

ACKO HEALTH III PROSPECTUS

1. Introduction

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

Acko General Insurance provides the following benefits to its customers:

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

2. Policy Information

Eligibility Criteria

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

2.1. Policy Period

This policy can be purchased for a period of 1 year / 2 years / 3 years.

2.2. Sum Insured

Sum Insured options 3 Lakhs, 5 Lakhs, 10 Lakhs, 15 Lakhs, 25 Lakhs, 50 Lakhs, 1 Crore, 1.5 Crores, 2.5 Crores, 5 Crores, 10 Crores, Unlimited.

2.3. Premium Payment Option

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

Frequency of payment: For 1 Year Policy- Monthly / Quarterly / Half Yearly / Single payment; For 2 Years or 3 Years Policy- Single payment

3. Benefits

3.1. Basic Benefits

Below are all available benefits under ACKO Health III. Only those mentioned in your Schedule apply to you.

3.1.1 In-patient Hospitalization – Part of Base SI

Covers medical expenses for hospitalization exceeding 24 hours including:

- Hospital room rent (includes associated medical expenses like RMO, nursing & monitoring)
- ICU/CCU/HDU charges
- Operation room charges (if any surgery done)
- Treating doctor/medical practitioner fees
- Medicines prescribed and used in treatment during the course of hospitalization by the treating medical practitioner.
- Diagnostic tests directly related to the current hospitalization during the course of hospitalization

- Associated medical expenditures (IV fluids, blood transfusion, surgical appliances used, consumables, enteral feedings)
- Cost of prosthetics/surgical devices/medical appliances **if implanted internally** during surgery, e.g. stent (Note: External Prosthesis are not covered).

3.1.2 Room Rent /ICU – Part of Base SI

We cover room rent and ICU charges for the room category as specified in the schedule.

3.1.3 Day Care Treatment – Part of Base SI

If any insured under this policy undergoes Day Care Treatment (including AYUSH treatment) in a Hospital/Nursing Home/Day Care Centre, we cover the expenses. OPD treatments are out of scope of coverage.

- List of day care procedures is hosted on our website at https://acko-cms.ackoassets.com/Acko_Day_Care_List_2d5b412dbf.pdf.

3.1.4 Pre and Post Hospitalization Medical Expenses – Part of Base SI

We cover relevant medical expenses (consultations, investigations, diagnostics, medicines) incurred:

- In the pre-hospitalization period up to number of days specified in the schedule, and
- In the post-hospitalization period up to number of days specified in the schedule, only if the related hospitalization/day care claim is admissible.

3.1.5 Road Ambulance Limit – Part of Base SI

If an insured needs emergency transport to a Hospital/Day Care Centre by ambulance or public transport, we cover the reasonable cost of such transportation up to the limit specified in the schedule.

Payable only if:

- Transport was medically necessary for emergency care to reach the facility
- We admit the claim for in-patient (3.1.1) or day care (3.1.3).

3.1.6 Domestic Emergency Evacuation Limit (India)- Part of base SI

If there is a medical emergency and adequate facilities are not available locally, we cover emergency evacuation to the nearest facility which is able to provide adequate care up to the limit specified in the schedule.

Key conditions:

- Attending a Medical Practitioner must certify in writing that evacuation is medically necessary to prevent immediate and significant effects of illness/injury.
- Pre-authorization is required by calling our call center, unless it is not reasonably possible; then seek authorization immediately after evacuation.
- We will consider illness/injury nature, condition, ability to travel, airport availability, weather, and distance, while reviewing the request.
- If the condition requires accompaniment of a qualified Medical Practitioner during transport, we treat it as emergency evacuation.
- Transport modes may include medically equipped specialty aircraft, commercial airline, train, ambulance, or air ambulance.
- Territory: within India only.

3.1.7 Domiciliary Treatment (Domiciliary Hospitalization)- Part of base SI

We cover costs of such domiciliary hospitalization if anyone insured takes treatment at home (instead of a hospital) due to:

- Inability to be moved, OR
- Non-availability of hospital beds.

Conditions:

- Must continue for at least 3 consecutive days.
 - If \geq 3 days → covered from day 1

- If <3 days → not payable
- The treating Medical Practitioner must confirm in writing that domiciliary hospitalization was medically necessary.
- Payable on reimbursement basis only.

3.1.8 Organ Donor Expenses- Part of base SI

If anyone insured requires organ transplant, we cover the organ donor's in-patient hospitalization expenses for harvesting the organ within the inpatient Sum insured of the insured.

Payable only if all the following conditions are met:

- We admit the insured person's claim under In-patient Hospitalization (3.1.1) related to the same illness/injury.
- Donation complies with Transplantation of Human Organs Act, 1994 (and amendments) and other applicable laws.
- The organ is for use by the insured person and transplant is advised in writing by the treating Medical Practitioner.

Not covered:

- Donor's pre/post-hospitalization expenses
- Donor screening costs
- Organ acquisition costs
- Transport/preservation costs of the organ
- Experimental/investigational transplants

3.1.9 Second Opinion- Part of base SI

If an insured under this policy seeks a second opinion for alternate evaluation of diagnosis or treatment, we cover expenses.

Your choice: You decide whether to obtain and act on the second opinion.

Payable only if:

- Consultation is on an OPD basis, AND
- The first opinion advises hospitalization, surgery or day care treatment.

3.1.10 AYUSH Treatment (In-patient only)- Part of base SI

We indemnify in-patient medical expenses for AYUSH treatment if anyone insured undergoes medically necessary treatment at an AYUSH Hospital/healthcare facility for:

- Ayurveda
- Yoga & Naturopathy
- Unani
- Siddha
- Homeopathy

Please find the list of standard treatment guidelines & treatment covered namayush.gov.in/content/standard-treatment-guidelines.

3.1.11 Modern Treatment- Part of base SI

If anyone insured undergoes in-patient or day care treatment for the following procedures, we indemnify medical expenses related to the procedures:

- Uterine Artery Embolization and HIFU
- Balloon Sinuplasty
- Deep Brain Stimulation
- Oral chemotherapy
- Immunotherapy (Monoclonal Antibody via IV injection)
- Intravitreal injections
- Robotic surgeries
- Stereotactic radiosurgeries

- Bronchial Thermoplasty
- Vaporisation of prostate (Green laser / Holmium laser)
- IONM (Intra-Operative Neuro Monitoring) when used with surgery warranting it
- Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for hematological conditions

3.2. Basic Benefit Options

The benefits specified in this section are available as optional benefits in addition to the base coverage. Only those benefits selected by the insured and explicitly mentioned in the Policy Schedule shall be applicable.

3.2.1 Waiver of Non-payable Medical Expenses

We cover the non-payable expenses which are hosted on our website (https://acko-cms.ackoassets.com/List_of_Non_Payable_Medical_Expenses_bf94e7b012.pdf), only if:

- Expenses are medically necessary, AND
- We admit the claim for in-patient (3.1.1) or day care (3.1.3) or domiciliary treatment (3.1.7). Expenses paid are part of the base SI

3.2.2 Reduction in Specific Illness Waiting Period - Comprehensive

We remove waiting periods listed in 4.1.2

Rules:

- Only at the inception of first policy or member addition.
- Once opted for, this benefit cannot be excluded in the subsequent year.

3.2.3 Reduction in Specific Illness Waiting Period – Essential

We remove waiting periods listed in 4.1.2 **except** cataract and arthropathies (excluding infectious aetiology) for insured above age 50.

Rules:

- Only at the inception of first policy or member addition.
- Once opted for, this benefit cannot be excluded in the subsequent year.

3.2.4 Preventive Health Check-up - Additional benefit and not part of base SI

For insured persons aged **above 18**, we facilitate and provide tests as per Schedule:

- CBC, ESR, HbA1C
- Serum Creatinine, Cholesterol, HDL, Triglycerides
- Routine Urine Analysis
- SGOT, SGPT, GGT
- Uric Acid

How it's provided:

- Arranged and paid at our Network Providers/Empaneled Service Providers only.
- If we are not able to provide a network provider for the tests, then we may reimburse at our discretion up to ₹900 only on submission of report + invoice/payment proof.
- Tests beyond the list mentioned above are not payable and shall be deducted from claim payout. If breakup is not available, then proportionate deduction will be done in case if package billing is done.

3.2.5 Inflation Protect Sum Insured

We provide an additional Sum Insured next year as per Schedule.

Key rules:

- Only if policy is active/renewed next year.
- Cannot exceed Base Sum Insured.
- If Base Sum Insured is reduced: calculated on revised Base Sum Insured.

- If Base Sum Insured is increased: calculated on Base Sum Insured of the last completed Policy Year.
- Applicable annually subject to continuation.
- If you switch from an Individual policy to a Floater policy, we will carry forward the lowest bonus amount among all insured persons.
- If you split a Floater policy into multiple Individual policies, the bonus will be divided proportionately based on the Sum Insured chosen for each new policy.
- Making a claim does not reduce or stop the bonus from accumulating.
- Can be used for all covers specified in Schedule as applicable for base Sum Insured.

3.2.6 Initial 30 Days Waiting Period Waiver

We waive the initial 30-day waiting period.

Rules:

- Since the inception of the first policy or member addition.
- Once opted for, this benefit cannot be excluded in the subsequent year.

3.2.7 Worldwide In-Patient Hospitalization- Part of base SI

If opted, this benefit extends your **in-patient hospitalization cover outside India**.

Conditions:

- You must inform us within **48 hours of admission**
- Must be advised in writing by the treating Medical Practitioner
- Payment will be converted into INR based on RBI exchange rate on date of payment.

3.2.8 Cumulative Bonus

We provide an additional Sum Insured in renewal year as per Schedule.

Key rules:

- Only if policy is active/renewed next year.
- Fixed percentage of Base SI added every renewal
- Capped at maximum limit specified in Schedule.
- If Base Sum Insured is reduced: calculated on revised Base Sum Insured.
- If Base Sum Insured is increased: calculated on Base Sum Insured of the last completed Policy Year.
- Applicable annually subject to continuation.
- If you switch from an Individual policy to a Floater policy, we will carry forward the lowest bonus amount among all insured persons.
- If you split a Floater policy into multiple Individual policies, the bonus will be divided proportionately based on the Sum Insured chosen for each new policy.
- Making a claim does not reduce or stop the bonus from accumulating.
- Can be used for all covers specified in Schedule as applicable for base Sum Insured.

3.2.9 No Claim bonus Sum Insured

We will provide an additional Sum Insured in renewal year if no claim made in the previous year as per Schedule.

Key rules:

- Only if policy and this cover is active/renewed next year.
- Fixed percentage of Base SI added every renewal.
- No Inpatient hospitalization or day care claim in previous year.
- Cannot exceed Base Sum Insured.
- If Base Sum Insured is reduced: calculated on revised Base Sum Insured.
- If Base Sum Insured is increased: calculated on Base Sum Insured of the last completed Policy Year.
- Applicable annually subject to continuation.

- If you switch from an Individual policy to a Floater policy, we will carry forward the lowest bonus amount among all insured persons.
- If you split a Floater policy into multiple Individual policies, the bonus will be divided proportionately based on the Sum Insured chosen for each new policy.
- Can be used for all covers specified in Schedule as applicable for base Sum Insured.

3.2.10 No Claim Discount

We provide an additional discount in premium in renewal year if no claim made in the previous year as per Schedule.

Key rules:

- Only if policy is active/renewed next year.
- Fixed discount percentage of total premium as mentioned in the schedule.
- No Inpatient hospitalization or day care claim in previous year.
- Not applicable to newly added members.

3.2.11 Restore Sum Insured

If you exhaust your total Sum Insured in a Policy Year, we **automatically refill (restore) it**.

How It Works:

Restoration happens only:

- Not applicable for the first claim in the Policy Year.
- Available for related/unrelated illnesses as specified in Schedule.
- In individual plans it works per person; in floater plans it works for the whole family.

Key Rules

- Available on Individual or floater basis depending on plan sum insured opted.
- Not carried forward if unused.
- Can restore multiple times if specified as unlimited.

3.2.12 First Notification of Claim

If opted, insured must notify us within 48 hours of hospitalization or before discharge (whichever earlier).

Benefit:

- Premium discount provided.

If notification is not done:

- Compulsory co-payment (as per Schedule) will apply on final admissible claim amount.

3.2.13 Preferred Providers Network

If opted, insured agrees to use only hospitals within our Preferred Provider Network for In-patient hospitalization or Day Care treatment.

Benefit:

- Premium discount provided.

If notification is not done:

- Compulsory co-payment (as per Schedule) will apply on final admissible claim amount.

3.2.14 Co-pay

If opted, insured agrees to bear a fixed percentage of every admissible claim.

Key Rules:

- Percentage as per Schedule.
- Applies on final admissible amount after assessment.
- Does not reduce Sum Insured.

- Premium discount applicable.

3.2.15 Floater Deductible

We indemnify medical expenses exceeding the Annual Aggregate Deductible during a Policy Year.

Key Rules:

- Deductible applies on cumulative admissible claims.
- We pay only the amount exceeding deductible.
- Deductible does not reduce Sum Insured.
- Deductible applicable for coverage applicable in Base SI.

3.2.16 Individual Deductible

We indemnify medical expenses from individual member in the policy exceeding the deductible during a Policy Year.

Key Rules:

- Deductible applies on cumulative admissible claims from individual member.
- We pay only the amount exceeding deductible.
- Deductible does not reduce Sum Insured.
- Deductible applicable for coverage applicable in Base SI.

3.2.17 All medically necessary hospitalization

If opted, we cover list of exclusions mentioned below.

Exclusion List:

- Venereal/sexually transmitted diseases except HIV.
- Hazardous/adventure sports as a professional (para-jumping, rock climbing, mountaineering, rafting, motor/horse racing, scuba, hand gliding, sky diving, deep-sea diving etc.)
- External congenital anomaly/defects
- Specific treatments:
 - analysis/adjustment of spinal subluxation; manipulation of skeletal structure
 - muscle stimulation except for fractures (excluding hairline) and dislocations of mandible/extremities.

3.3. Add on Benefits

The benefits listed in this section are available as add-ons with the basic benefits. Only those benefits under this section that are opted for by the insured and specifically mentioned in the policy schedule will be applicable. The amount specified in the Policy schedule against this benefit denotes the Company's maximum liability in respect to the benefit and shall not reduce the Sum Insured of the policy.

3.3.1 Doctor-on-call - Additional benefit and not part of base SI

Access to a doctor or general medical practitioner for medical consultation any time via online portal/chat/callback/voice/video.

Please note that we will make the consultation available either directly by us or facilitate it through our empaneled service provider.

Important rules:

- Consultation must be requested by the insured person.
- It is not a substitute for medical advice by treating physicians.
- We make no warranties on correctness; and assume no liability for errors/omissions.
- Doctor-on-call is a facilitation service; and is not for medico-legal use.

3.3.2 Value Added Services - Additional benefit and not part of base SI

If opted, we provide value added services as specified in policy schedule.

The below list of value added services is indicative and subject to service provider/availability:

1. e-Consultation
2. Wellness Coach
3. Lab Services (Home Collection)
4. Pharmacy (Home Delivery)
5. Vital/Physical Activity Monitoring Services
6. Reminder Notifications
7. Medical Wallet
8. Report Aggregation
9. Home Care Services
10. Ambulance Arrangement Services
11. Pick-up and Drop Services for Consultation
12. Prioritizing Appointments

Important

- Provide facilitation services through empaneled service provider.
- Cost will be borne by insured unless specified in schedule.
- ACKO acts only as facilitator.
- No liability for provider negligence.

4. What is not covered

We are not liable for payments caused by, arising out of, or attributable to exclusions below. Waiting periods apply individually for each insured person and claims shall be assessed accordingly.

4.1. Standard Exclusions

4.1.1. Pre-Existing Diseases (PED)

- Expenses for PED and direct complications are excluded until the waiting period expires (months) as specified in the Policy Schedule from inception of the first policy with us.
- If Sum Insured is enhanced, exclusion applies afresh to the extent of Sum Insured increase.
- In case of portability, If continuous coverage exists per IRDAI portability norms, waiting period reduces to the extent of prior coverage.
- Coverage after the waiting period is subject to PED being declared at the time of inception of policy and accepted by us without any specific exclusion or condition. Non-disclosure of a PED warrants policy cancellation with forfeiture of the premium and denial of any benefit under the policy.

4.1.2. Specified disease/procedure waiting period

- Listed conditions/surgeries/treatments excluded until waiting period expires (months) as per Schedule from inception.
- If SI is enhanced, it applies afresh to the extent of SI increase.
- If the condition falls under the PED waiting period too, the longer waiting period applies.
- Applies whether first diagnosed before or after inception (unless due to accident). Declaration/acceptance does not remove this waiting period unless the Schedule explicitly says so.
- In case of portability, If continuous coverage exists per IRDAI portability norms, waiting period reduces to the extent of prior coverage.

List of specified diseases/procedures (as per policy):

- **Eyes:** Cataract, Glaucoma, disorders of lens, disorders of retina
- **Stone:** Pancreatitis and stones in biliary and urinary system
- **Genitourinary:** Abnormal utero-vaginal bleeding, female genital prolapse, endometriosis/adenomyosis, fibroids, PCOD, dilation & curettage or hysterectomy conditions, any surgery of genitourinary system unless necessitated by malignancy
- **Cysts/Tumor:** All benign or in situ neoplasms/tumors, cyst, sinus, polyp, nodules, swelling, mass or lump
- Hyperplasia of prostate, hydrocele, varicocele, spermatocele
- **Rectal:** Hemorrhoids, fissure/fistula/abscess of anal/rectal region, pilonidal sinus, rectal prolapse

- **Hernia:** Hernia of all sites
- **Arthritis:** Osteoarthritis, systemic connective tissue disorders, dorsopathies, spondylopathies, inflammatory polyarthritis, arthrosis incl. rheumatoid arthritis, gout, intervertebral disc disorders, joint replacement
- **Kidney:** Chronic kidney disease and failure
- Varicose veins of lower extremities
- **ENT:** Middle ear & mastoid disease incl. otitis media, cholesteatoma, tympanic membrane perforation, tonsils & adenoids, nasal septum, nasal sinuses/polyp
- Internal congenital anomaly
- **Gastrointestinal:** Gastritis, GERD, ulcer, erosion, varices of upper GI tract
- Ligament, tendon & meniscal tear
- Neurodegenerative disorders: Parkinson's, Alzheimer's, dementia etc.
- Any other conditions mentioned in Schedule under this head

4.1.3. 30-day waiting period

- Expenses for treatment of any illness within 30 days from first policy commencement excluded, except accidents.
- Not applicable if insured has continuous coverage >12 months.
- Applies to enhanced SI portion if SI increased later.

4.1.4. Investigation & Evaluation

- Admissions primarily for diagnostics/evaluation are excluded.
- Diagnostics not related/incidental to current diagnosis and treatment are excluded.

4.1.5. Rest cure, rehabilitation, respite care

- Admissions primarily for enforced bed rest and not active treatment. This also Includes:
- Custodial care at home/nursing facility for ADLs
- Terminal illness services addressing physical/social/emotional/spiritual needs

4.1.6. Obesity/weight control

Surgical obesity treatment excluded unless ALL conditions are met:

- surgery advised by doctor
- supported by clinical protocols
- member age ≥ 18
- BMI ≥ 40 OR BMI ≥ 35 with severe co-morbidities after failure of less invasive methods:
 - obesity-related cardiomyopathy
 - coronary heart disease
 - severe sleep apnea
 - uncontrolled type 2 diabetes

4.1.7. Change-of-gender treatments

Excluded.

4.1.8. Cosmetic/plastic surgery

Excluded unless reconstruction after accident/burn/cancer or medically necessary to remove direct/immediate health risk, certified by attending Medical Practitioner.

4.1.9. Breach of law

Excluded if treatment arises from breach of law with criminal intent.

4.1.10. Excluded Providers

Treatment at providers excluded by the insurer (disclosed on [website](#)/notified) not admissible.

- Exception: life-threatening/accident → expenses up to stabilization limited to SI payable, not complete claim. Insured should be shifted to another facility which is not excluded after stabilization for the rest of the claim to be payable.

4.1.11.

Treatments at health hydros, nature cure clinics, spas or similar establishments; or private beds registered as nursing homes attached to such establishments; or admissions arranged wholly/partly for domestic reasons.

4.1.12.

Dietary supplements and OTC substances (vitamins/minerals/organic substances) unless prescribed as part of hospitalization/day care.

4.1.13. Refractive error

Correction of eyesight due to refractive error < 7.5 diopters excluded.

4.1.14. Unproven treatments

Unproven treatments/services/supplies lacking significant medical documentation or not approved for medical use as per prevailing protocols excluded.

4.1.15. Sterility & infertility

Expenses related to sterility and infertility. This includes:

- contraception/sterilization
- assisted reproduction (AI/IVF/ZIFT/GIFT/ICSI)
- gestational surrogacy
- reversal of sterilization

4.1.16. Maternity

Excluded:

- childbirth (incl. complicated delivery/C-section) and pre/post hospitalization
- miscarriage (unless due to accident)
- lawful medical termination of pregnancy

Exception: ectopic pregnancy

4.2. Specific Exclusions

4.2.1. Permanent Exclusions

- Treatment outside India; if Worldwide In-Patient Hospitalization cover is available in your policy schedule, this exclusion shall be waived off.
- OPD consultations/diagnostics/pharmacy/procedure, unless covered by OPD add-on cover opted or as part of Pre/Post hospitalization of admitted in-patient/day care claim.
- self-harm/attempted suicide
- dental treatment (unless due to accident and forming part of in-patient or pre/post)
- circumcision unless necessitated by illness/injury
- prosthetics/devices not implanted internally by surgery
- war/war-like situations, rebellion, revolution, terrorism, nuclear/biological/chemical emissions
- hormonal therapies (growth hormone, HRT, hormonal medication)
- substance abuse/addictions, withdrawal and de-addiction, oral/oropharynx/respiratory cancer excluded in tobacco user
- sleep disorders (sleep apnea, snoring etc.)
- Venereal/sexually transmitted diseases except HIV.
- Hazardous/adventure sports as a professional (para-jumping, rock climbing, mountaineering, rafting, motor/horse racing, scuba, hand gliding, sky diving, deep-sea diving etc.)
- External congenital anomaly/defects
- Specific treatments:
 - analysis/adjustment of spinal subluxation; manipulation of skeletal structure
 - muscle stimulation except for fractures (excluding hairline) and dislocations of mandible/extremities.

4.2.2. Named Ailment Waiting Period / Exclusion

Any named ailment waiting/exclusion stated in the schedule for an insured supersedes standard waiting periods.

4.2.3. Medical Practitioner Exclusion

A medical practitioner sharing residence and/or a family member is not treated as a Medical Practitioner for coverage

5. What You Need to Know

5.1. Sum Insured basis (Individual vs Floater)

- **Individual:** Sum Insured applies separately to each insured person.
- **Floater:** One Sum Insured is shared by all insured persons in the floater unit.

5.2. What counts as “Total Sum Insured” for Basic Benefits

For a Policy Year, our maximum cumulative liability for a Basic Benefit equals:

- Base Sum Insured
- Inflation Protect Sum Insured (if opted)
- No Claim Bonus Sum Insured (if opted)
- Cumulative Bonus (if opted)

5.3. Consequential losses not covered

We are **not** liable for losses arising from opinions/errors/omissions of Network Providers or Empaneled Service Providers. Your recourse is against those providers.

5.4. Reasonable and Customary Charges

We pay only charges that are reasonable and customary (we may determine this with reference to our benchmark tariff or usage database for the area, provider type and medical condition/procedure).

5.5. Medically Necessary Treatment

Hospitalization must be medically necessary and prescribed in writing by a Medical Practitioner.

5.6. Grace period (renewal + instalments)

- For instalment premium:
 - 15 days grace for monthly instalments
 - 30 days grace for quarterly/half-yearly/annual instalments
 - Coverage continues during the grace period for installment payments.
 - If not paid within the grace period → policy cancelled.
- For renewal:
 - 30 days grace period to renew and maintain continuity.
 - No liability for claims arising out of any insured event that occurred during the grace period.

5.7. Premium Payment in Instalments

- No interest: We will not charge interest if you miss the due date.
- Claim situation: If a claim arises, all future installments would become immediately due and may be deducted from the claim payment if the amount is adequate to cover the pending premiums.

5.8. Revision of Policy Terms / Premium Rates

Upon completion of regulatory requirements, we may revise the policy terms, including premium rates. If we do, we will inform you at least 3 months before the change takes effect.

5.9. Endorsements (Changes in Policy)

This Policy is the complete insurance contract. Any change will be issued by us through a written or electronic endorsement and communicated to you.

Change of policyholder:

- Normally allowed only at renewal, and the new policyholder must be a legal heir/immediate family member, subject to our acceptance and any additional premium. The renewal will be treated as continuous (no break).

- During the policy period, change is allowed only if the current policyholder dies or moves out of India.

Refund:

- In case of member deletion or changes in coverage that result in refund of premium, premium shall be refunded provided no claim is paid/outstanding for the insured/dependents.

5.10. Nomination

At the time you buy the policy, you must nominate a person to receive claim payments if you (the policyholder) die.

- Any change in nomination must be given to us in writing and will apply only after we record it through an endorsement.
- For reimbursement claims, we pay the policyholder. If the policyholder has expired, we pay the nominee named in the Schedule/endorsement. If there is no valid nominee, we pay the legal heirs/legal representatives as certified by appropriate authorities.

Any such payment will be treated as a full and final discharge of our liability under this Policy.

5.11. Geography

Zone-wise classification (for premium)

For premium calculation, we classify cities of residence into two zones. For family floater policies, one zone applies to all members under the policy.

- Zone A: Delhi/NCR; Mumbai (including Navi Mumbai, Thane, Kalyan); Kolkata (including Howrah); and certain non-preferred pin codes based on company/industry experience as mentioned in https://acko-cms.ackoassets.com/Annexure_Zone_Classification_d9845ed62d.pdf.
- Zone B: Rest of India.

5.12. Underwriting loadings & conditions

- Based on health status and declarations at enrollment stage, we may apply a risk loading on premium (excluding taxes/levies) or impose special conditions like waiting periods or exclusions. These can apply from the first policy start date and continue on renewals. We will not apply loadings based on individual claim experience.
- We may apply a specific sublimit on a medical condition/ailment depending on the past history and declarations, or additional waiting periods on pre-existing diseases, or exclusions as part of the special condition as mentioned in the Policy Schedule.
- We will communicate any loading/special condition through a counter-offer letter. You must confirm consent and pay any extra premium (if applicable) within 7 working days from the counter-offer letter date.
- If you don't accept or respond within 7 working days, we will cancel the proposal and refund the premium paid. We will not issue the policy without your consent.

5.13. Complete Discharge

If we pay any amount for a claim under this Policy—whether to the Insured Person, their nominee/legal representative, the Hospital/Nursing Home, or an assignee—that payment will be treated as a full and final settlement for that amount for that particular claim.

5.14. Renewal

Policy is ordinarily renewable except on grounds such as established fraud, non-disclosure, misrepresentation (and subject to product not being withdrawn). Renewal cannot be denied because you made a claim. Fresh underwriting generally only if coverage is enhanced (underwriting only on enhanced portion).

5.15. Free look period

- 30 days from date of receipt of policy to review the terms and conditions of the Policy, and to return the same if not acceptable (only at inception, not renewals/porting).
- If no claim is made during free look, the insured is entitled to:
 1. A refund of the premium paid, minus medical examination expenses and stamp duty; and
 2. If risk has commenced, a deduction for proportionate risk premium for the covered period; or

3. If only part of the coverage has commenced, a proportionate premium based on the coverage during that period.

5.16. Portability

You may port to other insurers as per IRDAI guidelines:

- Waiting periods (PED, specified disease, 30-day) reduced by number of continuous preceding years of coverage.
- Portability benefit limited to previous sum insured + accrued bonus (as part of base SI); not on additional increased SI.
- Application must reach us at least 30 days before, but not earlier than 60 days from renewal due date
- We can consider proposal for portability even if the Policyholder has approached within 15 days from the renewal date of the existing policy, but there shall not be any break in policy

5.17. Migration

You may migrate within ACKO to other health products as per IRDAI guidelines:

- Waiting periods reduced by continuous preceding years of coverage.
- Migration benefit limited to previous sum insured + accrued bonus (as part of base SI); not on increased SI.

5.18. Moratorium period

After 60 continuous months (5 continuous years) of coverage (including portability and migration):

- No policy/claim contestable on grounds of non-disclosure/misrepresentation, except established fraud.
- For enhanced SI, 60 months applies from enhancement date for enhanced portion.
- Still subject to limits/sub-limits/co-pay/deductibles.

5.19. Cancellation

- You may request to cancel your policy with 7 days' written notice → refund of proportionate premium for unexpired period be made.
No refund if any claim admitted/lodged or any benefit availed.
- Company may cancel on established Non-disclosure/Misrepresentation/fraud with 15 days' notice → no refund.

5.20. Automatic changes/termination triggers

Coverage for an insured person terminates on:

- Insured person's death (others continue to the end of period). 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.
- Exhaustion of sum insured for the policy year (but policy can renew as per terms)
Other termination rules apply basis misrepresentation/fraud/non-disclosure; non-cooperation; non-payment within grace period etc.

5.21. Multiple policies

If you have multiple indemnity policies:

- You can choose which insurer/policy to claim under (within chosen policy limits).
- You can claim disallowed amounts from other policy/policies if allowed here (subject to terms and conditions).
- If the claim exceeds SI under one policy, you can choose insurers for the balance.
- You cannot be paid more than hospitalization costs.

5.22. Fraud / non-disclosure

- Fraudulent claims or false statements → policy be void ab-initio; premiums forfeited; benefits forfeited; any amounts paid thus far must be repaid back to Acko.
- Definition of fraud includes false suggestions, active concealment, acts to deceive, or legally-declared fraud.

- Insurer may not repudiate for fraud if beneficiary proves misstatement was true to best knowledge and no intent to suppress; burden rules as per policy.

6. What You Need to Do

6.1. Your disclosure duty

You must disclose all material facts asked in the proposal and any relevant connected documents. You must also disclose accurately before endorsement/variation/reinstatement as warranted.

6.2. Keep records

Maintain accurate medical records and provide information required for claim settlement within specified time.

6.3. Notice & communication

All policy-related communication should be in writing, sent to insurer address/electronic modes as per Schedule.

7. What you need to do in case of claim

You can submit claims as Cashless (network provider) or Reimbursement (you pay first, we reimburse if the claim is admissible).

7.1. Claim registration / intimation

- Notify via app/email/call center or through TPA at hospital.
- You may need to provide:
 - Policy card- Policy/UHID number (you can access from the app)
 - Photo ID and address proof
 - Name of the insured, nature of illness/injury, hospital/doctor, admission date, other details

7.2. Cashless claims (Network provider)

Cashless means we pay the network hospital directly to the extent authorized on your behalf. You would be able to access the as on date network hospital list at our [website](#) or App, which would help you decide the nearest facility to use for cashless utilization.

You still pay to hospital:

- non-covered expenses
- expenses above SI/limits as applicable

Pre-authorization

- **Planned admission:** Request approval at least 2 days before admission
- **Emergency admission:** Within 48 hours of admission
- The hospital sends a pre-auth form with medical details.
- We review eligibility and issue authorization letters if admissible. Authorization letter clearly specifies the approval boundaries e.g. Diagnosis, Procedure, Hospital, Insured, Date of admission, Approved Amount and Deductions, etc, and in case if any change fresh request should be raised.
- If additional details are required, approval is issued only after receipt of such details

Enhancement to pre-authorized amount

If treatment cost exceeds the approved amount thus far while all other approval boundaries remain valid:

- The hospital requests enhancement with reasons/justification.
- Approval depends on policy eligibility and available limits

Discharge

- Hospital submits final bill and discharge summary to us asking approval for balanced enhanced amount
- You pay the balance and non-admissible expenses directly to the hospital

If cashless is denied (due to insufficient Sum Insured or missing information), you may pay the bill and claim reimbursement which would be decided basis admissibility.

7.3. Reimbursement claims

Submit documents within **15 days** from discharge through Acko app. You would be able to use both network and non-network providers for reimbursement facility, however we encourage you to use network provider and cashless facility for better convenience.

Non-network providers are those which are neither part of the network nor excluded providers and fulfill the definition of hospital as per policy terms and conditions.

Hospitalization reimbursement documents:

- Claim form (filled & signed)- Digital submission through App doesn't necessitate this
- Original discharge/day care/transfer summary
- Original death summary (if death case)
- Hospital registration certificate/number for non-network provider (or facility certificate, wherever required e.g. new hospital for which no past claim experience exist with Acko and we aren't able to independently verify)
- Original hospital bill with detailed break-up
- Original payment receipts (receipt nos., stamp/seal)
- Original pharmacy/medicine receipts
- Implant invoice/stickers/barcode copies
- Lab/test reports with prescription + diagnostic invoices/receipts
- First consultation paper related to past medical ailment (origin/duration/progress)
- Previous consultation papers/history (for current illness)
- FIR/MLC (in case of accident)
- Alcohol/intoxication history at incident (certified by first treating doctor) for accident cases
- Medical prescriptions and advice for admission/procedure
- Indoor case papers/nursing sheet (where required)
- Ambulance invoices and details in prescribed format
- Vaccination invoice and payment receipt, if part of hospitalization
- Bank details for NEFT (not mandatory if verified details available with Acko)
- Aadhaar/other Govt photo ID + PAN (not mandatory if already linked)
- KYC resubmission if changes as per AML guidelines
- Legal heir/succession certificate where applicable
- Doctor certificate for domiciliary treatment circumstances (domiciliary claims)
- Any other documents required to assess admissibility

Additional documents for specific benefits:

- Domestic emergency evacuation: medical evacuation needs and fit to fly certificate
- Second opinion: treating doctor recommendation for in-patient + records + second opinion paper + payment receipt

7.4. Scrutiny, assessment, investigation & timelines

- We check claim forms and documents; deficiencies of information/documents which cannot be procured by us directly from the provider (if any) are communicated.
- If deficiencies aren't met in 10 working days of first intimation, we remind every 10 days (max 3 reminders).
- We may settle claim after deducting parts where deficiency remains, at our discretion, if the claim is otherwise valid. If a claim is not admissible, we shall communicate in writing with reasons.

Pre/post hospitalization claims:

- Pre/Post-hospitalisation claim documents must be submitted within 15 days after completion of post-hospitalisation cover period.
- Pre/post claims processed after a related hospitalization claim is admitted.

Penal interest:

- In case of delay beyond 15 days from date of receipt of necessary documents, we pay interest from date of intimation to date of payment at rate 2% above RBI bank rate.

Representation against rejection:

- You may represent within 15 days of receiving the decision of rejection.

Claim payment terms:

- No liability once applicable SI/limits is exhausted.
- Payable only in India and INR.
- SI/limit reduces by amount paid/payable.
- Relapse within 45 days of discharge counts as the same claim (Any one illness).
- Cashless payment to network provider; reimbursement to insured; if insured dies, to nominee or legal heir as per rules.

8. What you need to do in case of Grievance Redressal

8.1. Queries

- Helpline: 1800 266 2256**
- Email: hello@acko.com**

8.2. Grievances

- Toll-free: 1800 210 4990 (10 AM – 7 PM, all days)
- Email: grievance@acko.com.
Acknowledgement within 24 hours; final resolution within 14 days.

8.3. Senior Citizens Support

- Phone: 080-62370023
- Email: grievance.healthseniorcitizen@acko.com
Acknowledgement within 24 hours; final resolution within 14 days. You can also email grievance@acko.com.

8.4. Escalation – Chief Grievance Officer

- Email: gro@acko.com
- Address: ACKO General Insurance Limited, 36/5 Hustlehub One East, Somasandrapalya, 27th Main Road, Sector 2, HSR Layout, Bengaluru, Karnataka – 560102
CGO responds within 7 days.

8.5. If still unresolved

- Approach **IRDAI** through Bima Bharosa portal (<https://bimabharosa.irdai.gov.in/>) or toll-free numbers **1800 4254 732 / 155255** or email complaints@irdai.gov.in
- For more details, visit <https://irdai.gov.in/igms1>
- You may also approach the **Insurance Ombudsman (Jurisdiction Based)** for grievance redressal (details available at <https://cioins.co.in/Ombudsman>). and are also listed on our website

9. Schedule of Benefits

Sum Insured mentioned below for

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

Benefit Type	Product Features	Coverage Details
	Base Sum Insured	3Lakhs / 5Lakhs / 10Lakhs / 15Lakhs / 20Lakhs / 25Lakhs / 50Lakhs / 1cr / 1.5cr / 2.5cr / 5cr / 10cr / Unlimited
	In-Patient Hospitalization	Covered up to Sum Insured
	Room Rent/ ICU	Room Category: General Ward / Shared Room / Single AC Room / Up to SI
	Day Care Treatment	Covered up to Sum Insured
		Pre: 30, 60, 90 Days

Basic Benefit	Pre or Post Hospitalization Medical Expenses	Post: 60, 90, 120, 180 Days
	Road Ambulance Limit	1k / 2k / 3k / 4k / 5k / 6k / 7k / 8k / 9k / 10k / Up to Sum Insured
	Domestic Emergency Evacuation Limit	1Lakh / 2Lakhs / 3 Lakhs / 4 Lakhs / 5 Lakhs / 6 Lakhs / 7 Lakhs / 8 Lakhs / 9 Lakhs / 10 Lakhs / Up to Sum Insured
	Domiciliary Treatment Cover	Covered up to Sum Insured
	Organ Donor Expenses	Covered up to Sum Insured
	Second Opinion	Covered
	Ayush Treatment	Covered up to Sum Insured
	Modern Treatment	Covered up to Sum Insured
Basic Benefit Options	Worldwide In-patient Hospitalization	Yes / No
	Restore Sum Insured	Once for unrelated/ Once for related and unrelated/Unlimited times for unrelated/ Unlimited times for related and unrelated
	Cumulative Bonus	1X/2X/3x/4X/5X/10X
	No Claim Bonus Sum Insured	5% / 10% / 15% / 20% / 25% / 50%
	No Claim Discount	5% / 10% / 15%/ 20%
	First Notification of Claim (FNOC)	Compulsory Co-pay if no FNOC: 10% / 15% / 20%
	Preferred Providers Network (PPN)	Compulsory Co-pay If no PPN: 10% / 15% /20%
	Co-pay	Compulsory Co-pay: 5% / 10% / 15%/ 20% / 25% / 30%/40%/50%
	Individual Deductible	In the range: 0.5 Lakhs to 25Lakhs
	Floater Deductible	In the range: 0.5 Lakhs to 25Lakhs
	Waiver of Non-payable Medical Expenses	Yes / No
	All Medically Necessary Hospitalization	Yes / No
	Reduction in Specific Illness Waiting Period-Comprehensive	1 Year/ 2 Year
	Reduction in Specific Illness Waiting Period-Essential	1 Year/ 2 Year
	Preventive Health Check-up	Once in a year/ Once in two years/ Once in three years
Inflation Protect Sum Insured	5%/10%/15%/20%/25%/50%	
Initial 30 days waiting period waiver	Yes/No	
Add-on Benefits	Doctor on Call	No. of consultations allowed: 1/ 2/3/4/5/6/7/8/9/10/ Unlimited
	Value Added Services	1. e-Consultation
		2. Wellness Coach
		3. Lab Services (Home Collection)
		4. Pharmacy (Home Delivery)
		5. Vital/Physical Activity Monitoring Services
		6. Reminder Notifications
		7. Medical Wallet
		8. Report Aggregation
		9. Home Care Services
		10. Ambulance Arrangement Services
		11. Pick-up and Drop Services for Consultation
		12. Prioritizing Appointments

Disclaimer: All covers and plans may not be available at all times. Availability is subject to eligibility and other conditions. Please refer to the product purchase journey to view the plans and covers applicable to you at the time of purchase.

Annexure 2: Benefit Illustration
Illustration 1:

Age of the Members Insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on floater basis with overall Sum Insured (Only one sum insured is available for the entire family)			
	Premium (₹)	Sum Insured (₹)	Premium (₹)	Discount (if any)	Premium after discount (₹)	Sum Insured (₹)	Premium or consolidated premium for all members of the family (₹)	Floater discount (if any)	Premium after discount (₹)	Sum Insured (₹)
0 – 15	4,485	3,00,000	4,485	0	4,485	3,00,000	1,45,634	0	1,45,634	3,00,000
21 - 25	6,680	3,00,000	6,680	0	6,680	3,00,000				
31 - 35	6,680	3,00,000	6,680	0	6,680	3,00,000				
36 – 40	8,200	3,00,000	8,200	0	8,200	3,00,000				
51 – 55	18,168	3,00,000	18,168	0	18,168	3,00,000				
56 – 60	23,895	3,00,000	23,895	0	23,895	3,00,000				
61 – 65	32,856	3,00,000	32,856	0	32,856	3,00,000				
66 – 70	44,670	3,00,000	44,670	0	44,670	3,00,000				
Total Premium for all members of the family is ₹ 1,45,634 when each member is covered separately. Sum Insured available for each member separately is ₹ 3,00,000			Total Premium for all members of the family is ₹ 1,45,634 when they are covered under a single policy. Sum Insured available for each family member is ₹ 3,00,000				Total Premium when policy is opted on a floater basis is ₹ 1,45,634. Sum Insured ₹ 3,00,000 is available for the entire family			

Coverage assumptions:

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

Relationship	Age Band
Self	36 – 40
Spouse	31 – 35
Father	56 – 60
Father-in-Law	66 – 70
Mother	51 – 55
Mother-in-Law	61 – 65
Son	0 -15
Daughter	21 – 25

4. Coverage is standard for Zone 2.

Illustration 2:

Age of the Members Insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on floater basis with overall Sum Insured (Only one sum insured is available for the entire family)			
	Premium (₹)	Sum Insured (₹)	Premium (₹)	Discount (if any)	Premium after discount (₹)	Sum Insured (₹)	Premium or consolidated premium for all members of the family (₹)	Floater discount (if any)	Premium after discount (₹)	Sum Insured (₹)
16 – 20	8,015	3,00,000	8,015	0	8,015	3,00,000	2,07,320	0	2,07,320	3,00,000
21 – 25	8,015	3,00,000	8,015	0	8,015	3,00,000				
41 – 45	12,030	3,00,000	12,030	0	12,030	3,00,000				
46 – 50	16,117	3,00,000	16,117	0	16,117	3,00,000				
71 – 75	69,509	3,00,000	69,509	0	69,509	3,00,000				
76 – 80	93,633	3,00,000	93,633	0	93,633	3,00,000				
Total Premium for all members of the family is ₹ 2,07,320 when each member is covered separately. Sum Insured available for each member separately is ₹ 3,00,000			Total Premium for all members of the family is ₹ 2,07,320 when they are covered under a single policy. Sum Insured available for each family member is ₹ 3,00,000				Total Premium when policy is opted on a floater basis is ₹ 2,07,320 . Sum Insured ₹ 3,00,000 is available for the entire family			

Coverage assumptions:

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

Relationship	Age Band
Self	46 – 50
Spouse	41 – 45
Son	16 – 20
Daughter	21 – 25
Mother	71 – 75
Father	76 – 80

4. Coverage is standard for Zone 1.

Annexure 3: Plans Offered

Particulars	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6
Basic Benefits						
In-Patient Hospitalization	✓	✓	✓	✓	✓	✓
Room Rent/ ICU	Up to SI	Up to SI	Up to SI	Up to SI	Up to SI	Up to SI
Day Care Treatment	✓	✓	✓	✓	✓	✓
Pre and Post Hospitalization Medical Expenses	60/180 days	60/180 days	60/180 days	60/180 days	60/180 days	60/180 days
Road Ambulance Limit	Up to SI	Up to SI	Up to SI	Up to SI	Up to SI	Up to SI
Domestic Emergency Evacuation Limit	Up to SI	Up to SI	Up to SI	Up to SI	Up to SI	Up to SI
Domiciliary Treatment	✓	✓	✓	✓	✓	✓
Organ Donor Expenses	✓	✓	✓	✓	✓	✓
Second Opinion	✓	✓	✓	✓	✓	✓
Basic benefit options						
Waiver of non-payable medical expenses	✓	✓	✓	✓	✓	✓
Reduction in Specific Illness Waiting Period - Essential	2 years		2 years	2 years		2 years
Preventive Health Check up	Once a year	Once a year		Once a year	Once a year	
*Inflation Protect Sum Insured				10% of SI	10% of SI	
Initial 30 days waiting period waiver	✓		✓	✓		✓
Individual Deductible	✓	✓	✓			
Floater Deductible	Optional	Optional	Optional			✓
Add-on benefits						
Doctor on Call	Unlimited times	Unlimited times		Unlimited times	Unlimited times	

*Not applicable for Unlimited Sum Insured

Note: All the above plans may be available with Deductible options.

Disclaimer: All covers and plans may not be available at all times. Availability is subject to eligibility and other conditions. Please refer to the product purchase journey to view the plans and covers applicable to you at the time of purchase.