Acko Surrogacy & Oocyte Cover

Policy Wordings

Hi ACKO Customer,

This document contains detailed policy wording for each cover, exclusion, claims & grievance process. We have simplified your way around the document. Click on any section below to go there.

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Section 1: Preamble

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

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

Some keywords related to and used in the Policy have been defined in Section 2 (Definitions). This

document explains the following details related to Your Policy:

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

Section 2: Definitions

2.1 Standard Definitions

1. **Accident** or **Accidental** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **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:
      - Having at least 5 in-patient beds;
      - Having qualified AYUSH Medical Practitioner in charge round the clock;
      - Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
      - Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
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. **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 by the insurer.
5. **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.
6. **Day Care Centre** means any institution established for Day Care Treatment of Illness and/or Injuries or a medical set-up with a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criterion asunder:
   a. has Qualified Nursing staff under its employment;
   b. has qualified Medical Practitioner(s) in charge;
   c. has a 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.
7. **Day Care Treatment** refers to 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 a Hospitalization of more than 24 hours.

   Treatment normally taken on an outpatient basis is not included in the scope of this definition.
8. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and Surgery.
9. **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:
   i. the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
   ii. the patient takes treatment at home on account of non-availability of room in a Hospital.

10. **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.

11. **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.

    In Case of Premium Payment in instalments:
    a) The grace period of fifteen days (where premium is paid on a monthly instalments) and thirty days (where premium is paid in quarterly/half yearly/annual instalments) is available on the premium due date, to pay the premium.
    b) If the premium is paid in instalments during the policy period, coverage will be available for the grace period also.

    In case of Renewal: If the policy is renewed during grace period of 30 days, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected. However, no policy coverage shall be available during the period for which no premium is received.

12. **Hospital** means any institution established for Inpatient Care and Day Care Treatment of Illness

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

a. has Qualified Nursing staff under its employment round the clock;
b. has at least 10 Inpatient beds in towns having a population of less than 10,00,000 and at least 15 Inpatient beds in all other places;
c. has qualified Medical Practitioner(s) in charge round the clock;
d. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
e. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

13. **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hoursexcept for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.
14. **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 whichaims 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:
   a. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
   b. it needs ongoing or long-term control or relief of symptoms
   c. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
   d. it continues indefinitely
   e. it recurs or is likely to recur

15. **Injury** means Accidental physical bodily harm excluding Illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.
16. **In-patient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hoursfor a covered event.
17. **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 wherethe level of care and supervision is considerable more sophisticated and intensive than in the ordinary and other wards.
18. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses on a per day basis 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.
19. **Maternity Expenses Shall include:**
    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 Policy Period.
20. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
21. **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 otherHospitals or doctors in the same locality would have charged for the same medical treatment.
22. **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 the scope and jurisdiction of his licence.
23. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in Hospital or part of a stay inHospital which:
    a. is required for the medical management of the Illness or Injury suffered by the insured;
    b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    c. must have been prescribed by a Medical Practitioner;
    d. must conform to the professional standards widely accepted in international medical practice or by the medicalcommunity in India.

24. **Migration** means the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre- existing conditions and time bound exclusions, with the same insurer.
25. **Network Provider** means Hospital enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a Cashless Facility.
26. **New Born Baby** means baby born during the policy period and is aged up to 90 days.
27. **Non-Network Provider** means any Hospital, Day Care Centre or other provider that is not part of the network.
28. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication
29. **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.
30. **Pre-existing Disease** means any condition, ailment, injury or disease
    a. 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
    b. for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.
31. **Pre-hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:
    a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was
    required, and
    b. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
32. **Post-hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the Hospital, provided that:
    a. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalization was required, and
    b. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
33. **Portability** means the right accorded to an individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.
34. **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.
35. **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.
36. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.
37. **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 or prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.
38. **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. **Base Sum Insured** means the coverage amount for which the premium is computed and charged for this policy.
2. **Partner Network** means Hospital, Diagnostic Centers, Clinics, Doctors, Health Care Workers, empanelled by the Insurer and/or by a consolidator to provide health related medical services.
3. **Insured Person** is the one for whom the company has received full premium (including additional premium if any), completed the risk assessment and issued the policy. The names of the Insured persons covered in the policy are specified in the policy document, who are also referred as You/Your/Policyholder in this policy.
4. **Policy Year** means the period of one year from the date of commencement of the policy.
5. **Intending Couple** means a couple who have a medical indication necessitating gestational surrogacy and who intend to become parents through surrogacy.
6. **Intending Woman** means an Indian woman who is a widow or divorcee between the age of 35 to 45 years and who intends to avail the surrogacy;

7. **Surrogacy** means a practice whereby an intending woman bears and gives birth to a child for an intending couple with theintention of handing over such child to the intending couple after the birth.
8. **Surrogacy Clinic** means surrogacy clinic, centre or laboratory, conducting assisted reproductive technology services, invitro fertilisation services, genetic counselling centre, genetic laboratory, Assisted Reproductive Technology Banks conducting surrogacy procedure or any clinical establishment, by whatsoever name called, conducting surrogacy procedures in any form.
9. **Surrogacy Procedures** means all gynaecological, obstetrical or medical procedures, techniques, tests, practices or services involving handling of human gametes and human embryo in surrogacy
10. **Surrogate mother** means a woman who agrees to bear a child (who is genetically related to the intending couple or intending woman) through surrogacy from the implantation of embryo in her womb and fulfils the conditions as provided in sub-clause (b) of clause (iii) of Section 4 of the THE SURROGACY (REGULATION) ACT, 2021
11. **An Oocyte** means naturally ovulating oocyte in the female genetic tract;
12. **Oocyte Donor:** Is a woman who donates her eggs to another woman, who might not be able to conceive by herself naturally.
13. **Oocyte Retrieval:** Is a procedure in order to remove Oocytes from the ovary of a woman, to enable fertilization.

Section 3: Benefits

3.1 Benefit Options

I. Option A – Surrogacy Cover (Coverage of 36 months)

II. Option B – Oocyte Cover (Coverage of 12 months)

All the benefits listed below can be availed for the options above :-

3.1.1 In-patient Hospitalization

In the event of hospitalization, we will cover the medical expenses for the insured in the policy if:

- Admitted for 24 hours or more
- The hospitalization is ONLY for any complication arising due to pregnancy through surrogacy, post-partum delivery And/Or due to Oocyte Retrieval

We will cover the following medical expenses for:

- Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to 1% of the sum insured per day.
- Intensive Care Unit (ICU)/ Intensive Cardiac Care Unit (ICCU) expenses up to 2% of sum insured per day.
- Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor/ surgeon or to the hospital Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.
- **AYUSH Treatment:**

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

- **Modern Treatment:**

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

a. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
b. Balloon Sinuplasty

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

Coverage applicable for listed conditions for Surrogate Mother:

Sr No	Complications of delivery
1	Perineal tears during childbirth
2	Postpartum haemorrhage
3	Episiotomy Complications
4	Post partum Endometritis
5	Postpartum depression/Psychosis
6	Anaesthesia complications
7	Infection or sepsis
8	Stroke
9	Amniotic fluid embolism
10	Postpartum preeclampsia
11	Pulmonary edema
12	HELLP syndrome
13	Heart related complications
14	Peripartum (postpartum) cardiomyopathy
15	Thrombotic pulmonary embolism (DVT)
17	Postpartum Respiratory Failure
18	Postpartum peritonitis

Coverage applicable for listed conditions for Oocyte Donor:

Sr No	Complications of Oocyte retrieval
1	Infection or sepsis
2	Bleeding
3	Ovarian hyperstimulation syndrome (OHSS)
4	Injury to surrounding structures due to procedure
5	Anaesthesia complications

Note: The definitions of the above-mentioned conditions is mentioned in the Annexure.

- Please Note:-
  i) The Coverage under this policy is only applicable for 1 surrogacy procedure and the surrogate mother will be covered for complication arising due to that 1 procedure only.
  ii) We will not pay if only investigations were carried out and no treatment was done, even if the insured was admitted.

3.1.2 Day Care Treatment

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

- We will pay for expenses incurred on hospitalization for more than 2 hours under Day Care Treatment if, thehospitalization is ONLY for any complication arising due to pregnancy, post-partum delivery And/Or due to Oocyte Retrieval
- Any treatment undertaken as an Out-Patient or in an out-patient department & diagnostics is not covered

3.1.3 Pre or Post Hospitalization Medical Expenses

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

Please Note:

- We will pay such expenses incurred for **30 days before** the date of admission and **60 days after** date of discharge **IF these are related** to the condition for which hospitalization claim is paid.

3.1.4 Road Ambulance Limit

If anyone insured under the policy needs to be transported to a hospital or day care centre by an ambulance or public transport for emergency care, then we will cover the reasonable cost of such transportation.
We will cover the reasonable costs incurred during transportation to a hospital or day care centre by an ambulance or public transport for anyone insured under the policy and requiring emergency care subject to a maximum of Rs.2000/- per hospitalization.
Note:

- We will pay the costs associated with this benefit only if we have accepted a claim under Basic Benefit 3.1.1 (In-patient Hospitalization) or Basic Benefit 3.1.2 (Day Care Treatment) or Basic Benefit
- We will pay the costs associated with this benefit only if it is medically necessary to transport anyone insured under the policy & requiring emergency care by an ambulance or public transport.

3.1.5 Domiciliary Treatment

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

Note:

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

Section 4: Exclusions

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

4.1 Standard Exclusions

4.1.1 30-day waiting period

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

4.1.2 Investigation & Evaluation

a. Expenses related to any admission primarily for diagnostics and evaluation purposesonly are excluded.

b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

4.1.3 Rest Cure, rehabilitation and respite care

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

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

4.1.4 Cosmetic or plastic Surgery

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

4.1.5 Hazardous or Adventure Sports

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

4.1.6 Breach of Law

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

4.1.7 Excluded Providers

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

4.1.8 Treatment for, alcoholism, drug or substance abuse or any addictive condition and

consequences thereof.

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

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

4.1.11 Refractive Error

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

4.1.12 Unproven Treatments

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.

4.1.13 Sterility and Infertility

Expenses related to sterility and infertility. This includes:

(i) Any type of contraception, sterilization

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

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

4.2 Specific Exclusions

4.2.1 Dental

Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and Gingiva unless necessitated due to an Accident.

4.2.2 Medically Unnecessary Treatment

Any treatments which are not specified by a medical practitioner or falls under medically necessary treatment description in the definition section of the policy wordings

4.2.3 War and Exposure to Hazardous Substances

Treatment for any Injury or Illness resulting directly or indirectly from nuclear, radiological emissions, war or war like situations (whether war is declared or not), rebellion (act of armed resistance to an established government or leader), acts of terrorism, nuclear, biological or chemical emissions, rebellion, revolution, acts of terrorism.

4.2.4 External Congenital Anamoly

Screening, counseling or treatment related to external Congenital Anomaly

4.2.5 Unrecognised Physician or Hospital:

a. Treatment or Medical Advice provided by a Medical Practitioner not recognized by the Medical Council of India or by Central Council of Indian Medicine or by Central council of Homeopathy.

b. Treatment provided by anyone with the same residence as an Insured Person or who is a member of the Insured
Person's immediate family or relatives.
c. Treatment provided by Hospital or health facility that is not recognized by the relevant authorities in India.

4.2.6 Expenses for Child Delivery (normal or caesarean)

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

4.2.7 Excluded Expenses

We shall not be liable to pay the expenses towards Non-Payable Expenses as listed in Annexure 1 for any claim under Hospitalization, Day Care Treatment & Domiciliary Treatment

4.2.8 Surrogacy & Oocyte Specific Exclusions

1. Complications of pregnancy to the Surrogate Mother, which is:
   a. Other than Altruistic Surrogacy
   b. For second Surrogacy
   c. If the Surrogate Mother donates her own gametes
2. Newborn baby through Surrogacy to the Surrogate Mother.
3. Miscarriage/Medical termination other than in case of Life- Threatening condition to the Surrogate Mother
4. Treatment taken on OPD basis.
5. Surrogacy Treatment Procedure Cost from Policy Commencement Date till completion of embryo implantation process.
6. Surrogacy which is for Commercial Purposes
7. Treatment or Complications arising out of any Pre-Existing
8. conditions/ disease.
9. Any illness, sickness or disease other than the complications arising out of pregnancy and post-partum delivery for the Surrogate mother or any complications arising out of Oocyte retrieval for the Oocyte donor.
10. Complications arising due to Oocyte retrieval, if the Insured is donating for second time.
11. Any claim with respect to abandon or disown or exploit or cause to be abandoned, disowned or exploited in any form, the child or children born through Surrogacy.

Section 5: General Terms And Conditions

5.1 Standard General Terms and Clauses

5.1.1 Disclosure of Information

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

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

5.1.2 Condition Precedent to Admission of Liability

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

5.1.3 Material Change

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

5.1.4 Records to be maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy

5.1.5 Complete Discharge

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

5.1.6 Notice and Communication

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

5.1.7 Territorial Limit

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

5.1.8 Multiple Policies

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

5.1.9 Fraud

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

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

repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue a insurance Policy:—

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

The company shall not repudiate the policy on the ground of fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

5.1.10 Cancellation

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, 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.

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.

The Company may cancel the Policy at any time on grounds of mis-representation, non- disclosure of material facts , fraud by the Insured Person, by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of mis-representation ,non- disclosure of material facts or fraud.

5.1.11 Automatic change in Coverage under the policy

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

1. In the case of his/ her (Insured Person) demise.

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

2. Upon exhaustion of sum insured and cumulative bonus, for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

5.1.12 Territorial Jurisdiction

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

and according to Indian law.

5.1.13 Renewal of Policy

Renewal is not applicable under this product.

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

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

5.1.15 Free look period

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 he/she is not satisfied with any of the terms and conditions, he/she has the option to cancel his/her 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.

5.1.16 Endorsements (Changes in Policy)

This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.

5.1.17 Terms and conditions of the Policy

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

5.1.18 Nomination

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

and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

5.1.19 Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits 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, as applicable.

For Detailed Guidelines on Migration, kindly refer Insurance Regulatory and Development Authority of India (Insurance Products) Regulations, 2024 F. No. IRDAI/Reg/8/202/2024 dated 20th March, 2024 and Master Circular on IRDAI (Insurance Products) Regulations 2024- Health Insurance Ref:

IRDAI/HLT/CIR/PRO/84/5/ 2024 dated 29th May 2024 and subsequent amendments thereof.

5.1.20 Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits 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, as applicable.

For Detailed Guidelines on Portability, kindly refer Insurance Regulatory and Development Authority of India (Insurance Products) Regulations, 2024 F. No. IRDAI/Reg/8/202/2024 dated 20th March, 2024 and Master Circular on IRDAI (Insurance Products) Regulations 2024- Health Insurance Ref: IRDAI/HLT/CIR/PRO/84/5/ 2024 dated 29th May 2024 and their subsequent amendments thereof.

5.1.21 Grace Period

The policy may be renewed in 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.

In Case of Premium Payment in instalments:

a) The grace period of fifteen days (where premium is paid on a monthly instalments) and thirty days (where premium is paid in quarterly/half yearly/annual instalments) is available on the premium due date, to pay the premium.

b) If the premium is paid in instalments during the policy period, coverage will be available for the grace period also.

In case of Renewal: If the policy is renewed during grace period of 30 days, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected. However, no policy coverage shall be available during the period for which no premium is received.

5.1.22 Moratorium Period

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.

5.2 Specific Terms and Clauses

5.2.1 Alterations in the Policy

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

5.2.2 Material Information for administration

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

Material information to be disclosed includes every matter that You and/or the Insured Person is aware of, or could reasonably be expected to know, that relates to questions in the proposal form and which is

relevant to Us in order to accept the risk of insurance and if so on what terms. You must exercise the same duty to disclose those matters to Us before the Renewal, extension, variation, endorsement or reinstatement of the Policy. Accordingly, We reserve the right to apply additional options, exclusions and/or adjust the scope of cover and / or premium, if necessary, to reflect any circumstances or material facts declared to Us.

5.2.3 Geography

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

5.2.4 Premium

The premium payable under this Policy shall be the amount specified in the Schedule. No receipt for premium shall be valid except on Our official form signed by Our duly authorised official. Payment of premium instalments under this Policy will be allowed on a monthly/quarterly/half yearly or yearly basis.

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

5.2.5 Parties to the Policy

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

5.2.6 Currency

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

5.2.8 No Constructive Notice

Any knowledge or information of any circumstance or condition in relation to You/Insured Person in Our possession or in the possession of any of Our officials shall not be deemed to be notice or be held to bind or prejudicially affect Us, or absolve You/Insured Person from their duty of disclosure, notwithstanding subsequent acceptance of any premium.

5.2.9 Endorsements

The Policy will allow the following endorsements during the Policy Year. Any request for endorsement must be made only in writing by You. Any endorsement would be effective from the date of the request received from You, or the date of receipt of premium, whichever is later other than for rectification of date of birth or gender which will be with effect from the Commencement Date.

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

b) Financial Endorsements – which result in alteration in premium
   - Deletion of Insured Person on death or upon separation or You/Insured Person leaving

the country only if no claims are paid / outstanding.

- Change in Age/date of birth.
- Change in address (resulting in change in zone).

All endorsement requests may be assessed by the underwriting team and if required additional information/documents may be requested.

5.2.10 Special Conditions

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

5.2.11 Our Right of Termination

Termination of Policy

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

a. there is misrepresentation, fraud, non-disclosure of material fact by You / Insured Person and without any refund of premium, by giving 30 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.
b. there is non-cooperation by You / Insured person, and with refund of premium on pro rata basis after deducting Our expenses, by giving 30 days' notice in writing by Registered Post Acknowledgment Due /recorded delivery to Your last known address.
c. You/Insured Person does not pay the premiums owed under the Policy within the Grace Period/applicable revival period (where premium payment is in instalments).

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

Termination for Insured Person's cover

Cover under the Policy will end for an Insured Person or Dependent on occurrence of the following:

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

5.2.12 Underwriting Loadings & Discounts

a. We may apply a risk loading on the premium payable (excluding statutory levies and taxes) or special conditions on the Policy based upon the health status of the persons proposed to be insured and declarations made at the time of enrolment. These loadings will be applied from the Commencement Date of the first Policy including subsequent Renewal(s) with Us. There will be no loadings based on individual claims experience.
b. We may apply a specific Sub Limit on a medical condition/ailment depending on the past history and declarations, or additional Waiting Periods on Pre-Existing Diseases as part of the special Conditions specified in the Schedule.

c. We shall inform You about the applicable risk loading or special condition through a counter offer letter and You would be required to respond with Your consent and additional premium (if any) within 7 working days of the issuance of such counter offer letter.
d. In case, You neither accept the counter offer nor respond to Us within 7 working days, We shall cancel Your application and refund the premium paid. Your Policy will not be issued unless We receive Your consent.

5.2.13 Operation of Policy & Policy Schedule

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

5.2.14 Electronic Transactions

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

5.2.15 Communications & Notices

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

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

Section 6: Other Terms And Conditions

6.1 Claims Procedure

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

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

You can view our network hospital list directly in the ACKO app or on the ACKO website, or by calling our customer service number

Note:

- Our network hospital list occasionally changes, so ACKO recommends you check our network hospital link before your hospitalization for the most updated list of hospitals. As an insurance company, ACKO reserves the right to modify, add or restrict the list of network hospitals where you can avail a cashless policy.

6.1.1 Claims conditions

- For claims, we require you to submit any requested claims document within a set timelines to receive a payout.
- If you do not submit all of your documentation on time, we unfortunately may not be able to pay

your claim.

- However, if it was not possible for you to submit the documentation earlier, we will make exceptions to pay your claim to you.
- If you buy a policy from ACKO, you agree to assist our representatives in understanding whether your claim is admissible under the policy you have bought.
- As an ACKO customer, you agree to allow our medical practitioners and ACKO representatives to review your medical and hospitalization records and to investigate facts around your claim.
- There may be cases where we require you to go through a medical examination for confirmation before we pay your claim. ACKO will pay for your medical examination in such cases.

6.1.2 Claim registration

When you decide to go for a hospitalization which you plan to claim for, you or your dependents / nominee must notify ACKO - either directly through our app, email or call centre or through our TPA partners at the hospital cashless desk.

If you are planning a hospitalization, as an ACKO customer, you agree to inform us about the hospitalization ~3 days in advance of the planned hospitalization. If you have to undergo an emergency hospitalization, as an ACKO customer, you agree to inform us about your hospitalization within 48 hours of being admitted, before discharge. In case you delay informing ACKO outside these timelines, ACKO can choose to deny your claim.

When you notify ACKO or our network hospitals that you plan to go for a cashless hospitalization, you will be required to provide ACKO with the following -

- a copy of your policy card (available in the app)
- a photo ID proof
- an address proof (e.g. a voter ID card / driving license / passport / PAN card / any other identity proof as approved by ACKO).

When you file a claim with ACKO, you may be required to inform ACKO of the following:

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

6.1.3 Cashless claims process

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

Pre-Authorisation Process

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

1. For Planned Hospitalization:
    a) You shall at least 3 days prior to the Date of Admission to the Hospital approach the

Network Provider for Hospitalization for undergoing medical Treatment.

b) The Network Provider will issue the request for authorisation letter for Hospitalization in the pre authorisation form.
c) The Network Provider shall send the pre-authorisation form along with all the relevant details to the 24 hour authorisation/ cashless department along with contact details of the treating Medical Practitioner and the Insured Person.
d) Upon receiving the pre-authorisation form and all related medical information from the Network Provider, We will verify the eligibility of cover under the Policy.
e) Wherever the information provided in the request is sufficient to ascertain the authorisation and the claim is admissible, We shall issue the authorisation letter to the Network Provider.
f) Wherever additional information or documents are required, We will call for the same from the Network Provider and upon satisfactory receipt of the last necessary documents, the authorisation will be issued.
g) The authorisation letter will include details of sanctioned amount, diagnosis, and date of approval.
h) The authorisation letter shall be valid only for a period of 15 days from the date of issuance of authorisation.

2. In case of Emergency Hospitalization
   a) You may approach the Network Provider for Hospitalization for medical Treatment.
   b) The Network Provider shall forward the request for authorisation to Us within 48 hours of admission to the Hospital as per the process specified under Section 6.1.3 1 above.
   c) It is agreed and understood that We may continue to discuss the Insured Person's condition with the treating Medical Practitioner till Our recommendations on eligibility of coverage for the Insured Person are finalized.
   d) In the interim, the Network Provider may either consider treating the Insured Person by taking a token deposit or treating him as per their norms in the event of any situation which requires saving of life, limb, sight or any other Emergency Care.
   e) The Network Provider shall refund such deposit amount to the Insured Person less any token amount to take care of non-covered expenses once the pre- authorisation is issued.

Enhancement to Pre-Authorised Amount:

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

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

Discharge Process:

At the time of discharge -

- The Network Provider may forward a final request for authorisation for any residual amount to Us along with the discharge summary and the detailed bill break up in accordance with the process described at 6.1.3 1 above.

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

Note:

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

Submission of Claim Documents:

- The Network Provider will send the claim documents along with the invoice and discharge voucher, duly signed by the Insured Person directly to Us.
- The following claim documents should be submitted to Us within 15 days from the date of discharge of the Insured Person from the Hospital:
  - Original pre-authorisation request
  - Copy of pre-authorisation approval letter (s)
  - Documents listed under Section 6.1.4 (Reimbursement Claim Process).
- We may call for any additional documents as required based on the circumstances of the claim.

Note:

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

6.1.4 Claim Reimbursement Process

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

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

Claim related to Hospitalization

- Claim form duly filled and signed by the insured
- Original Discharge summary
- Original Death Summary (in case of death)
- Original hospital bill with detailed break-up of charges applied by hospital
- Original payment receipts with receipt numbers & stamp/ seal of the provider
- Original Pharmacy/ medicine receipts with receipt numbers & stamp / seal of the provider
- Copy of Invoice/Stickers/barcode in case of implants
- Copy of all Laboratory and test reports
- First consultation paper from doctor stating the origin duration and progress of illness
- Copy of FIR/ MLC certificate (Accident claims)
- Copy of medical prescription
- Duly filled NEFT Mandate form (NEFT details and cancelled cheque of the proposer with Name of the client/ Bank Name / IFSC code and account number or First page of passbook with Name of

the client/ Bank Name/IFSC code and account number)

- A copy of your Aadhaar card, or any other government photo ID and PAN Card. This is not mandatory if your ID card is linked with the policy while issuance or in a previous claim
- Other documents as may be required by Acko General Insurance to determine the admissibility of claim
- Certificate from the treating doctor stating the circumstances due to which domiciliary treatment was administered (for domiciliary hospitalization claims only)

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

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

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

6.1.5 Scrutiny of Claim Documents

- We shall scrutinize the claim form and the accompanying documents. Any deficiency in the documents shall be intimated to the Insured Person / Network Provider as the case may be.
- If the deficiency in the necessary claim documents is not met or are partially met in 10 working days of the first intimation, We shall remind the Insured Person/Network Provider of the same every 10 (ten) days thereafter.
- We will send a maximum of 3 (three) reminders.
- We may, at Our sole discretion, decide to deduct the amount of claim for which deficiency is intimated to the Insured Person and settle the claim if we observe that such a claim is otherwise valid under the Policy.
- In case a reimbursement claim is received when a pre-authorisation letter has been issued, before approving such a claim, a check will be made with the Network Provider whether the pre-authorisation has been utilized as well as whether the Insured Person has settled all the dues with the Network Provider. Once such a check and declaration is received from the Network Provider, the case will be processed.
- The Pre and Post-Hospitalization Medical Expenses Cover claim per Basic Benefit 3.2.4 (Pre and Post-Hospitalization Medical Expenses) shall be processed only after the Hospitalization claim has been admitted under Basic Benefit 3.2.1 (In-patient Hospitalization).

6.1.6 Claim Assessment

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

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

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

Claim Assessment for fixed benefits:

We will pay fixed benefit amounts as specified in the Schedule in accordance with the terms of this

Policy. We are not liable to make any reimbursements of Medical Expenses or pay any other amounts not expressly specified in the Policy.

6.1.7 Claims Investigation

We shall make the payment of admissible claim (as per terms and conditions of the Policy) OR communicate Our rejection/non admissibility of claim under the Policy within 15 days. For detailed turn-around time, please visit https://www.acko.com/gi/customer-service/turn-around-time/.
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, Operations and Allied Matters of Insurers) Regulations, 2024 read along with Master Circular on Protection of Policyholders' Interests, 2024**"

Pre and Post-Hospitalization Medical Expenses Cover claims

The Insured Person should submit the Post-Hospitalization Medical Expenses claim documents at his/her own expense within 15 days of completion of the Post-Hospitalization period of cover.

We shall receive Pre and Post- Hospitalization Medical Expenses Cover claim documents either along with papers for Basic Benefit 3.1.1 (In-patient Hospitalization) or separately and process the same based on merit of the claim derived on the basis of the documents received.

6.1.8 Settlement and Repudiation of a claim

As an insurance, We shall settle the claim within 15 days in accordance with the provisions of the "IRDAI (Insurance Products) Regulations, 2024 along with the Master Circular on Health Insurance Business", as amended from time to time.

In the case of delay in the payment of a claim We shall be liable to pay interest from the date of receipt of the last necessary document to the date of payment of claim at a rate 2% above the bank rate.
However, where the circumstances of a claim warrant an investigation in Our opinion, We shall initiate and complete such investigation at the earliest, in any case not later than 15 days. In such cases, We shall settle the claim within 15 days. In such cases, if there is a delay beyond stipulated 15 days We shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of the intimation to the date of payment of claim.

6.1.9 Representation against Rejection

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

6.1.10 Claim Payment Terms

We shall have no liability to make payment of a claim under the Policy in respect of an Insured Person once the applicable Sum Insured for that Insured Person is exhausted.
All claims will be payable in India and in Indian rupees.
The Sum Insured opted under the Policy shall be reduced by the amount payable / paid under the Policy terms and conditions and any covers applicable under the Policy and only the balance shall be available as the Sum Insured for the unexpired Coverage Period or Policy Year, as the case may be.
If the Insured Person suffers a relapse within 45 days from the date of discharge from the Hospital for which a claim has been made, then such relapse shall be deemed to be part of the same claim and all the limits for "Any one illness" under this Policy shall be applied as if they were under a single claim.
For Cashless claims, the payment shall be made to the Network Provider whose discharge would be complete and final.
For Reimbursement claims, the payment shall be made to the Insured Person. In the unfortunate event of the Insured Person's death, We will pay the Nominee (as named in the Schedule) and in case of no Nominee, to the legal heir who holds a succession certificate or

indemnity bond to that effect, whichever is available and whose discharge shall be treated as full and

final discharge of Our liability under the Policy.

6.2 Grievance Redressal

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

Complaints will be acknowledged within 24 hours of receipt. A final resolution will be provided within 14 days from receipt of the complaint 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 or you wish to pursue other avenues for redressal of grievances, You may also approach Insurance Regulatory and Development Authority of India (IRDAI) through the Bima Bharosa Portal - https://bimabharosa.irdai.gov.in/ or at their toll free no. 1800 4254 732 / 155255 or through email on complaints@irdai.gov.in.

Insurance Ombudsman for Redressal, whose details are given below: General Manager Consumer Affairs Department- Grievance Redressal Cell Website: https://cioins.co.in/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:

Jurisdiction	Ombudsman Office Address & Contact Details
Gujarat, Dadra & Nagar Haveli, Daman and Diu	**Ahmedabad** Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD- 380001 oio.ahmedabad@cioins.co.in 079 - 25501201/02
Karnataka	**Bengaluru** Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru- 560078 oio.bengaluru@cioins.co.in 080 - 26652048 / 26652049
Madhya Pradesh, Chhattisgarh	**Bhopal** 1st floor, "Jeevan Shikha", 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Arera Hills Bhopal- 462011 oio.bhopal@cioins.co.in 0755 - 2769201 / 2769202 / 2769203
Odisha	**Bhubaneswar** 62, Forest park, Bhubaneswar- 751009 oio.bhubaneswar@cioins.co.in 0674 - 2596461/ 2596455/ 2596429/ 2596003
Punjab, Haryana (excl Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh	**Chandigarh** Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh- 160017 oio.chandigarh@cioins.co.in 0172-2706468
Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry)	**Chennai** Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI- 600018. oio.chennai@cioins.co.in 044 - 24333668 / 24333678
Delhi & following Distts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh	**Delhi** 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi-110002 oio.delhi@cioins.co.in 011 - 46013992/ 23213504/ 23232481
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	**Guwahati** Jeevan Nivesh, 5th Floor, Near Pan Bazar, S.S. Road, Guwahati- 781001(Assam) oio.guwahati@cioins.co.in

	0361 - 2632204 / 2602205 / 2631307
Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry	**Hyderabad** 6-2-46, 1st floor, "Moin Court", Lane Opp. Hyundai Showroom, A. C. Guards, Lakdi-Ka-Pool, Hyderabad- 500004. oio.hyderabad@cioins.co.in 040 - 23312122 / 23376991 / 23376599 / 23328709 / 23325325
Rajasthan	**Jaipur** Jeevan Nidhi- II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur-302005. oio.jaipur@cioins.co.in 0141- 2740363
Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry	**Kochi** 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M. G. Road, Kochi- 682011. oio.ernakulam@cioins.co.in 0484 – 2358759
West Bengal, Sikkim, Andaman & Nicobar Islands	**Kolkata** Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, Kolkata- 700072 oio.kolkata@cioins.co.in 033 - 22124339 / 22124341
Distts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar	**Lucknow** 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow- 226001. oio.lucknow@cioins.co.in 0522 - 4002082 / 3500613
Metropolitan Region excl wards in Mumbai – i.e M/E, M/W, N , S and T covered under Office of Insurance Ombudsman Thane and excluding areas of Navi Mumbai	**Mumbai** 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai- 400054 oio.mumbai@cioins.co.in 022 - 69038800/27/29/31/32/33
State of Uttarakhand and the following Distts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur	**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
Bihar, Jharkhand	**Patna** 2nd Floor, Lalit Bhawan, Bailey Road, Patna- 800001. oio.patna@cioins.co.in 0612-2547068
State of Goa and State of Maharashtra excl areas of Navi Mumbai, Thane distt, Palghar Distt, Raigad distt & Mumbai Metropolitan Region	**Pune** Jeevan Darshan Bldg., 3rd Floor, C.T.S. Nos. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune- 411030. oio.pune@cioins.co.in 020-24471175
Area of Navi Mumbai, Thane Distt, Raigad Distt, Palghar Distt and wards of Mumbai, M/East, M/West, N, S and T."	**Thane** 2nd Floor, Jeevan Chintamani Building, Vasant rao 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.

Annexure 1: List of non-payable expenses

Sr. No.	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES

Sr. No.	Item
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE TABLETS
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]

Sr. No.	Item
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY
69	ADMINISTRATIVE CHARGES
70	REGISTRATION FEES
71	BIO – MEDICAL WASTE CHARGES
72	HOUSE KEEPING CHARGES

Annexure 2: Definitions of listed complications for Surrogacy and Oocyte cover

Coverage applicable for listed conditions for Surrogate Mother:		
Sr No	**Complications of delivery**	**Definition**
1	Perineal Tears During Childbirth	Tears that occur in the perineum (the area between the vaginal opening and the anus) during vaginal delivery. These tears vary in severity, from minor (first-degree) to severe (fourth-degree) tears that extend through the vaginal walls and into the rectal tissues.
2	Postpartum Haemorrhage	Excessive bleeding following childbirth. It is generally classified as early (within 24 hours after delivery) or late (after 24 hours and up to 12 weeks postpartum). This condition requires prompt medical attention to prevent severe blood loss and complications.
3	Episiotomy Complications	Problems arising from an episiotomy, a surgical cut made in the perineum to facilitate delivery. Complications can include infection, increased pain, delayed healing, or more extensive tearing.
4	Postpartum Endometritis	An infection of the endometrium (the lining of the uterus) occurring after childbirth. It typically presents with fever, uterine tenderness, and abnormal discharge. It is treated with antibiotics.
5	Postpartum Depression/Psychosis	Mood disorders that affect women after childbirth. Postpartum depression includes feelings of sadness, anxiety, and exhaustion that interfere with daily functioning. Postpartum psychosis is a severe mental health condition that may involve hallucinations, delusions, and extreme agitation and requires immediate psychiatric intervention.
6	Anaesthesia Complications	Problems arising from the use of anaesthesia during childbirth. These can include allergic reactions, breathing difficulties, or complications related to the anaesthesia's effects on other bodily systems.
7	Infection or Sepsis	Infections can occur in various areas after childbirth, leading to sepsis, a severe, body-wide response to infection that can cause organ failure and is life-threatening. Symptoms include fever, rapid heart rate, and confusion.
8	Stroke	A sudden disruption of blood flow to the brain, leading to potential brain damage. It can occur postpartum due to increased risk factors such as high blood pressure or preeclampsia.
9	Amniotic Fluid Embolism	A rare but serious condition where amniotic fluid enters the maternal bloodstream, leading to an allergic-like reaction. It can cause severe respiratory distress, cardiovascular collapse, and bleeding.
10	Postpartum Preeclampsia	A continuation or recurrence of preeclampsia (high blood pressure and damage to organs) after delivery. It can lead to high blood pressure, organ dysfunction, and other complications.

11	Pulmonary Edema	Fluid accumulation in the lungs that can occur postpartum, particularly in women with preeclampsia or heart conditions. It leads to difficulty breathing and requires medical treatment.
12	HELLP Syndrome	A severe form of preeclampsia characterized by haemolysis (destruction of red blood cells), elevated liver enzymes, and low platelet count. It can cause liver damage, bleeding issues, and is a medical emergency.
13	Heart-Related Complications	Includes various cardiovascular issues that may arise postpartum, such as arrhythmias, heart failure, or exacerbation of pre-existing heart conditions.
14	Peripartum (Postpartum) Cardiomyopathy	A form of heart failure that occurs during the last month of pregnancy or up to five months after delivery. It is characterized by the weakening of the heart muscle, leading to decreased heart function.
15	Thrombotic Pulmonary Embolism (DVT)	A blockage in the pulmonary arteries usually caused by blood clots that travel from the deep veins of the legs (deep vein thrombosis). It can be a serious condition requiring immediate treatment.
16	Postpartum Respiratory Failure	A condition where the respiratory system fails to provide adequate oxygen or remove carbon dioxide from the blood, which can be caused by various factors including infections or severe complications.
17	Postpartum Peritonitis	An inflammation of the peritoneum (the lining of the abdominal cavity) following childbirth, often due to infection. It can cause severe abdominal pain and require surgical intervention.

Coverage applicable for listed conditions for Oocyte Donor:

Sr No	Complications of Oocyte retrieval	Definition
1	Infection or sepsis	Infection is the invasion and multiplication of pathogenic microorganisms (such as bacteria, viruses, fungi, or parasites) in the body, which can lead to local or systemic inflammation and tissue damage.
2	Bleeding	Some bleeding from the vaginal area or from the ovaries might occur due to ovarian drill/spill from oocyte donor
3	Ovarian Hyperstimulation Syndrome (OHSS)	A complication typically associated with fertility treatments where the ovaries become excessively swollen and painful. It can cause abdominal pain, bloating, and fluid retention.
4	Injury to Surrounding Structures Due to Procedure	Risk of damage to surrounding organs, such as the bladder, bowel, or blood vessels, during the retrieval process
5	Anaesthesia complications	Anaesthesia complications refer to adverse effects or problems that can arise as a result of administering anaesthesia during medical or surgical procedures. These complications can vary based on the type of anaesthesia used (local, regional, or general) and the patient's individual health factors.