

Arogya Sanjeevani Policy - Acko General Insurance Limited

Prospectus

1. Eligibility Criteria

1. The minimum entry age is 18 years and maximum entry age restricted to 65 years.
2. Entry age for a dependent child is from 3 months to 25 years. Post this age, the child will be treated as an Adult in the Policy.
3. There is no maximum cover ceasing age.
4. 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.
5. This policy can be issued to an individual and/ or a family floater basis.
6. The Sum Insured for hospitalization cover may be taken on Individual or Floater basis for the family.
7. Relationship allowed in a policy: Self, spouse, son, daughter, father, mother, father-in-law, mother-in-law.

2. Policy Period

This policy will be issued for a period of 1 year. The Sum Insured & the benefits under the Policy will be applicable on Policy Year basis.

3. Sum Insured

Sum Insured options 1Lakh, 1.5Lakh, 2Lakh, 2.5Lakh, 3 Lakh, 3.5Lakh, 4Lakh, 4.5Lakh, 5Lakh

4. 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

The covers listed below are in-built Policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy.

5. Salient Benefits

a) Hospitalisation

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the policy schedule, for,

- i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000 /-, per day.
- ii. Intensive Care Unit (ICU)/ Intensive Cardiac Care Unit (ICCU) expenses up to 5% of sum insured subject to maximum of Rs. 10,000/- per day.

- iii. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor I surgeon or to the hospital
- iv. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

b) Other expenses

- i. Expenses incurred on treatment of cataract subject to the sub limits.
- ii. Dental treatment, necessitated due to disease or injury
- iii. Plastic surgery necessitated due to disease or injury.
- iv. All the day care treatments
- v. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- pre hospitalisation.

Note

- i. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment
- ii. In case of admission to a room/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ ICU /ICCU charges.

c) 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 limit of sum insured as specified in the policy schedule in any AYUSH Hospital.

d) Cataract Treatment

The Company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured or Rs.40,000/-, whichever is lower, per each eye in one policy year.

e) Pre-Hospitalization

The company shall indemnify pre-hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 30 days prior to the date of admissible hospitalization covered under the policy.

f) Post Hospitalization

The company shall indemnify post hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalization covered under the policy.

- g) 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. Intra vitreal injections
 - g. Robotic surgeries
 - h. Stereotactic radio surgeries
 - i. Bronchial Thermoplasty
 - j. Vaporisation of the prostate (Green laser treatment or holmium laser treatment)
 - k. IONM - (Intra Operative Neuro Monitoring)
 - l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

The expenses that are not covered in this policy are placed under List-I of Annexure-A. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-A respectively.

6. Waiting Period

The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

a) Pre-Existing Disease (Code- Excl01)

- a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.
 - i. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- b. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
- c. Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

b) First Thirty Days Waiting Period (Code- Excl03)

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

c) Specific Waiting Period (Code- Excl02)

- a. Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24/36 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.
- b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c. If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
- d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

i. 24 Months waiting period

- i. Benign ENT disorders
- ii. Tonsillectomy
- iii. Adenoidectomy
- iv. Mastoidectomy
- v. Tympanoplasty
- vi. Hysterectomy
- vii. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
- viii. Benign prostate hypertrophy
- ix. Cataract and age related eye ailments
- x. Gastric/ Duodenal Ulcer
- xi. Gout and Rheumatism
- xii. Hernia of all types
- xiii. Hydrocele
- xiv. Non Infective Arthritis

- xv. Piles, Fissures and Fistula in anus
- xvi. Pilonidal sinus, Sinusitis and related disorders
- xvii. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
- xviii. Calculi in urinary system Gall Bladder and Bile duct, excluding malignancy.
- xix. Varicose Veins and Varicose Ulcers
- xx. Internal Congenital Anomalies

ii. 48 Months waiting period

- i. Treatment for joint replacement unless arising from accident
- ii. Age-related Osteoarthritis & Osteoporosis

7. Exclusions

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

a) Investigation & Evaluation (Code- Excl04)

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

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

- a. Expenses related to any admission primarily for enforced bed rest and not for receiving treatment This also includes:
 - i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
 - ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

c) Obesity/ Weight Control (Code- Excl06)

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

- 1. Surgery to be conducted is upon the advice of the Doctor
- 2. The surgery/ Procedure conducted should be supported by clinical protocols
- 3. The member has to be 18 years of age or older and
- 4. Body Mass Index (BMI);
 - a) greater than or equal to 40 or
 - b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
 - i. Obesity-related cardiomyopathy

- ii. Coronary heart disease
- iii. Severe Sleep Apnea
- iv. Uncontrolled Type2 Diabetes

d) Change-of-Gender treatments: (Code- Excl07)

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

e) Cosmetic or plastic Surgery: (Code- Excl08)

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

f) Hazardous or Adventure sports: (Code- Excl09)

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

g) Breach of law: (Code- Excl10)

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

h) Excluded Providers: (Code-Excl11)

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

- i) Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof: (Code-Excl12)
- j) Treatments received in health spas, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. (Code-Excl13)
- k) Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure (Code-Excl14)

l) Refractive Error:(Code- Exc115)

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

m) Unproven Treatments:(Code- Excl16)

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

n) Sterility and Infertility: (Code- Excl17)

Expenses related to sterility and infertility. This includes:

1. Any type of sterilization
2. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as I V F, ZI FT, GIFT, ICSI
3. Gestational Surrogacy
4. Reversal of sterilization

o) Maternity Expenses (Code - Excl18):

- i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
 - ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.
- p) War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.
- q) Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss , claim or expense. For the purpose of this exclusion:
- i. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
 - ii. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
 - iii. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.
- r) Any expenses incurred on Domiciliary Hospitalization and OPD treatment
- s) Treatment taken outside the geographical limits of India

- t) In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes.

8. Loading

We may apply a risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance). The Maximum risk loading applicable for an individual will not exceed above 100% per diagnosis/ medical condition and an overall risk loading of over 150% per person. These loadings are applied from Commencement Date of the Policy including subsequent Renewal(s) with us or on the receipt of the request for increase in sum insured (for the increased sum insured).

The application of loading does not mean that the Illness/ condition, for which loading has been applied, would be covered from inception. Any waiting periods of Pre-existing Conditions, First 30 Days waiting period and 24 months waiting period for specified illnesses or specifically mentioned on the Schedule shall be applied on the Illness/condition, as applicable.

9. Terms of renewal:

Life Long Renewal - This Policy is ordinarily Renewable for life except on grounds of fraud, or misrepresentation. We are NOT under any obligation to: (1) Send Renewal notice or reminders, or (2) Renew it on same terms or premium as the expiring Policy.

Grace Period - All applications for Renewal must be received by Us before the end of the Policy Period. Grace Period of 30 days for renewing the policy is provided under this Policy. Any disease/ condition contracted in the break in period will not be covered and will be treated as Pre-existing Disease.

Change in Premium - Any change in benefits or premium (other than due to change in Age) will be done with the approval of the Insurance Regulatory and Development Authority of India and will be intimated atleast 3 months in advance.

In the event of this policy being withdrawn in future, We will intimate you about the same 3 months prior to expiry of the Policy. You will have the option to migrate to similar indemnity health insurance policy available with Us at the time of Renewal with all the accrued continuity benefits such as waiver of waiting periods provided that the Policy has been maintained without a break as per Portability guidelines.

We will not apply any additional loading on your policy premium at Renewal based on claim experience.

Change in Sum Insured - Sum insured can be changed (increased/ decreased) only at the time of renewal or at any time, subject to underwriting by the Company. For any increase in SI, the waiting period shall start afresh only for the enhanced portion of the sum insured.

10. Claims Procedure and Settlement

a) Procedure for cashless claims:

- i. Treatment may be taken in a network provider and is subject to pre authorization by the Company or its authorized TPA.

- ii. Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization.
- iii. The Company/ TPA upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter to the hospital after verification.

At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.

- iv. The Company / TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.
- v. In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company/ TPA for reimbursement.

b) Procedure for reimbursement claims:

For reimbursement of claims the insured person may submit the necessary documents to TPA (if applicable)/Company within the prescribed time limit as specified hereunder.

SI No	Type of Claim	Prescribed Time limit
1.	Reimbursement of hospitalization, day care and pre hospitalization expenses	Within thirty days of date of discharge from hospital
2.	Reimbursement of post hospitalization expenses	Within fifteen days from completion of post hospitalization treatment

c) Notification of Claim

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

- i. Within 24hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.
- ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

d) Documents to be submitted:

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

- i. Duly Completed claim form
- ii. Photo Identity proof of the patient
- iii. Medical practitioner's prescription advising admission
- iv. Original bills with itemized break-up
- v. Payment receipts
- vi. Discharge summary including complete medical history of the patient along with other details.
- vii. Investigation/ Diagnostic test reports etc. supported by the prescription from attending medical practitioner
- viii. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases)

- ix. Sticker/Invoice of the Implants, wherever applicable.
- x. MLR (Medico Legal Report copy if carried out and FIR (First information report) if registered, where ever applicable.
- xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque
- xii. KYC (Identity proof with Address) of the proposer, where claim liability is above ₹ 1 Lakh as per AML Guidelines
- xiii. Legal heir/succession certificate, wherever applicable
- xiv. Any other relevant document required by Company/TPA for assessment of the claim.

e) Co-payment

Each and every claim under the Policy shall be subject to a Co-payment of 5% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co-payment.

f) Claim Settlement (provision for Penal Interest)

- i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
- ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate
- iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle the claim within 45 days from the date of receipt of last necessary document.
- iv. In case of delay beyond stipulated 45 days the company shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

g) Services Offered by TPA

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of pre-authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include

- i. Claim settlement and claim rejection;
- ii. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

h) Payment of Claim

All claims under the policy shall be payable in Indian currency only.

11. General Conditions:

▪ 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 you are not satisfied with any of the terms and conditions, you have the option to cancel your policy. This option is available in case of policies with a term of one year or more. If you have not made any claim during the Free Look Period, then you shall be entitled to:

1. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
2. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
3. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

▪ Cancellation (other than Free Look Period)

- a) You may terminate this Policy at any time by giving The Insured may cancel this Policy by giving 7 days' written notice, and in such an event, the Company shall
 - a. refund proportionate premium for unexpired policy period, if the term of policy upto one year and there is no claim (s) made during the policy period.
 - b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.

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.

- b) 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.

▪ Migration:

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per extant Guidelines related to Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, as per Guidelines on migration, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per below:

- i. The waiting periods specified in Section 6 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
- ii. Migration benefit will be offered to the extent of sum of previous sum insured and accrued bonus/multiplier benefit (as part of the base sum insured), migration benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Migration, kindly refer to www.acko.com/gi

▪ Portability

The Insured Person will have the option to port the Policy to other insurers as per extant Guidelines related to portability. If such person is presently covered and has been

continuously covered without any lapses under any health insurance plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

- i. The waiting periods specified in Section 6 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
- ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

▪ **Tax Benefit**

The premium amount paid under this policy qualifies for deduction as per the provisions of Section 80D of the Income Tax Act, 1961 and any amendments made thereto, from time to time.

▪ **Endorsements**

This Policy constitutes the complete contract of insurance. This Policy cannot be changed or varied by anyone (including an insurance agent or broker) except by the Company and any change We make will be evidenced by a written endorsement signed and stamped by Us.

▪ **Premium Payment in Instalment's**

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

- i. Grace Period would be given to pay the instalment premium due for the Policy.
- ii. During such grace period, Coverage will not be available from the instalment premium payment due date till the date of receipt of premium by Company.
- iii. The Benefits provided under - "Waiting Periods", "Specific Waiting Periods" Sections shall continue in the event of payment of premium within the stipulated grace Period.
- iv. No interest will be charged If the instalment premium is not paid on due date.
- v. In case of instalment premium due not received within the grace Period, the Policy will get cancelled.

▪ **Prohibition on Rebates:** Section 41 of the Insurance Act 1938 stipulates as follows:

- No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer.
- Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees."

▪ **Contact Us:** You can reach Us through any of the following methods:

Website	www.acko.com/gi
E-mail	hello@acko.com
Toll Free	1800 266 2256

For Grievance:

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

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

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

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

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

Email: gro@acko.com

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

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

Insurance Ombudsman for Redressal, whose details are given below:

General Manager Consumer Affairs Department- Grievance Redressal Cell

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

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

12. Schedule of Benefits

Name	Arogya Sanjeevani Policy- Acko General Insurance Limited
Product Type	Individual/ Floater
Category of Cover	Indemnity
Sum insured (₹) Lakhs	1, 1.5, 2, 2.5, 3, 3.5, 4, 4.5, 5 On Individual basis SI shall apply to each individual family Member On Floater basis SI shall apply to the entire family
Policy Period	1 year
Eligibility	Policy can be availed by persons between the age of 18 years and 65years, as Proposer. Proposer with higher age can obtain policy for family, without covering self. Policy can be availed for Self and the following family members legally wedded spouse. Parents and Parents- in -law. Dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals
Grace Period	For monthly payment of mode, a fixed period of 15 days is to be allowed as Grace Period and for all other modes of payment a fixed period of 30 days be allowed as grace period.

Hospitalization	Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible
Expenses	Time limit of 24 hrs. shall not apply when the treatment is undergone in a Day Care Centre.
Pre - Hospitalization	For 30 days prior to the date of hospitalization
Post Hospitalization	For 60 days from the date of discharge from the hospital
Sublimit for room /doctor's fee	1. Room Rent, Boarding, Nursing Expenses all-inclusive as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs .5000 /- per day. 2.Intensive Care Unit (ICU) charges / Intensive Cardiac Care Unit (ICCU) charges all-inclusive as provided by the Hospital / Nursing Home up to 5% of the sum insured subject to maximum of Rs. 1 0,000/-, per day
Cataract Treatment	Up to 25% of Sum insured or Rs.40,000/-, whichever is lower, per eye, under one policy year.
AYUSH	Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines shall be covered up to sum insured, during each Policy year as specified in the policy schedule.
Pre-Existing Disease	Only PEDs declared in the Proposal Form and accepted for coverage by the company shall be covered after a waiting period of 3 years
Cumulative bonus	Increase in the sum insured by 5% in respect of each claim free year subject to a maximum of 50% of SI. In the event of claim the cumulative bonus shall be reduced at the same rate.
Co Pay	5% co pay on all claims
Note: Policy Term and Conditions & Premium rates are subject to change with prior approval from IRDAI. Tax benefits are subject to changes in tax laws. Please consult your financial/tax advisor for more details.	

ANNEXURE: 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 (₹)
16 – 20	3,431	3,00,000	3,431	0	3,431	3,00,000				
21 - 25	3,431	3,00,000	3,431	0	3,431	3,00,000				
31 - 35	3,897	3,00,000	3,897	0	3,897	3,00,000				
36 – 40	3,897	3,00,000	3,897	0	3,897	3,00,000	39,528	12,116	27,412	3,00,000
51 – 55	6,694	3,00,000	6,694	0	6,694	3,00,000				
61 – 65	9,957	3,00,000	9,957	0	9,957	3,00,000				
Total Premium for all members of the family is ₹ 39,528 when each member is covered separately.			Total Premium for all members of the family is ₹ 39,528 when they are covered under a single policy.				Total Premium when policy is opted on a floater basis is ₹ 27,412.			
Sum Insured available for each member separately is ₹ 3,00,000			Sum Insured available for each family member is ₹ 3,00,000				Sum Insured ₹ 3,00,000 is available for the entire family			
56 – 60	8,219	3,00,000	8,219	0	8,219	3,00,000				

Coverage assumptions:

- The family of the proposer comprises spouse, one daughter and one son.
- Parents and mother-in-law are covered additionally
- Age band of family members:

Relationship	Age Band
Self	36 – 40
Spouse	31 – 35
Father	56 – 60
Mother	51 - 55
Mother-in-Law	61 – 65
Son	16 – 20
Daughter	21 – 25

- Coverage is standard

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	3,431	3,00,000	3,431	0	3,431	3,00,000	17,454	5,972	11,482	3,00,000
21 – 25	3,431	3,00,000	3,431	0	3,431	3,00,000				
41 - 45	4,491	3,00,000	4,491	0	4,491	3,00,000				
46 – 50	6,101	3,00,000	6,101	0	6,101	3,00,000				
Total Premium for all members of the family is ₹ 17,454 when each member is covered separately.			Total Premium for all members of the family is ₹ 17,454 when they are covered under a single policy.				Total Premium when policy is opted on a floater basis is ₹ 11,482.			
Sum Insured available for each member separately is ₹ 3,00,000			Sum Insured available for each family member is ₹ 3,00,000				Sum Insured ₹ 3,00,000 is available for the entire family			

Coverage assumptions:

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

Relationship	Age Band
Self	46 – 50
Spouse	41 – 45
Son	16 – 20
Daughter	21 – 25

- Coverage is standard.