. Withdrawal of offer of employment by an employer.
13. Medical exclusions
    i. Any unemployment if it arises as a result of intentional self-inflicted injuries.
    ii. Any unemployment if it arises as a result of termination of service on the grounds of a Pre-Existing Diseases.
    iii. Any unemployment if it arises as a result of intake of alcohol or drugs by the Insured Person.
    iv. Any unemployment if it arises as a result of insured person being on family leave or sick leave due to childbirth or pregnancy.

C. Specific Exclusion (Applicable for Section 4.2. Griha Raksha)

We do not cover losses and expenses for any loss or damage or destruction of the Insured Property that is directly or indirectly as a result of or is caused by or arising from events, stated below:

1. Your deliberate, wilful or intentional act or ommission, or of anyone on Your behalf, or with Your connivance.
2. War, invasion, act of foreign enemy hostilities or war-like operations (whether war is declared or not), civil war, mutiny, civil commotion amounting to a popular rising, military rising, rebellion, revolution, insurrection or military or usurped power.
3. Ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from combustion of nuclear fuel, or the radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component that is part of it.
4. Pollution or contamination, unless
    i. the pollution or contamination itself has resulted from an Insured Event, or
    ii. an Insured Event itself results from pollution or contamination.
5. Loss, damage or destruction to any electrical/electronic machine, apparatus, fixture, or fitting by over-running, excessive pressure, short circuiting, arcing, self- heating or leakage of electricity from whatever cause (lightning included). This exclusion applies only to the particular machine so lost, damaged or destroyed.
6. Loss or damage to bullion or unset precious stones, manuscripts, plans, drawings, securities, obligations or documents of any kind, coins or paper money, cheques, vehicles, and explosive substances unless otherwise expressly stated in the policy.
7. Loss of any Insured Property which is missing or has been mislaid, or its disappearance cannot be linked to any single identifiable event.
8. Loss or damage to any Insured Property removed from Your Home to any other place.
9. Loss of earnings, loss by delay, loss of market or other consequential or indirect loss or damage of any kind or description whatsoever.
10. Any reduction in market value of any Insured Property after its repair or reinstatement.

11. Any addition, extension, or alteration to any structure of Your Home Building that increases its Carpet Area by more than 10% of the Carpet Area existing at the Commencement Date or on the date of renewal of this Policy, unless You have paid additional premium and such addition, extension or alteration is added by Endorsement.
12. Costs, fees or expenses for preparing any claim.

Section 6. General Terms and Clauses

I. Standard General Terms and Clauses

1. Disclosure of Information

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

"Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

2. Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

3. Claim Settlement (provision for Penal interest

i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document.

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

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 15 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 15 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

4. Complete Discharge

Any payment to the policyholder, insured person or insured person's nominees or insured person's legal representative or assignee or to the Hospital, as the case may be, for any Benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

5. Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on insured person's behalf to obtain any Benefit under this policy, all Benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a. the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

b. the active concealment of a fact by the insured person having knowledge or belief of the fact;

c. any other act fitted to deceive; and

d. any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy Benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

6. Redressal of Grievance

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

For resolution of grievance, insured may contact the company on our toll-free helpline number 1800 210 4990 (Operating hours: 10 AM – 7 PM, all days of the week).

Senior Citizens Support: Phone: **080-62370023** Email: grievance.healthseniorcitizen@acko.com

you can also write to grievance@acko.com. Your complaint will be acknowledged by us within 24 working hours.

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

Email: gro@acko.com

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

The Chief Grievance Officer will provide a final response within 7 days of receipt of the escalation. If in case your issue remains unresolved within 14 days of lodging a complaint with us and you wish to pursue other avenues for redressal of grievances, you may approach IRDAI by calling on the Toll-Free no. 155255 or you can register an online complaint on the website https://irdai.gov.in/igms1

Insurance Ombudsman for Redressal, whose details are given below:

General Manager Consumer Affairs Department- Grievance Redressal Cell

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

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

Where the grievance is not resolved, the insured may, subject to vested jurisdiction, approach the Insurance Ombudsman for the redressal of grievance. The details of the Insurance Ombudsman are available in **Annexure IV.**

7. Migration (Applicable to Section 3 and 4.1.)

In case of migration of one policy to another with the same Insurer, the policyholder (including all members under family cover and group insurance policies) can transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy to the migrated policy.

8. Portability (Applicable to Section 3 and 4.1.)

a. A Policyholder has the choice to port his/ her policies from one Insurer to another. The Acquiring and the Existing Insurers shall jointly, ensure that the entire underwriting details and claim history of the Policyholders are seamlessly transferred.
b. The existing insurer shall provide the information sought by the Acquiring insurer immediately but not more than 72 hours of receipt of request through Insurance Information Bureau of India (IIB) https://iib.gov.in/ portal.
c. The Acquiring insurer shall decide and communicate on the proposal immediately but not more than 5 days of receipt of information from Existing insurer.
d. The policyholder is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease , Moratorium period etc from the Existing Insurer to the Acquiring Insurer in the previous policy.

9. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavor to give notice for Renewal. However, the Company is not under obligation to give any notice for Renewal.

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

iii. Request for Renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the Grace Period.

v. No loading shall apply on Renewals based on individual claims experience

10. Moratorium Period (Applicable to Section 3 and 4.1.)

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

11. Premium Payment in instalments (Applicable to Section 3 and 4.1.)

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

i. Grace Period of 30 days (for half yearly/quarterly instalment) & 15 days (for monthly instalment) would be given to pay the instalment premium due for the policy.

ii. During such Grace Period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.

iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated Grace Period.

iv. No interest will be charged if the instalment premium is not paid on due date.

v. In case of instalment premium due not received within the Grace Period, the policy will get cancelled.

vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

12. Free Look Period (Applicable to Section 3 and 4.1.)

A period of 30 days (from the date of receipt of the policy document) is available to the policyholder to review the terms and conditions of the policy. If you are not satisfied with any of the terms and conditions, you have the option to cancel your policy. This option is available in case of policies with a term of one year or more.

If you have not made any claim during the Free Look Period, then you shall be entitled to:

1. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

2. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

3. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

13. Nomination (Applicable to Section 3 and 4.1.):

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

II. Specific Terms and Clauses

1. Alterations in the Policy

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

2. Material Information for administration

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

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

facts declared to Us.

3. 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.

4. Geography & Policy Currency:

This Policy applies to events or occurrences taking place in the Geographical Scope specified in the Policy Schedule / Certificate of Insurance. All payments under this Policy will only be made in the currency specified in the Policy Schedule.

5. Dispute Resolution & Applicable Law

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

6. 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 Policy Schedule / Certificate of Insurance, then such special condition shall have effect accordingly.

7. Notices & Communications:

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

8. Electronic Transactions:

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

9. Assignment:

The Policy and the benefits under this Policy can be assigned in only in accordance with applicable law. For Loan linked policies only, if opted, agreed per the applicable Loan agreement and specified as such in the Certificate of Insurance, it is hereby declared and agreed that:

i. From the commencement of the Coverage Period, any claims payable by Us to the Insured Person, and all rights, titles, benefits and interest of the Insured Person under this Policy stand assigned in favour of the bank/financial institution as specified in the Certificate of Insurance;

ii. Upon any claim becoming payable under this Policy, the same shall be paid by Us to the financial institution as specified in the Certificate of Insurance, without any reference/ notice to the Insured Person, but not exceeding the Principal Outstanding Amount which is due to the financial institution on

the date that the claim becomes payable. In the event of any claim amount payable under this Policy exceeding the Principal Outstanding Amount, We shall pay such component of the claim amount as is exceeding the Principal Outstanding Amount to the Insured Person;

iii. The receipt of such claim amount in the manner aforesaid by the financial institution specified in the Certificate of Insurance, and/or the Insured Person shall completely discharge Us from all liability under the Policy and shall be binding on the Insured Person and his/her heirs, executors, administrators, successors or legal representatives, as the case may be.

10. Cancellation :

I. The policyholder may cancel his/her policy at any time during the term, by giving 7 days notice in writing. We Will
   a. refund proportionate premium for unexpired policy period, if the term of policy upto one year and there is no claim (s) made during the policy period.
   b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.

II. The Company may cancel the Policy at any time on grounds of misrepresentation, nondisclosure of material facts ,established fraud by the Insured Person, by giving 7 days written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or established fraud.

III. Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

11. Claims Procedure (Applicable to Section 3)

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 center. 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 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 arriving at 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.

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.

2 Policyholder's / Insured Person's Duty at the time of Claim On occurrence of an event which may lead to a claim under this Policy, the Insured Person shall:

i. Forthwith intimate, file and submit the claim form and documents as prescribed in accordance with the procedure set out under Section 3, 4 and 5 as mentioned below.

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

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

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

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.

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

ii. 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:

i. Policy Number

ii. Name of the Policyholder

iii. Name of the Insured Person in whose relation the claim is being lodged

iv. Nature of Illness / Injury / Critical Illness

v. Name and address of the attending Medical Practitioner and Hospital

vi. Date of Admission

vii. Any other information that may be reasonably requested by Us

4 Cashless Process

Cashless Facility for Hospitalization expenses shall be limited exclusively to Medical Expenses incurred for Treatment undertaken in a Network Provider.

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 / Group) (if applicable) directly with the Hospital.

Pre-Authorisation Process

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

(a) For Planned Hospitalization:

i. 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.

ii. The Network Provider will issue the request for authorisation letter for Hospitalization in the pre-authorisation form.

iii. The Network Provider shall send the pre-authorisation form along with all the relevant details to the 24 (twenty-four) 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.

iv. 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.

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

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

(b) In case of Emergency Hospitalization

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

ii. The Network Provider shall forward the request for authorisation to Us within 48 hours of admission to the Hospital as per the process under Section 4 (a) above.

iii. 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.

iv. 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 medical Emergency.

v. 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:

i. 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.

ii. We shall accept or decline such request for enhancement of pre- authorised limit for enhancement.

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 4 (a) above.

Discharge Process:

At the time of discharge:

i. 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 4 (a) above.

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

Note: (Applicable to 4(a) & 4(b): 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 / Group) (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. Claim Form duly filled and signed

ii. Original pre-authorisation request

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

iv. Copy of Photo ID of Insured Person verified by the Hospitals

v. Original discharge/death summary

vi. Operation theatre notes (if applicable)

vii. Original Hospital main bill and break up bill

viii. Original investigation reports, X Ray, MRI, CT Films, HPE

ix. Medical Practitioner's reference slips for investigations/pharmacy

x. Original pharmacy bills

xi. MLC/FIR report/post mortem report (if applicable and conducted)

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

5 Claim Reimbursement Process

(a) Collection of Claim Documents for indemnity-based covers

i. 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/gi

ii. List of necessary claim documents to be submitted for reimbursement are as following: i. Claim Form duly filled and signed

iii. Copy of Photo ID of Insured Person verified by the Hospitals

iv. Original discharge/death summary

v. Operation theatre notes (if applicable)

vi. Original Hospital main bill and break up bill

vii. Original investigation reports, X Ray, MRI, CT Films, HPE

viii. Medical Practitioner's reference slips for investigations/pharmacy

ix. Original pharmacy bills

x. MLC/FIR report/post mortem report (if applicable and conducted)

xi. Any other information relevant to the Injury/Hospitalization/illness

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 submission of claim documents as specified in 5 (a) above, then in addition to the documents mentioned in 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.

6 Scrutiny of Claim Documents

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

ii. If the deficiency in the necessary claim documents is not met or are partially met in 10 working days of the first intimation, We shall remind the Insured Person/Network Provider of the same every 10 (ten) days thereafter.

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

iv. We may, at Our sole discretion, decide to deduct the amount of claim for which deficiency is intimated to the Insured Person and settle the claim if we observe that such a claim is otherwise valid under the Policy.

v. 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.

7 Claim Assessment

We will pay the fixed or indemnity amount as specified in the applicable Benefit or Benefit Option in accordance with the terms of this Policy.

We will assess all admissible claims under the Policy in the following progressive order –

i. If any Sub-Limit on Medical Expenses are applicable as specified in the Policy Schedule / Certificate of Insurance, Our liability to make payment shall be limited to the extent of the applicable Sub Limit for that Medical Expense.

ii. Opted Deductible (Per claim / Aggregate / Group), if any, shall be applicable on the amount payable by Us after applying the above.

iii. 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)–

i. Opted Deductible (Group / Per claim / Aggregate), & Co-Payments (if opted) ii. Sum Insured

ii. Cumulative Bonus (if applicable)

iii. Restored Sum Insured (if applicable)

iv. Additional Buffer (if applicable)

Claim Assessment for fixed benefits:

We will pay fixed benefit amounts as specified in the Policy Schedule / Certificate of Insurance 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 specified in the Policy.

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. 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. 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.

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

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

In case of delay beyond stipulated 30 days We shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

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.

12 Claim Payment Terms

i. We shall have no liability to make payment of a claim under the Policy in respect of an Insured Person once the Sum Insured for that Insured Person is exhausted.

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

iii. We are not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person could have reasonably minimised the costs incurred, or that is brought about or contributed to by the Insured Person by failing to follow the directions, Medical Advice or guidance provided by a Medical Practitioner.

iv. The Sum Insured opted under the Policy shall be reduced by the amount payable / paid under the Policy terms and conditions and any Benefit Options applicable under the Policy and only the balance shall be available as the Sum Insured for the unexpired Coverage Period or Policy Year, as the case may be.

v. 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 Policy Schedule / Certificate of Insurance) 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.

Claim Procedure (Applicable for Section 4 a. Loss of Job)

a. On the occurrence of or discovery of any event which may give rise to a claim under this Policy, We shall be provided with the following necessary information and documentation in respect of the claim within 30 days of the occurrence of the Insured Person's Injury, including but not limited to:

Name of Benefit	Documents required
Common Documents	• Our claim form duly completed and signed; • Name and address of the Insured Person in respect of whom the claim is being made; • Copies of valid KYC documents of the Nominee/claimant, any other regulatory requirements, as amended from time to time;
Loss of Job	• Income Tax Return (ITR) for number of years specified in Certificate of Insurance • Proof of Employment (Appointment Letter) • Latest copy of Salary Revision (if any) • Salary slip for last 3 months • Form 16 (if applicable) • Contact details of Employer • Proof of Loan taken and EMIs due (in cases where EMI is Sum Insured) from bank/financial institution where such loan has been taken • Reason for Retrenchment mentioned in the Relieving Letter

Claim Procedure (Applicable for Section 4 b. Griha Raksha)

If You suffer a loss because of an Insured Event, You must make a claim for Your financial loss at Your cost. The procedure for making a claim is given below. These include things that **You must do**, and that **You must not do**. It is important to comply with these to ensure that it does not prejudice Your claim in any manner.

1. **Immediate notice to Us**
   a. As soon as any physical loss or damage occurs to Your Home Building or Home Contents due to an Insured Event, You must immediately give notice to Us of the loss or damage. This is necessary for Us to survey/ investigate the loss or damage, as may be required.
   b. You can give notice to any of Our offices or call-centres.
   c. You must state in this notice

i. the Policy Number,
ii. Your name,
iii. details of report to the police that You made,
iv. details of report to any Authority that You made,
v. details of the Insured Event,
vi. a brief statement of the loss,
vii. particulars of any other insurance of Your Home Building or any of Your Home Contents,
viii. details of loss or damage under any Optional Cover or Add-ons,
ix. submit photographs of loss or physical damage, wherever possible.

2. Steps to prevent loss and damage

a. You must take all reasonable steps to prevent further loss or damage to Your Home Building and Home Contents.
b. Until We have inspected Your Home Building and Home Contents, and have given Our consent,
   i. You must not sell, give away or dispose of any damaged items of any property for which You are making a claim;
   ii. You must not wash or clean, or remove any damaged item or debris, except for any urgent necessity;
   iii. You must not carry out repairs, unless such repairs are urgent and You cannot contact Us.

3. Immediate notice to Authorities

a. As soon as any loss or damage occurs to the Insured Property, You must give immediate report to appropriate legal authorities. For example, You must report to the fire brigade of the local authority and the police if there is damage by fire/ explosion / implosion or lightning. In case of subsidence/landslide/rockslide, You must inform the District Administration. In the event of impact damage of any kind or Riot Strikes, Malicious damages and acts of terrorism, You must inform the police. If there is a theft within 7 (seven) days following an Insured Event You must inform the police.
b. We may, but not necessarily, waive this condition if We are satisfied that by reason of extreme hardship it was not possible for You or any other person on Your behalf to give such report.

4. Submit claim

a. Claim form:
   i. You must submit Your claim in Our claim form at the earliest opportunity, but within 30 days from the date You first notice the loss or damage. The claim form is available in any of Our branches, and on Our web-site.
   ii. You must state in Your claim the details of any other insurance policy that covers the damage or loss for which You have filed Your claim, whether You have purchased such other insurance, or someone else has purchased it for You.
b. We shall not be liable for any loss or damage after the expiry of 12 months from the happening of the loss or damage unless the claim is the subject of pending action or arbitration. If We disclaim liability for a claim You have made and if the claim is not made a subject matter of a suit in a court of law within a period of 12 months from the date of disclaimer, the claim shall not be recoverable hereunder.

5. Establish loss

a. You must prove that the Insured Event has occurred, and the extent of physical loss or damage You have suffered with full details.
b. When We request,
   i. You must support Your claim for Home Building and/or Home Contents with plans, specification books, vouchers, invoices pertaining to costs incurred by You for reconstruction/replacement/repairs.
   ii. You must allow Us, Our officers, surveyors or representatives to inspect the loss or damage to Your Home Building and/or Home Contents, and to take measurements, samples, damaged items or parts, and photographs that are relevant.
   iii. You must give Us authority to see the relevant records and get information about the Event and Your loss from the police or any other authority.
c. For Optional Cover of Personal Accident, Death Certificate and Post Mortem report (wherever necessary) shall be submitted.

6. Fraudulent claim

If You, or anyone on Your behalf, make a false or fraudulent claim, or support a claim with any false or

fraudulent statement or documents:

i. We will not pay,
ii. We can cancel the Policy: in such a case, You will lose all benefits under this Policy and premium that You have paid, and
iii. We can also inform the police, and start legal proceedings against You.

7. Other insurance

a. If You have any other policy with Us or any other Insurance Company (taken by You or by anyone else for You) covering in whole or in part any claim that You have made under this Policy, You have a right to ask for settlement of Your claim under any of these policies.
b. If You choose to claim under this Policy from Us, We will settle Your claim within the limits and the terms and conditions of this Policy.
c. After We pay the amount under Your claim, We have the right to ask for contribution from the Insurers that have given You the other policies.
d. We will ensure that Our actions do not impose any liability on You.

8. Recovery action by Us

a. When We accept and pay Your claim under the Policy, We can start legal proceedings to recover the amount or property from the third party who has caused the loss or damage to Your Home Building or Home Contents. You must give authority to Us to take such action and exercise this right effectively, when We request You, whether before or after making payment of Your claim. You must give all information, cooperation, assistance and help for this purpose. You must not do anything which will prejudice Our right. We can do this
   i. without seeking Your consent,
   ii. in Your name, and
   iii. whether or not Your loss has been fully compensated.

b. Any amount We recover from such person will be applied first to the costs of the legal proceedings and recovery, then to the claim amount We have paid or must pay to You. We will pay You any balance.
c. You can start legal proceedings against any person who has caused the loss or damage only with Our prior consent, and on conditions that We will impose. You must not compromise or settle any claim against such person without Our consent. If You recover any amount from such person, You must return to Us the amount We have paid for Your claim. We can take over the conduct of legal proceedings that You have started and continue the proceedings in Your name.

Section 7. Annexures

a. Annexure I: Critical Illness

The Critical Illnesses specified below shall be covered under the Critical Illness Benefit in the below combination, as may be specified in the Schedule or Certificate of Insurance. Please refer to the definitions of the same after the table.

S.NO.	CRITICAL ILLNESS	GROUP			
		15 CI's	18 CI's	25 CI's	36 CI's
1	Cancer of Specified Severity	√	√	√	√
2	Kidney Failure Requiring Regular Dialysis	√	√	√	√
3	Multiple Sclerosis with Persisting Symptoms	√	√	√	√
4	Major Organ / Bone Marrow Transplant	√	√	√	√
5	Open Heart Replacement or Repair of Heart Valves	√	√	√	√
6	Open Chest CABG	√	√	√	√
7	Permanent Paralysis of Limbs	√	√	√	√
8	Myocardial Infarction (First Heart Attack – of Specific Severity)	√	√	√	√
9	Stroke Resulting in Permanent Symptoms	√	√	√	√
10	Benign Brain Tumor	√	√	√	√
11	Parkinson's Disease	√	√	√	√
12	Coma of Specified Severity	√	√	√	√
13	End Stage Liver Failure	√	√	√	√
14	Alzheimer's Disease	√	√	√	√
15	Aorta Graft Surgery	√	√	√	√
16	Major Burns	×	√	√	√
17	Loss of Hearing (Deafness)	×	√	√	√
18	Loss of Speech	×	√	√	√
19	Loss of Vision (Blindness)	×	×	√	√
20	Motor Neurone Disease with Permanent Symptoms	×	×	√	√
21	Loss of Limbs	×	×	√	√
22	Aplastic Anaemia	×	×	√	√
23	End Stage Lung Failure	×	×	√	√
24	Primary (Idiopathic) Pulmonary Hypertension	×	×	√	√
25	Bacterial Meningitis	×	×	√	√
26	Apallic Syndrome or Persistent Vegetative State (PVS)	×	×	×	√
27	Coronary Angioplasty (PTCA)[1]	×	×	×	√
28	Encephalitis	×	×	×	√

29	Fulminant Hepatitis	×	×	×	√
30	Chronic Relapsing Pancreatitis	×	×	×	√
31	Major Head Trauma	×	×	×	√
32	Medullary Cystic Disease	×	×	×	√
33	Muscular Dystrophy	×	×	×	√
34	Poliomyelitis	×	×	×	√
35	Systemic Lupus Erythematous	×	×	×	√
36	Brain Surgery	×	×	×	√

Critical Illness Definition:

1. Cancer of Specific Severity

I) A malignant tumor characterized by the uncontrolled growth & 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.

II) The following are excluded
- i) 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 & CIN-3;
- ii) Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
- iii) Malignant melanoma that has not caused invasion beyond the epidermis;
- iv) 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;
- v) All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
- vi) Chronic lymphocyctic leukaemia less than RAI stage 3;
- vii) Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification;
- viii) All Gastro-Intestinal Stromal Tumours histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. Myocardial Infraction (First Heart attack of specified severity)

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

II) The following are excluded:
- i) Other acute Coronary Syndromes
- ii) Any type of angina pectoris
- iii) 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

I) 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.

II) The following are excluded:

i) Angioplasty and/or any other intra-arterial procedures

4. Open Heart Replacement or Repair of Heart Valves

I) 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. Kidney Failure Requiring Dialysis

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

6. Stroke Resulting in Permanent Symptoms

I) Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolization 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.

II) The following are excluded:
- i) Transient ischemic attacks (TIA)
- ii) Traumatic injury of the brain
- iii) Vascular disease affecting only the eye or optic nerve or vestibular functions.

7. Major Organ/Bone Marrow Transplant

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

II) The following are excluded:
- i) Other stem-cell transplants Where only islets of langerhans are transplanted

8. Permanent Paralysis of Limbs

I) 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.

9. Multiple Sclerosis with Persisting Symptoms

I) The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
- i) investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
- ii) there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II) Other causes of neurological damage such as SLE is excluded.

10. Coma of Specified Severity

I) 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:
   i) no response to external stimuli continuously for at least 96 hours;
   ii) life support measures are necessary to sustain life; and
   iii) permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

11. Motor Neuron Disease with Permanent Symptoms

I) 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.

12. Blindness

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

II) 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.

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

13. Third Degree Burns

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

14. Parkinson's Disease

I) The unequivocal diagnosis of progressive, degenerative idiopathic Parkinson's disease by a Neurologist acceptable to Us.

II) The diagnosis must be supported by all of the following conditions:
   i) the disease cannot be controlled with medication;
   ii) signs of progressive impairment; and
   iii) inability of the Insured Person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons) for a continuous period of at least 6 months:

III) 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

IV) Parkinson's disease secondary to drug and/or alcohol abuse is excluded.

15. Benign Brain Tumor

I) 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.

II) This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.
i) Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
ii) Undergone surgical resection or radiation therapy to treat the brain tumor.

III) 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.

16. Alzheimer's Disease

I) Alzheimer's disease is a progressive degenerative Illness of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. It affects the brain, causing symptoms like memory loss, confusion, communication problems, and general impairment of mental function, which gradually worsens leading to changes in personality.

II) Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the Insured Person. The diagnosis must be supported by the clinical confirmation of a specialist Medical Practitioner (Neurologist) and supported by Our appointed Medical Practitioner, evidenced by findings in cognitive and neuro radiological tests (e.g. CT scan, MRI, PET scan of the Brain). The disease must result in a permanent inability to perform three or more Activities with Loss of Independent Living or must require the need of supervision and permanent presence of care staff due to the disease. This must be medically documented for a period of at least 90 days

III) The following conditions are however not covered:
i) non-organic diseases such as neurosis and psychiatric Illnesses;
ii) alcohol related brain damage; and
iii) any other type of irreversible organic disorder/dementia.

17. Aorta Graft Surgery

I) The actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of **"Aorta"** shall mean the thoracic and abdominal aorta but not its branches.

II) The Insured Person understands and agrees that We will not cover:
Surgery performed using only minimally invasive or intra arterial techniques.
Angioplasty and all other intra arterial, catheter based techniques, "keyhole" or laser procedures

III) The Aorta is the main artery carrying blood from the heart. Aortic Graft Surgery benefit covers Surgery to the Aorta wherein part of it is removed and replaced with a graft.

18. Deafness

I) 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 90decibels across all frequencies of hearing” in both ears.

19. Loss of Limbs

I) 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 directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

20. Loss of Speech

I) 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 and Ear, Nose, Throat (ENT) specialist.

21. 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 500/mm^3 or less
   ii) Platelets count less than 20,000/mm^3 or less
   iii) Absolute Reticulocyte count of 20,000/mm^3 or less

III) Temporary or reversible Aplastic Anaemia is excluded.

IV) In this condition, the bone marrow fails to produce sufficient blood cells or clotting agents.

22. End Stage Liver Failure

I) Permanent and irreversible failure of liver function that has resulted in all three of the following:
   i) Permanent jaundice; and
   ii) Ascites; and
   iii) Hepatic encephalopathy.

II) Liver failure secondary to alcohol or drug abuse is excluded.

23. End Stage Lung Failure

I) 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; and
   ii) Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
   iii) Arterial blood gas analysis with partial oxygen pressures of 55mmHg or less (PaO2 <55 mm Hg); and
   iv) Dyspnea at rest.

24. Primary (Idiopathic) Pulmonary Hypertension

I) 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.

II) The NYHA Classification of Cardiac Impairment are as follows:
   i) Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
   ii) Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.
   iii) 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.

25. 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 resulting in permanent inability to perform three or more Activities for Loss of Independent Living.

II) This diagnosis must be confirmed by:
   i) The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
   ii) A consultant neurologist certifying the diagnosis of bacterial meningitis.

Bacterial Meningitis in the presence of HIV infection is excluded.

26. Apallic Syndrome or Persistent Vegetative State (PVS)

I) Apallic Syndrome or Persistent vegetative state (PVS) or unresponsive wakefulness syndrome (UWS) is a universal necrosis of the brain cortex with the brainstem remaining intact. The patient should be in a vegetative state for a minimum of four weeks in order to be classified as UWS, PVS, Apallic Syndrome.

II) The diagnosis must be confirmed by a Neurologist acceptable to Us and the condition must be documented for at least one month.

III) In this condition, the patient with severe brain damage progresses who was in coma, progresses to a wakeful conscious state, but not in a state of true awareness.

27. Coronary Angioplasty (PTCA)

I) 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).

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

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

The maximum benefit pay-out for Coronary Angioplasty is restricted to the Sum Insured or INR 10,00,000, whichever is lesser.

28. Encephalitis

I) Severe inflammation of the brain tissue due to infectious agents like viruses or bacteria which results in significant and permanent neurological deficits for a minimum period of 30 days, certified by a specialist Medical Practitioner (Neurologist).

II) The permanent deficit should result in permanent inability to perform three or more Activities for Loss of Independent Living.

III) Exclusions:
i) Encephalitis in the presence of HIV infection is excluded.

29. 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.

30. Chronic Relapsing Pancreatitis

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 relapses in the form of sub lethal attacks of acute pancreatitis, irreversible morphological change and typically causing pain and/or permanent impairment of function. The condition must be confirmed by elevated levels of pancreatic function tests including serum amylase, serum lipase, and radiographic and imaging evidence. Relapsing Pancreatitis caused directly or indirectly, wholly or partly, by alcohol is excluded

31. Major Head Trauma

i) 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.
ii) 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

iii) 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.

iv) The following are excluded:
i) Spinal cord injury;

32. Medullary Cystic Disease

A progressive hereditary disease of the kidneys characterised by the presence of cysts in the medulla, tubular atrophy and intestitial fibrosis with the clinical manifestations of anaemia, polyuria and renal loss of sodium, progressing to chronic renal failure. The diagnosis must be supported by renal biopsy.

33. Muscular Dystrophy

I) A group of hereditary degenerative diseases of muscle characterised by progressive and permanent weakness and atrophy of certain muscle groups. The diagnosis of muscular dystrophy must be unequivocal and made by a Neurologist acceptable to Us, with confirmation of at least 3 of the following 4 conditions:
   i) Family history of muscular dystrophy;
   ii) Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;
   iii) Characteristic electromygrom; or
   iv) Clinical suspicion confirmed by muscle biopsy.

II) The condition must result in the inability of the Insured Person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons) for a continuous period of at least 6 months:

34. Poliomyelitis

I) The unequivocal diagnosis of infection with the polio virus must be established by a Consultant Neurologist. The infection must result in irreversible paralysis as evidenced by impaired motor function or respiratory weakness. Expected permanence and irreversibility of the paralysis must be confirmed by a Consultant Neurologist after at least 6 months since the beginning of the event.

II) Exclusions:
   i) Cases not involving irreversible paralysis will not be eligible for a claim
   ii) Other causes of paralysis such as Guillain-Barré Syndrome are specifically excluded.

35. Systemic Lupus Erythematous

I) A multi-system, multifactorial, autoimmune disorder characterised by the development of auto-antibodies directed against various self-antigens. Systemic lupus erythe-matosus 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 World Health Organization (WHO) classification). The final diagnosis must be confirmed by a registered Medical Practitioner specialising in Rheumatology and Immunology acceptable to Us, Other forms, discoid lupus, and those forms with only haematological and joint involvement are however not covered:

   The WHO lupus classification is as follows:

   i) Class I: Minimal change – Negative, normal urine.
   ii) Class II: Mesangial – Moderate proteinuria, active sediment.
   iii) Class III: Focal Segmental – Proteinuria, active sediment.
   iv) Class IV: Diffuse – Acute nephritis with active sediment and/or nephritic syndrome.
   v) Class V: Membranous – Nephrotic Syndrome or severe proteinuria.

36. Brain Surgery

I) The actual undergoing of surgery to the brain under general anesthesia during which a craniotomy is performed.

II) Exclusion:
   i) Burr hole surgery / brain surgery on account of an accident.

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

List of excluded expenses (non-medical) are as specified below:

S. No.	List of excluded (non-medical) items	
	I TOILETRIES/COSMETICS/PERSONAL COMFORT OR CONVENIENCE	
1.	HAIR REMOVAL CREAM	Not Payable
2.	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	Not Payable
3.	BABY FOOD	Not Payable
4.	BABY UTILITES CHARGES	Not Payable
5.	BABY SET	Not Payable
6.	BABY BOTTLES	Not Payable
7.	BRUSH	Not Payable
8.	COSY TOWEL	Not Payable
9.	HAND WASH	Not Payable
10.	MOISTURISER PASTE BRUSH	Not Payable
11.	POWDER	Not Payable
12.	RAZOR	Not Payable
13.	SHOE COVER	Not Payable
14.	BEAUTY SERVICES	Not Payable
15.	BELTS/ BRACES	Essential and may be paid specifically for cases who have undergone surgery of thoratic or lumar spine
16.	BUDS	Not Payable
17.	BARBER CHARGES	Not Payable
18.	CAPS	Not Payable
19.	COLD PACK/HOT PACK	Not Payable
20.	CARRY BAGS	Not Payable
21.	CRADLE CHARGES	Not Payable
22.	COMB	Not Payable
23.	DISPOSABLES RAZORS CHARGES (for site preparations)	Payable
24.	EAU-DE-COLOGNE / ROOM FRESHNERS	Not Payable
25.	EYE PAD	Not Payable
26.	EYE SHEILD	Not Payable
27.	EMAIL / INTERNET CHARGES	Not Payable
28.	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)	Not Payable
29.	FOOT COVER	Not Payable

30.	GOWN	Not Payable
31.	LEGGINGS	Essential in varicose vein surgery and will be payable if the surgery itself is payable
32.	LAUNDRY CHARGES	Not Payable
33.	MINERAL WATER	Not Payable
34.	OIL CHARGES	Not Payable
35.	SANITARY PAD	Not Payable
36.	SLIPPERS	Not Payable
37.	TELEPHONE CHARGES	Not Payable
38.	TISSUE PAPER	Not Payable
39.	TOOTH PASTE	Payable
40.	TOOTH BRUSH	Not Payable
41.	GUEST SERVICES	Not Payable
42.	BED PAN	Essential and may be paid specifically for cases who have undergone surgery of thoratic or lumar spine
43.	BED UNDER PAD CHARGES	Not Payable
44.	CAMERA COVER	Not Payable
45.	CLINIPLAST	Not Payable
46.	CREPE BANDAGE	Not Payable
47.	CURAPORE	Not Payable
48.	DIAPER OF ANY TYPE	Not Payable
49.	DVD, CD CHARGES	Not Payable (However if CD is specifically sought by the Insurer then payable)
50.	EYELET COLLAR	Not Payable
51.	FACE MASK	Not Payable
52.	FLEXI MASK	Not Payable
53.	GAUSE SOFT	Not Payable
54.	GAUZE	Not Payable
55.	HAND HOLDER	Not Payable
56.	HANSAPLAST/ ADHESIVE BANDAGES	Not Payable
57.	INFANT FOOD	Not Payable
58.	SLINGS	Payable for upper fractures
59.	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Exclusion in the Policy unless otherwise specified
60.	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.,	Exclusion in the Policy unless otherwise specified
61.	HOME VISIT CHARGES	Exclusion in the Policy unless otherwise specified
62.	DONOR SCREENING CHARGES	Exclusion in the Policy unless otherwise specified
63.	ADMISSION/REGISTRATION CHARGES	Exclusion in the Policy unless otherwise specified
64.	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Exclusion in the Policy unless otherwise specified
	EXPENSES FOR INVESTIGATION/ TREATMENT	

65.	IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Exclusion in the Policy unless otherwise specified
66.	WARD AND THEATRE BOOKING CHARGES	Payable under OT charges, not payable separately
67.	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS	Rental charged by the hospital payable. Purchase of instrument not payable
68.	MICROSCOPE COVER	Payable under OT charges, not payable separately
69.	SURGICAL BLADES, HARMONIC SCALPEL, SHAVER	Payable under OT charges, not payable separately
70.	SURGICAL DRILL	Payable under OT charges, not payable separately
71.	EYE KIT	Payable under OT charges, not payable separately
72.	EYE DRAPE	Payable under OT charges, not payable separately
73.	X-RAY FILM	Payable under Radiology charges, not as consumable
74.	SPUTUM CUP	Payable under Investigation charges, not as consumable
75.	BOYLES APPARATUS CHARGES	Payable under OT charges, not payable separately
76.	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of cost of Blood, not payable
77.	ANTISEPTIC OR DISINFECTANT LOTIONS	Not Payable - Part of Dressing charges
78.	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES	Not Payable - Part of Dressing charges
79.	COTTON	Not Payable - Part of Dressing charges
80.	COTTON BANDAGE	Not Payable - Part of Dressing charges
81.	MICROPORE/ SURGICAL TAPE	Not Payable – Payable by the patient when prescribed, otherwise included as Dressing charges.
82.	BLADE	Not Payable
83.	APRON	Not Payable - Part of Hospital Services / Disposable Linen to be part of OT/ICU charges
84.	TORNIQUET	Not Payable - (Service is charged by hospital, consumables cannot be separately charged)
85.	ORTHOBUNDLE, GYNAEC BUNDLE	Part of dressing charges
86.	URINE CONTAINER	Not Payable
II ELEMENTS OF ROOM CHARGE		
	LUXURY TAX	Actual tax levied by

87.		government is payable. Part of room charge for sublimit
88.	HVAC	Part of room charge not payable separately
89.	HOUSE KEEPING CHARGES	Part of room charge not payable separately
90.	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge not payable separately
91.	TELEVISION AND AIR CONDITIONER CHARGES	Part of room charge not payable separately
92.	SURCHARGES	Part of room charge not payable separately
93.	ATTENDANT CHARGES	Not Payable - Part of room charges
94.	IM IV INJECTION CHARGES	Part of nursing charges, not payable
95.	CLEAN SHEET	Part of Laundry separately
96.	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
97.	BLANKET/WARMER BLANKET ADMINISTRATIVE OR NON-MEDICAL CHARGES	Not Payable - Part of room charges
III **ADMINISTRATIVE OR NON-MEDICAL CHARGES**		
98.	ADMISSION KIT	Not Payable
99.	BIRTH CERTIFICATE	Not Payable
100.	BLOODRESERVATIONCHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
101.	CERTIFICATE CHARGES	Not Payable
102.	COURIER CHARGES	Not Payable
103.	CONVENYANCE CHARGES	Not Payable
104.	DIABETIC CHART CHARGES	Not Payable
105.	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
106.	DISCHARGE PROCEDURE CHARGES	Not Payable
107.	DAILY CHART CHARGES	Not Payable
108.	ENTRANCE PASS / VISITORS PASS CHARGES	Not Payable
109.	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	To be claimed by patient under Post Hosp where admissible
110.	FILE OPENING CHARGES	Not Payable
111.	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
112.	MEDICAL CERTIFICATE	Not Payable
113.	MAINTAINANCE CHARGES	Not Payable
114.	MEDICAL RECORDS	Not Payable
115.	PREPARATION CHARGES	Not Payable

116.	PHOTOCOPIES CHARGES	Not Payable
117.	PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
118.	WASHING CHARGES	Not Payable
119.	MEDICINE BOX	Not Payable
120.	MORTUARY CHARGES	Payable upto 24hrs, shifting charges not payable
121.	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
IV EXTERNAL DURABLE DEVICES		
122.	WALKING AIDS CHARGES	Not Payable
123.	BIPAP MACHINE	Not Payable
124.	COMMODE	Not Payable
125.	CPAP/ CAPD EQUIPMENTS	Not Payable
126.	INFUSION PUMP – COST	Not Payable
127.	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
128.	PULSEOXYMETER CHARGES	Not Payable
129.	SPACER	Not Payable
130.	SPIROMETRE	Not Payable
131.	SPO2 PROBE	Not Payable
132.	NEBULIZER KIT	Not Payable
133.	STEAM INHALER	Not Payable
134.	ARMSLING	Not Payable
135.	THERMOMETER	Not Payable (Paid by Patient)
136.	CERVICAL COLLAR	Not Payable
137.	SPLINT	Not Payable
138.	DIABETIC FOOT WEAR	Not Payable
139.	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
140.	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
141.	LUMBO SACRAL BELT	Essential and should be paid specifically for cases who have undergone surgery of limbar spine
142.	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/quadraplegia for any reason and at reasonable cost of approximately Rs.200/day
143.	AMBULANCE COLLAR	Not Payable
144.	AMBULANCE EQUIPMENT	Not Payable
145.	MICROSHEILD	Not Payable
146.	ABDOMINAL BINDER	Essential and should be paid in post-surgery patients of major abdominal surgery including TAH, LSCS, incisional hernia repair, explanatory laparotomy

		for intestinal liver transplant etc. Obstruction.
V ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION		
147.	BETADINE \ HYDROGEN PEROXIDE\SPIRIT\DISINFECTANTS ETC	May be payable when prescribed for patient not payable for hospital use in OT or ward or for dressing in hospital
148.	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	Post-hospitalization nursing charges not payable
149.	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES	Patient Diet provided by hospital is payable
150.	SUGAR FREE Tablets	Payable - Sugar free variants of admissible medicines are not excluded
151.	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)	Payable when prescribed
152.	Digestion gels	Payable when prescribed
153.	ECG ELECTRODES	Upto 5 electrodes are required for every case visiting OT or ICU. For Longer stay in ICU, may require a change and atleast one set every second day must be payable
154.	GLOVES Sterilized Gloves	Payable /unsterilized gloves not payable
155.	HIV KIT	Payable - Payable Pre-operative screening
156.	LISTERINE/ ANTISEPTIC MOUTHWASH	Payable when prescribed
157.	LOZENGES	Payable when prescribed
158.	MOUTH PAINT	Payable when prescribed
159.	NEBULISATION KIT	If used during hospitalization is payable reasonably
160.	NOVARAPID	Payable when prescribed
161.	VOLINI GEL/ ANALGESIC GEL	Payable when prescribed
162.	ZYTEE GEL	Payable when prescribed
163.	VACCINATION CHARGES	Routine Vaccination not payable / post bite vaccination payable
VI PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE		
164.	AHD	Not Payable - Part of Hospital's internal cost
165.	ALCOHOL SWABES	Not Payable - Part of Hospital's internal cost
166.	SCRUB SOLUTION/STERILLIUM	Not Payable - Part of Hospital's internal cost
VII OTHERS		

167.	VACCINE CHARGES FOR BABY	Payable as per plan
168.	TPA CHARGES	Not Payable
169.	VISCO BELT CHARGES	Not Payable
170.	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, OVERY KIT, ETC]	Not Payable
171.	EXAMINATION GLOVES	Not Payable
172.	KIDNEY TRAY	Not Payable
173.	MASK	Not Payable
174.	OUNCE GLASS	Not Payable
175.	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not Payable, except for telemedicine consultation where covered by policy
176.	OXYGEN MASK	Not Payable
177.	PAPER GLOVES	Not Payable
178.	PELVIC TRACTION BELT	Should be payable in case PIVI requiring traction as this is generally not reused
179.	REFERAL DOCTOR'S FEES	Not Payable
180.	ACCU CHECK (Glucometery/ Strips)	Not Payable Pre-hospitalization or post hospitalization/ Reports and charts required / Device not payable
181.	PAN CAN	Not Payable
182.	SOFNET	Not Payable
183.	TROLLY COVER	Not Payable
184.	UROMETER, URINE JUG	Not Payable
185.	AMBULANCE	Payable as per plan
186.	TEGADERM / VASOFIX SAFETY	Payable - maximum of 3 in 48 Hrs and then 1 in 24 hrs
187.	URINE BAG	Payable where medically necessary till a reasonable cost – Maximum 1 per 24 hrs.
188.	SOFTOVAC	Not Payable
189.	STOCKINGS	Essential for case like CABG etc. where it should be paid

Annexure III: Standard Special Clause: Agreed Bank Clause (For Griha Raksha Cover Mentioned Above)

If You have mortgaged, hypothecated or created any security over Your Home or any of its Contents in favour of a Bank, and the Bank has an interest in the Policy, the name of such Bank will also be shown in the Policy Schedule under the title 'Agreed Bank Clause'. If You choose to add the name of such Bank at any time during the Policy Period, this will be shown as an Endorsement.

Under this Clause You agree as follows:

i. We shall pay to the Bank the entire amount that We are liable to pay under this Policy. Such Bank will receive it for its own demand, and as agent for any other person interested in the amount.

ii. When We pay the amount to the Bank, Our liability under this Policy will be discharged, and will be binding on all of You and all persons named as the insured.

iii. Any notice or communication We make to the Bank under the provisions of this Policy shall be

sufficient notice or communication to You.

iv. Any settlement or compromise that We make with the Bank will be binding on You and all persons named as the insured. However, such settlement or compromise will not affect the rights of the Bank to recover any amount from You or any other person.

v. If You make any change in the use of Your Home or sell or transfer the Insured Property, such actions will not prejudice the interest of the Bank under the Policy and this clause, unless the condition has been broken by the Bank or its employees.

vi. If You commit any act or omission that will increase the risk, the insurance cover will not be invalidated. However, the Bank shall notify Us of any change or ownership, or alterations and increase in risks as soon they become known to the Bank, and shall pay additional premium from the time of such change.

vii. When We pay the amount to the Bank, We will become legally and automatically subrogated to all rights of the Bank to the extent of such payment. This will not impair or prejudice the rights of the Bank to recover any amount from You or any other person. N.B: The Bank shall mean the first named Financial Institution/Bank named in the policy.

Annexure IV: List of Insurance Ombudsman

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:

Sl. No	Office of Insurance Ombudsman	Address	Email	Landline NOs.
1	AHMEDABAD	Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road,AHMEDABAD – 380 001.	oio.ahmedabad@cioins.co.in	079 - 25501201/02
2	BENGALURU	Jeevan Soudha Building,PID No. 57-27-N-19,Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078.	oio.bengaluru@cioins.co.in	080 - 26652048 / 26652049
3	BHOPAL	1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Arera Hills Bhopal – 462 011.	oio.bhopal@cioins.co.in	0755 - 2769201 / 2769202 / 2769203
4	BHUBANESWAR	62, Forest park, Bhubaneswar – 751 009.	oio.bhubaneswar@cioins.co.in	0674 - 2596461 /2596455/2596429/2596003
5	CHANDIGARH	Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017.	oio.chandigarh@cioins.co.in	0172-2706468
6	CHENNAI	Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet CHENNAI – 600 018.	oio.chennai@cioins.co.in	044 - 24333668 / 24333678
7	DELHI	2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002.	oio.delhi@cioins.co.in	011 - 46013992/23213504/ 23232481
8	GUWAHATI	Jeevan Nivesh, 5th Floor, Near Pan Bazar , S.S. Road, Guwahati – 781001(ASSAM).	oio.guwahati@cioins.co.in	0361 - 2632204 / 2602205 / 2631307

9	HYDERABAD	6-2-46, 1st floor, "Moin Court", Lane Opp. Hyundai Showroom, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004.	oio.hyderabad@cioins.co.in	040 - 23312122 / 23376991 / 23376599 / 23328709 / 23325325
10	JAIPUR	Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005.	oio.jaipur@cioins.co.in	0141- 2740363
11	KOCHI	10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College Ground, M.G.Road, Kochi - 682 011.	oio.ernakulam@cioins.co.in	0484 - 2358759
12	KOLKATA	Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072.	oio.kolkata@cioins.co.in	033 - 22124339 / 22124341
13	LUCKNOW	6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226001.	oio.lucknow@cioins.co.in	0522 - 4002082 / 3500613
14	MUMBAI	3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.	oio.mumbai@cioins.co.in	022 - 69038800/27/29/31/32/33
15	NOIDA	Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301.	oio.noida@cioins.co.in	0120-2514252 / 2514253
16	PATNA	2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001.	oio.patna@cioins.co.in	0612-2547068
17	PUNE	Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030.	oio.pune@cioins.co.in	020-24471175
18	THANE	2nd Floor,Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West)-400604	oio.thane@cioins.co.in	022-20812868/69

The updated details of Insurance Ombudsman offices are also available at the IRDAI website www.irdai.gov.in, or on the website of Council for Insurance Ombudsmen www.cioins.co.in or on the Company's website at www.acko.com/gi.