Yuvaan Health Insurance Policy

Prospectus

1. Product – Key Features

Yuvaan Health Insurance Policy is an Indemnity-based health insurance product for you and your family that offers a wide cover at affordable cost. Our cashless hospitalisation network spans 14000+ hospitals pan India.

COVERAGE AT A GLANCE:

Base Cover
In-Patient Hospitalisation Expenses
All Day Care Treatments
Pre-Hospitalisation – 60 Days & Post Hospitalisation Expenses – 90 Days
Organ Donor Expenses
Road Ambulance Expenses
Modern Treatment Methods & Advancement in Technology
Home Care Treatment

Optional Covers
Waiver of Co-Payment
Daily Cash Allowance on Hospitalisation

2. Cover Type

The Policy provides cover on an Individual Sum Insured basis or Family Floater Sum Insured basis. A separate Sum Insured for each Insured Person is provided under Individual Sum Insured basis while under Family Floater Sum Insured basis, the Sum Insured is shared by the whole family of the Insured as specified in the Policy Schedule and Our total liability for the family cannot exceed the Sum Insured and applicable Cumulative Bonus, if any, in a Policy period. The cover type basis shall be as specified in the Policy Schedule.

3. Family

An adult person can take a policy for himself or his/her family consisting of all or either of:

i. Self, Spouse, and dependent children on Individual Sum Insured basis;
ii. Self, Spouse, and dependent children on Floater Sum Insured basis;

4. Eligibility

Eligibility based on age:

i. Adults: 18 years to 45 years.
ii. Dependent Children: 91 days to 17 years, provided either or both parents are covered concurrently. In case, where both the parents of the child(ren) are already deceased, the minor child(ren) can be covered by the guardian without covering himself/herself.
Children aged 18 years or above will continue to be covered along with parents till the age of 26 years, provided they are unmarried/unemployed and dependent.
The upper age limit will not apply to mentally challenged child(ren).

In the event of children becoming independent, employed, getting married, or attaining 26 years of age, a separate policy shall be taken on the expiry of the current policy for which continuity benefits will be provided.

Beyond 45 years, only renewals are allowed.

Midterm inclusion of family members is allowed at pro-rata premium only in case of:

i. Newly married spouse within 60 (sixty) days of marriage.
ii. New born baby, between the ages of 91 days to 180 days, born to mother, insured under the policy.
iii. An adopted child between the ages of 91 days to 18 years within 60 days of the date of adoption.

5. Policy Term & Payment Options

Policy Term - One Year. Lifelong Renewable ordinarily.

Available Payment Option – Annually.

6. Co-Payment

Geographical Zones

The country is divided into three geographical zones: **Zone A**, **Zone B**, **Zone C**. The Zones are based on the following districts:

Zone	Districts
A	All Districts in NCT of Delhi (incl. Shahdara), Faridabad, Palwal, Gurugram, Rohtak, Jhajjar, Ghaziabad, Gautam Buddh Nagar, Bulandshahr, Ahmedabad, Ahmedabad City, Gandhi Nagar, Vadodara, Surat, Mumbai, Mumbai Suburban, Thane, Raigad (MH), Palghar
B	Ahmed Nagar, Amritsar, Anand, Bengaluru, Bhopal, Chennai, Coimbatore, Dakshina Kannada, Ernakulam, Howrah, Hyderabad, Indore, Jaipur, Jalgaon, Jodhpur, Kanpur, Nagar, Kheda, Kolhapur, Kolkata, Kottayam, Krishna, Lucknow, Ludhiana, Nagpur, Nashik, North 24 Parganas, Pune, Rajkot, Ranga Reddy, Solapur, Thiruvananthapuram, Tiruvallur, Valsad, Visakhapatnam.
C	Rest of India

i. If the insured has paid the premium for Zone C, a co-payment of 15% will apply for each and every claim amount for treatment taken in any city of Zone A.
ii. If the insured has paid the premium for Zone B, a co-payment of 10% will apply for each and every claim amount for treatment taken in any city of Zone A.

7. Sum Insured

For a new policy, the following Sum Insured options are available:
Rs. 5 lakhs, 10 lakhs, 15 Lakhs, 20 Lakhs.

8. Coverage

A. Base Covers

The Policy provides base coverage as described below in this section provided that the expenses are incurred on the written Medical Advice of a Medical Practitioner/ Mental Health Professional (in case of Mental illness) and are incurred on Medically Necessary Treatment of the Insured Person.

1. In-patient Hospitalisation Expenses Cover

We will pay the Reasonable and Customary Charges for the following Medical Expenses taken during Hospitalisation provided that the admission date of the Hospitalisation due to Illness or Injury is within the Policy Period:

i. Room, Boarding and Nursing expenses (all inclusive) incurred as provided by the Hospital/Nursing Home up to the limits provided below:

Sum Insured	Limit (Rs.) per day
Up to Rs. 10 Lakhs	Rs. 3,000 per day or Shared Accommodation whichever is higher
Above Rs. 10 Lakhs	Rs. 5,000 per day or Shared Accommodation whichever is higher

These expenses will include nursing care, RMO charges, patient's diet charges, IV Fluids/Blood transfusion/injection administration charges and similar expenses.

ii. Charges for accommodation in Intensive Care Unit (ICU)/ Intensive Cardiac Care Unit (ICCU).
iii. The fees charged by the Medical Practitioner, Surgeon, Specialists, and anaesthetists treating the Insured Person;
iv. Operation Theatre charges,
v. Anaesthesia, Blood, Oxygen, Surgical Appliances and/ or Medical Appliances, medicines and drugs, Cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like pacemaker, orthopaedic implants, infra cardiac valve replacements, vascular stents, relevant laboratory/ diagnostic tests, X-Ray, dialysis, chemotherapy, radiotherapy, and such other associated expenses related to the treatment.
vi. All Day Care treatments as per the definition of Clause II.A.12 as per policy wording are covered.

1.1 Note:

i. PROPORTIONATE PAYMENT CLAUSE: In case of admission to a room other than mentioned in Clause III.A.1.i of policy wording, the reimbursement/payment of all associated medical expenses incurred at the Hospital shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent.
Proportionate Deductions shall not be applied in respect of those hospitals where differential billing is not followed or for those expenses where differential billing is not adopted based on the room category.

ii. No payment shall be made under *clause 8.A.1.iii* other than as part of the hospitalisation bill. However, the bills raised by Surgeon, Anaesthetist directly and not forming part of the hospital bill shall be paid provided a pre-numbered bill/receipt is produced in support thereof, when such payment is made ONLY by cheque/credit card/debit card or digital/online transfer.

2. Pre-Hospitalisation and Post-Hospitalisation Expenses –

We will cover, on a reimbursement basis, the Insured Person's

i. Pre-hospitalisation Medical Expenses incurred due to an Illness or Injury during the period up to 60 days prior to hospitalisation; and
ii. Post- hospitalisation Medical Expenses incurred due to an Illness or Injury during the period up to 90 days after the discharge from the hospital.
iii. Home Care Treatment also will be deemed as hospitalisation for this cover

Conditions:

a. The Pre-hospitalisation and Post-hospitalisation Medical Expenses are related to the same Illness or Injury.

3. Organ Donor Expenses Cover

We will cover the In-patient Hospitalization Medical Expenses incurred for an organ donor's treatment during the Policy Period for the harvesting of the organ donated provided that:

i. The donation conforms to The Transplantation of Human Organs Act 1994 and the organ is for the use of the Insured Person;

ii. We have admitted a claim towards In-patient Hospitalisation under *Clause 8.A.1* and it is related to the same condition; organ donated is for the use of the Insured Person as certified in writing by a Medical Practitioner;

iii. We will not cover:

a. Pre-hospitalization Medical Expenses or Post-hospitalisation Medical Expenses of the organ donor;
b. Screening expenses of the organ donor;
c. Costs directly or indirectly associated with the acquisition of the donor's organ;
d. Transplant of any organ/tissue where the transplant is experimental or investigational;
e. Expenses related to organ transportation or preservation;
f. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

4. Modern Treatment Methods & Advancement in Technologies:

In case of an admissible claim under *Clause 8.A.1*, expenses incurred on the following procedures (wherever medically indicated) shall be covered:

i. Uterine Artery Embolization and HIFU (High Intensity focused ultrasound)
ii. Balloon Sinuplasty
iii. Deep Brain Stimulation
iv. Oral Chemotherapy
v. Immunotherapy - Monoclonal Antibody to be given as an injection
vi. Intra-vitreal injections
vii. Robotic Surgeries
viii. Stereotactic Radio Surgeries
ix. Bronchial Thermoplasty
x. Vaporization of the Prostrate (Green Laser Treatment or Holmium Laser Treatment)
xi. IONM - (Intra Operative Neuro Monitoring)
xii. Stem Cell Therapy; Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

5. Road Ambulance Cover

We will cover the costs incurred on transportation of the Insured Person by road Ambulance to a Hospital for treatment in an Emergency following an Illness or Injury which occurs during the Policy Period. The necessity of use of an Ambulance must be certified by the treating Medical Practitioner and becomes payable if a claim has been admitted under Clause 8.A.1 and the expenses are related to the same Illness or Injury.

We will also cover the costs incurred on transportation of the Insured Person by road Ambulance in the following circumstances under this cover, if:

a. it is medically required to transfer the Insured Person to another Hospital or diagnostic Centre during Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital;
b. it is medically required to transfer the Insured Person to another Hospital during Hospitalization due to lack of super specialty treatment in the existing Hospital.

6. Home Care Treatment

We will indemnify the Reasonable and Customary Charges for Home Care Treatment for any epidemic/ pandemic subject to a maximum of 10% of the Sum Insured or Rs. 30,000 per person per policy period, whichever is lower.

Home Care Treatment means Treatment availed by the Insured Person at home for any epidemic/ pandemic on positive diagnosis of the epidemic/ pandemic in a Government-authorised diagnostic Centre, which in normal course would require care and treatment at a hospital but is actually taken at home maximum up to 14 days per incident provided that:

i. The Medical Practitioner advises the Insured Person to undergo treatment at home.
ii. There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day throughout the duration of the home care treatment
iii. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.
iv. In case the insured intends to avail the services of non-network provider claim shall be subject to reimbursement, prior approval from the Insurer needs to be taken before availing such services.

In this benefit, the following shall be covered if prescribed by the treating Medical Practitioner and is related to treatment of epidemic/ pandemic,

a. Diagnostic tests undergone at home or at diagnostics centre
b. Medicines prescribed in writing
c. Consultation charges of the medical practitioner
d. Nursing charges related to medical staff
e. Medical procedures limited to parenteral administration of medicines
f. Cost of Pulse oximeter, Nebulizer and Rental cost for Oxygen cylinder, oxygen concentrator, if needed.

B. Optional Cover:

1. Waiver of Co-payment

If this cover is opted, then the applicable Co-Payment as per Clause V.B.5 of policy wording will be waived off, subject to payment of premium for Zone A.

2. Daily Cash Allowance on Hospitalisation

We will pay Daily Cash Allowance to the Insured Person for every continuous and completed period of 24 hours of Hospitalisation, subject to the hospitalisation claim being admissible under the policy, as per the table below:

Limit (Rs.) per day
Rs. 500 per day subject to a maximum of Rs. 5,000 per policy period
Rs. 1,000 per day subject to a maximum of Rs. 10,000 per policy period
Rs. 2,000 per day subject to a maximum of Rs. 20,000 per policy period

The aggregate of Daily Cash Allowance during the policy period shall not exceed 'per policy period limits' as mentioned in the table above.

Daily Cash Allowance will not be payable for Day Care Treatment claims. Deductible equivalent to Daily Cash Allowance for the first 24 hours Hospitalisation will be levied on each Hospitalisation during the Policy Period.

Payment under this benefit does not reduce the Total Sum Insured.

9. What Policy Does Not Cover

A. Waiting Periods

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

1. Pre-Existing Diseases (Code – Excl01)
   i. Expenses related to the treatment of a disclosed pre-existing disease (PED) and its direct complications shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first policy with us.
   ii. In case of enhancement of the Sum Insured, the exclusion shall apply afresh to the extent of the Sum Insured increase.
   iii. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Insurance Product) Regulations, then the waiting period for the same would be reduced to the extent of prior coverage.
   iv. Coverage under the policy after the expiry of 12 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

2. Specified Disease/Procedure Waiting Period (Code – Excl02)
   i. Expenses related to the treatment of the listed Conditions; surgeries/treatments shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
   ii. In case of enhancement of the sum insured the exclusion shall apply afresh to the extent of the sum insured increase.
   iii. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
   iv. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then the waiting period for the same would be reduced to the extent of prior coverage.
   v. List of specific diseases/procedures:
      a. Benign ENT disorders/ Acid peptic disease/ Benign skin disorders/cataract.
      b. Calculus (stone) Diseases of Gall Bladder including Cholecystectomy
      c. All types of Surgery for Hernia /Hydrocele
      d. Calculus of the Urinary system (Kidney Stone/Urinary Bladder/Ureteric Stone)
      e. Fissure / Fistula / Hemorrhoids/Pilonidal sinus/ varicose veins
      f. Gout/ Rheumatism/ Non infective arthritis
      g. Spinal diseases unless arising from accident
      h. Poly cystic ovarian disease/ Menorrhagia/ Fibromyoma/Hysterectomy
      i. Internal congenital anomaly
      j. All internal and external benign tumors, cysts, polyps of any kind, including benign breast lumps.
      k. Mental illness- Schizophrenia, Bipolar affective disorder, Depression, Obsessive compulsive disorder, Psychosis

3. 30-Day Waiting Period (Code – Excl03)
   i. 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.
   ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
   iii. The within-referred waiting period is made applicable to the enhanced sum insured in the event of granting a higher sum insured subsequently.

B. Standard Permanent Exclusions

The company shall not be liable to make any payment under this Policy in respect of any expenses incurred by You in connection with or in respect of:

4. Investigation & Evaluation (Code – Excl04)
   i. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
   ii. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

5. Rest Cure, Rehabilitation and Respite Care (Code – Excl05)

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, and moving around either by skilled nurses or assistants or non-skilled persons.
   ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

6. Obesity/Weight Control (Code – Excl06)

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

   i. Surgery to be conducted is upon the advice of the Doctor
   ii. The surgery/Procedure conducted should be supported by clinical protocols
   iii. The member has to be 18 years of age or older and
   iv. 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:
         b.1. Obesity-related cardiomyopathy
         b.2. Coronary heart disease
         b.3. Severe Sleep Apnea
         b.4. Uncontrolled Type2 Diabetes

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

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

8. Cosmetic or Plastic Surgery (Code – Excl08)

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

9. Hazardous or Adventure Sports (Code – Excl09)

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

10. Breach of Law (Code – Excl10)
    Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

11. Excluded Providers (Code – Excl11)
    Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed on 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. https://uiic.co.in/sites/default/files/Excluded_Providers_List.pdf

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

13. (Code – Excl13)
    Treatments received in health 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.

14. (Code – Excl14)
    Dietary supplements and substances that can be purchased without a prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of a hospitalisation claim or day care procedure.

15. Refractive Error (Code – Excl15)
    Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 diopters.

16. Unproven Treatments (Code – Excl16)
    Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

17. Sterility and Infertility (Code – Excl17)
    Expenses related to sterility and infertility. This includes:
    i. Any type of contraception, sterilization
    ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    iii. Gestational Surrogacy
    iv. Reversal of sterilization

18. Maternity (Code- Excl18)
    i Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy;
    ii Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

C. Specific Permanent Exclusions

1. All expenses caused by or arising from or attributable to foreign invasion, an act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing

duties in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military, or usurped power.

2. All Illnesses/expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or any nuclear waste from the combustion of nuclear fuel, nuclear/chemical/biological attack.
3. Any expenses incurred on Domiciliary Hospitalization.
4. Any expenses incurred on Out-patient treatment (OPD treatment). Procedures/treatments usually done in outpatient department are not payable under the policy even if admitted/converted as an in-patient in the hospital for more than 24 hours.
5. Any item(s) or treatment specified in 'List of Non-Medical Expenses under this Policy' as per clauses in Annexure – 1, unless specifically covered under the Policy.
6. Any treatment related to sleep disorder or sleep apnoea syndrome.
7. Artificial life maintenance including life support machine use, from the date of confirmation by the treating doctor that the patient is in a vegetative state.
8. Change of treatment from one system of medicine to another system unless recommended by the consultant/hospital under whom the treatment is taken.
9. Circumcision unless necessary for Treatment of an Illness or Injury not excluded hereunder or due to an Accident.
10. Congenital External Diseases or Defects or anomalies.
11. Cost of hearing aids; including optometric therapy.
12. Cost of routine medical examination and preventive health check-up.
13. Dental treatment or surgery of any kind unless necessitated by disease or accident and requiring hospitalisation.
14. Expenses in respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), Insured Person is not entitled to get the coverage for specified diseases.
15. Intentional self-inflicted Injury or attempted suicide.
16. Routine eye-examination expenses, cost of spectacles, contact lenses.
17. Stem cell implantation/Surgery/Therapy, harvesting, storage or any kind of treatment using stem cells except Hematopoietic stem cells for bone marrow transplant for haematological conditions; growth hormone therapy.
18. Treatments including Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy, chondrocyte or osteocyte implantation, procedures using platelet rich plasma, Trans Cutaneous Electric Nerve Stimulation; Use of oral immunomodulatory/ supplemental drugs.
19. Unless used intra-operatively, any expenses incurred on prosthesis, corrective devices; External and or durable Medical/ Non-medical equipment of any kind used for diagnosis and/or treatment and/or monitoring and/or maintenance and/or support including instruments used in treatment of sleep apnoea syndrome; Infusion pump, Oxygen concentrator, Ambulatory devices, sub cutaneous insulin pump and also any medical equipment, which are subsequently used at home. This is indicative. Please refer to clauses in Annexure-1 for the complete list of non-payable items.

20. Vaccinations or inoculations of any kind, except when required as part of hospitalization or a day care procedure for treatment following an animal bite.

10. Procedure for Taking a Policy

1. The duly completed and signed Proposal form giving details of all Insured persons along with Pre-Acceptance Health Check-up reports, if any, should be submitted to the nearest office of the Company.
2. The pre-acceptance health check-up reports, wherever required at Company's discretion have to be submitted at proposer's cost.

Notes

- The date of medical reports should not exceed 30 (thirty) days prior to the date of proposal.
- 50% of the cost of Pre-Acceptance Health check-up shall be reimbursed to the insured in case the proposal is accepted by the Company

11. Payment Of Premium

1. Applicable premium must be paid before the commencement of risk for this Policy to come into effect.
2. Premium payable – As per the Premium tables attached. The Premium can be paid online for renewals.
3. PAN details must be submitted by the insured. In case PAN is not available, Form 60 or Form 61 must be submitted.

12. Discounts, Loadings and Rewards

i *No Claim Rewards*

The Insured Person(s) shall be eligible for a No Claim Reward if no claim is reported under the expiring policy and the policy is renewed with Us without any break in policy. The No Claim Reward may either be a No Claim Discount (NCD), calculated as a percentage of the renewal premium, or a Cumulative Bonus (CB), calculated as a percentage of the expiring policy's Sum Insured. There are a maximum of 2 slabs of NCR, with each slab representing one claim-free year. In case no claim is reported, the Policyholder must choose one of the following options at the time of renewal. If no choice is explicitly made as per clause V.B.8.iii of policy wordings, the option selected in the expiring policy will be deemed chosen. If the option to choose an NCR is not exercised at the first renewal, the policyholder will automatically be entitled to the Cumulative Bonus.

a. No Claim Discount (NCD):

The Insured Person(s) shall receive a 10% discount on the renewal premium for the first slab, up to a maximum of 20%.

b. Cumulative Bonus (CB):

The Cumulative Bonus shall increase by 50% for the first slab, up to a maximum of 100% of the Sum Insured under the current policy year.

Notes on Cumulative Bonus (CB):

i. If the Insured Person(s) were covered under the expiring policy on an individual sum insured basis and had accumulated a CB, but renew on a floater sum insured basis, only the lowest CB slab among the insured persons will be carried forward in the renewed policy.

ii. If the Insured Person(s) covered under a floater policy with an accumulated CB choose to split the policy into two or more floater or individual policies upon renewal, the CB from the expiring policy will be apportioned among the renewed policies in proportion to their respective Sum Insured.
iii. If there is an enhancement of the Sum Insured at the time of renewal, the CB will be calculated on the Sum Insured from the last completed policy year.
iv. If the Sum Insured is reduced at the time of renewal, the CB will be reduced in the same proportion as the decrease in the Sum Insured in the current policy.

Notes on No Claim Rewards (NCR):

i. If a claim is reported in any particular year, the NCR accrued shall be reduced at the same rate at which it has accrued.
ii. Where the policy is on individual sum insured basis, the NCR shall be available to each insured person separately. If a claim is reported, the NCR will reduce by one slab as it was accrued for that person only.
iii. Where the policy is on floater sum insured basis, the NCR shall be available for the entire family. If a claim is reported from any insured person, the NCR will reduce by one slab as it was accrued for the entire family.
iv. If the policyholder opts to switch from the No Claim Discount (NCD) to the Cumulative Bonus (CB) or vice versa at the time of renewal, the premium and sum insured shall be suitably adjusted to ensure that the policyholder gets the benefit of either of the options only.
v. If a claim is reported in the expiring policy and notified to us after acceptance of the renewal premium, applicable No Claim Rewards will be adjusted accordingly.

ii *Family Discount*

In case of policies issued on Individual Sum Insured Basis, 5% family discount will be allowed if more than one person of a family is covered.

iii *Family Floater Discount*

If the policy is issued on Family Floater basis, a Family Floater Discount will be allowed based on the family composition.

iv *Direct Channel Discount*

A discount is applicable for fresh policies purchased online through the Company's website or directly from United India's office, without any agent or an intermediary.
For renewals, the discount shall be offered provided that both the renewing policy and expiring policy are without any agent or an intermediary.

v *Underwriting Loading for Pre-existing Conditions*

We may apply a risk loading on the premium payable based on your health status if accepted at the time of underwriting. Loadings will be applied from Inception Date of the first Policy including subsequent renewal(s).

The loadings are applicable on individual ailments only. In case of loading on two or more ailments, the loadings shall apply in conjunction on additive basis.

Note: The application of loading does not mean that the illness/ condition, for which loading has been applied, would be covered from inception. Any waiting period as mentioned in *Clause 9.A.1* above shall be applied on illness/condition, as applicable.

13. Change Of Sum Insured

1. The Insured can apply for change of Sum Insured at the time of renewal, by submitting a fresh proposal form/written request to the company.

2. Any request for enhancement of Sum Insured must be accompanied by a declaration that the Insured or any other Insured Person(s) in respect of whom such enhancement is sought is not aware of any symptoms or other indications that may give rise to a claim under the policy. The Company may require such Insured Person/s to undergo a medical examination to enable the Company to take a decision on accepting the request for enhancement in the Sum Insured.
3. The acceptance of enhancement of Sum Insured would be at the discretion of the company, subject to underwriting, based on the health condition of the Insured Persons & claim history of the policy.
4. All waiting periods as defined in the Policy wordings shall apply for the incremental portion of the Sum Insured from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy with the Company.

14. Cancellation

i. The policyholder may cancel his/her policy at any time during the term, by giving 7 days' notice in writing. The Insurer shall refund proportionate premium for unexpired policy period, if there is no claim (s) reported during the policy period.
ii. 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 7 days' written notice. There would be no refund of premium on cancellation on grounds of mis-representation, non-disclosure of material facts or fraud.

15. Policy cancellation for Premium payment through Lending Partner

If the premium tendered/paid towards the policy has been financed through a Lending Partner, and the policy is cancelled by invocation of the terms stated by the policy holder in the "Letter to the Insurer" or If the refund of premium is due for any reason whatsoever, the refund will be effected to the account which is mentioned by the policy holder in the "Letter to the Insurer" submitted by the policy holder.

16. Free Look Period

i. The free look period shall be applicable on new Yuvaan Health Insurance policies and not on renewals or at the time of porting/migrating the policy. The Insured shall be allowed free look period of of 30 days from the date of receipt of the policy document, whether received electronically or otherwise, to review the terms and conditions of the policy and to return the same if not acceptable.
ii. If the Insured has not made any claim during the free look period, the Insured shall be entitled to: a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges.

17. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud or misrepresentation by the Insured Person.

i. The Company will give notice for renewal.
ii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

v. An Insurer shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the policyholder, the Insurer may underwrite only to the extent of increased sum insured.
vi. No loading shall apply on renewals based on individual claims experience.

18. Migration Of Policy

The Insured Person will be provided facility to migrate the policy (including all member) to other health insurance products/plans offered by the company by applying for migration of the policy. 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 in waiting periods as per IRDAI guidelines on migration.

19. Portability

The Insured Person will be provided facility 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 related to portability. 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 in waiting periods as per IRDAI guidelines on portability.

20. 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. ln 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.

21. Tax Benefit

Tax rebate is available as per provision of Income Tax Rules under Section 80-D.

22. Claim Procedure

1. *Notification of Claim*

Upon the happening of any event which may give rise to a claim under this Policy, the Insured Person/Insured Person's representative shall notify the TPA /company in writing providing all relevant information relating to claim including plan of treatment, policy number etc. within the prescribed time limit as under:

i. Within 24 hours from the date of emergency hospitalisation 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 Hospitalisation

2. *Procedure for Cashless Claims*

i. Cashless facility for treatment in hospitals is subject to pre-authorization by the TPA.
ii. The booklet containing list of network provider/PPN hospitals shall be provided by the TPA. Updated list of network provider/PPN is available on website of the company (https://uiic.co.in/en/tpa-ppn-network-hospitals) and the TPA mentioned in the schedule.
iii. The customer may call the TPA's toll free phone number provided in the policy copy/on the health ID card for intimation of claim and related assistance. Please keep the ID number handy for easy reference.

iv. On admission in the network provider/PPN hospital, please produce the ID card issued by the TPA at the Hospital Helpdesk. The Cashless request form available with the network provider/PPN and TPA shall be filled and submitted to the TPA for authorization.
v. The TPA upon getting cashless request form and related medical information from the Insured Person/ network provider/PPN shall issue pre-authorization letter to the hospital after verification.
vi. At the time of discharge, the Insured Person shall verify and sign the discharge papers and pay for non-medical and inadmissible expenses.
vii. The TPA reserves the right to deny pre-authorization in case the Insured Person is unable to provide the relevant medical details.
viii. Denial of a Pre-authorization request is in no way to be construed as denial of treatment or denial of coverage. The Insured Person may get the treatment as per treating doctor's advice and submit the claim documents to the TPA for possible reimbursement

3. Procedure for reimbursement of Claims

i. In non-network hospitals payment must be made up-front and for reimbursement of claims the Insured Person may submit the necessary documents to TPA/Company within the prescribed time limit.
ii. Claims for Pre- and Post-Hospitalisation will be settled on reimbursement basis on production of relevant claim papers and cash receipts within the prescribed time limit.

4. Documents

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

a. Duly completed claim form
b. Attending medical practitioner's / surgeon's certificate regarding diagnosis/ nature of operation performed along with date of diagnosis, advise for admission, investigation test reports etc. supported by the prescription from attending medical practitioner.
c. Medical history of the patient as recorded, bills (including break up of charges) and payment receipts duly supported by the prescription from attending medical practitioner/ hospital.
d. Discharge certificate/ summary from the hospital.
e. Cash-memos from the Diagnostic Centre(s)/ hospital(s)/ chemist(s) supported by proper prescription.
f. Payment receipts from doctors, surgeons and anaesthetists.
g. Bills, receipts, Stickers of the Implants.
h. Any other document required by company/ TPA

Note: In the event of a claim lodged as per Settlement under multiple policies clause and the original documents having been submitted to the other Insurer, the company may accept the duly certified documents listed under *Clause 21.4* and claim settlement advice duly certified by the other Insurer subject to satisfaction of the company.

5. Time Limit for submission of documents

Type of Claim	Time Limit for submission of the documents to the Company/TPA
Reimbursement of hospitalisation, day care and pre-hospitalisation expenses	Within 15 (fifteen) days of date of discharge from hospital.
Reimbursement of post hospitalisation expenses	Within 15 (fifteen) days from completion of post-hospitalisation treatment.

Notes:

ii. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted.
iii. Waiver of *clause 22.5* may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the Insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time-limit.
iv. The Insured Person shall also give the TPA / Company such additional information and assistance as the TPA / Company may require in dealing with the claim including an authorisation to obtain Medical and other records from the hospital, lab, etc.
v. All the documents submitted to TPA shall be electronically collected by us for settlement/denial of the claims by the appropriate authority.
vi. Any medical practitioner or Authorised Person authorised by the TPA / Company shall be allowed to examine the Insured Person in case of any alleged injury or disease leading to Hospitalisation if so required.

6. *Services offered by TPA*

Servicing of claims i.e. claim admissions and assessments, under this Policy by way of preauthorization of cashless treatment or processing of claims, as per the 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.

23. 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 effected.

24. Withdrawal Of Policy

1. In the likelihood of this product being withdrawn in future, the Company will intimate the Policyholders about the same 90 days prior to expiry of the policy.
2. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break

25. Redressal Of Grievance

In case of any grievance the Insured Person may contact the company through:

Website: www.uiic.co.in
Toll-free: 1800 425 333 33
E-mail: customercare@uiic.co.in
Courier: Customer Care Department, Head Office, United India Insurance Co. Ltd., 24, Whites Road, Chennai, Tamil Nadu- 600014

Insured Person may also approach the grievance cell at any of the Company's branches with the details of grievance. If Insured Person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at customercare@uiic.co.in

For updated details of grievance officer, kindly refer the link https://uiic.co.in/en/customercare/grievance

If Insured Person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the **office of Insurance Ombudsman** of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. The contact details of the Insurance Ombudsman offices have been provided in Clauses of Annexure – 2 of the Policy Wordings.

The grievance may also be lodged at IRDAI Integrated Grievance Management System: https://igms.irda.gov.in/

26. IRDAI REGULATIONS

This policy is subject to Provisions of Insurance Act, 1938, IRDAI (Insurance Product) Regulations, 2024 and IRDAI (Protection of Policyholders' Interest) Regulations, 2024 as amended from time to time.

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Insurance is the subject matter of Solicitation

Table of Benefits

The following table of Benefits is intended as a brief indicative list for quick and easy reference. For details of what your coverage is, please refer to your Policy Schedule along with the Policy Wordings.

Features	
Age of Entry	Dependent Children – 91 Days to 17 years Adults – 18 years to 45 years
Policy Type	Individual Basis/ Family Floater Basis
SI Options (new)	Rs. 5 lakhs, 10 lakhs, 15 Lakhs, 20 Lakhs
Policy Period	1 Year
Base Cover	
Room Eligibility	1. Up to Rs 10 Lakhs: - Rs 3,000 per day or shared Accommodation whichever is higher. 2. Above Rs 10 Lakhs:-Rs 5,000 per day or Shared Accommodation whichever is higher.
ICU/ICCU	Actuals
Day Care Treatments	All Day Care Treatments as per the definition in the policy wordings are covered
Pre-Hospitalisation	60 Days
Post-Hospitalisation	90 Days
Road Ambulance	Covered
Modern Treatment MATs	Covered
Home Care Treatment	Covered as per Policy wording
Organ donor's medical expenses	Hospitalisation Expenses (excluding cost of organ) incurred for/by a Donor within the Sum Insured of the Insured Person
Optional Cover	
Waiver of Co-Payment	A Co-payment will be applied in the following cases: i If the insured has paid the premium for Zone C, a co-payment of 15% will apply for each and every claim amount for treatment taken in any city of Zone A. ii If the insured has paid the premium for Zone B, a co-payment of 10% will apply for each and every claim amount for treatment taken in any city of Zone A. If the optional cover is opted, the applicable co-payment at the time of claims will be waived off
Daily Cash Allowance on Hospitalisation	We will pay Daily Cash Allowance to the Insured Person for every continuous and completed period of 24 hours of Hospitalisation, subject to the hospitalisation claim being admissible under the policy
Sub-Limits	None

Yuvaan Health Insurance Policy

PREMIUM RATE TABLES

IMPORTANT INFORMATION

- All premium rates shown in this document are Annual Premium Rates in INR (₹) and are exclusive of Goods & Service Tax (GST) & Cess (if any). GST as applicable will be charged extra.
- Premium rates are applicable per individual insured member (unless explicitly specified) and will be based on their completed age.
- Premium rates in Section I are for standard healthy individuals. These may change post underwriting of proposal based on medical tests (where applicable) and information provided in the proposal form.
- Minimum, Maximum Entry Age:
  - Adults: 18 to 45 years
  - Children: 91 days to 17 years
- Premium rates vary depending on the Proposer's place of residence. In this regard, the country is divided into three geographical zones: **Zone A**, **Zone B**, **Zone C**. The Zones are based on the following districts in India:

Zone	Districts
A	All Districts in NCT of Delhi (incl. Shahdara), Faridabad, Palwal, Gurugram, Rohtak, Jhajjar, Ghaziabad, Gautam Buddh Nagar, Bulandshahr, Ahmedabad, Ahmedabad City, Gandhi Nagar, Vadodara, Surat, Mumbai, Mumbai Suburban, Thane, Raigad (MH), Palghar
B	Ahmed Nagar, Amritsar, Anand, Bengaluru, Bhopal, Chennai, Coimbatore, Dakshina Kannada, Ernakulam, Howrah, Hyderabad, Indore, Jaipur, Jalgaon, Jodhpur, Kanpur Nagar, Kheda, Kolhapur, Kolkata, Kottayam, Krishna, Lucknow, Ludhiana, Nagpur, Nashik, North 24 Parganas, Pune, Rajkot, Ranga Reddy, Solapur, Thiruvananthapuram, Tiruvallur, Valsad, Visakhapatnam
C	Rest of India

- **Co-payment**: Co-payment shall be applied under the following circumstances:
  - If the insured has paid the premium for Zone C, a co-payment of 15% will apply for each and every claim amount for treatment taken in Zone A.
  - If the insured has paid the premium for Zone B, a co-payment of 10% will apply for each and every claim amount for treatment taken in Zone A.
  - **Above co-payment can be waived off by paying the premium rate for Zone A.**

I. BASE COVER PREMIUM RATES (EXCL. GST)

Zone A - Premium by Age Band (in Years)													
Sum Insured	**0-17**	**18-25**	**26-30**	**31-35**	**36-40**	**41-45**	**46-50**	**51-55**	**56-60**	**61-65**	**66-70**	**71-75**	**Above 75**
5,00,000	2,943	4,966	5,517	6,621	8,046	11,694	14,076	17,275	24,805	34,230	41,818	47,214	54,465
10,00,000	3,511	5,924	6,583	7,899	9,600	13,953	16,796	20,499	29,435	42,887	52,395	59,155	68,240
15,00,000	3,806	6,420	7,135	8,563	10,405	15,126	18,207	22,099	31,732	46,323	56,593	63,895	73,705
20,00,000	4,018	6,780	7,533	9,040	10,987	15,972	19,224	23,334	33,506	48,959	59,814	67,532	77,902

Zone B - Premium by Age Band (in Years)													
Sum Insured	**0-17**	**18-25**	**26-30**	**31-35**	**36-40**	**41-45**	**46-50**	**51-55**	**56-60**	**61-65**	**66-70**	**71-75**	**Above 75**
5,00,000	2,513	4,242	4,713	5,655	6,872	9,988	12,023	14,756	21,187	29,239	35,720	40,329	46,523
10,00,000	2,999	5,061	5,623	6,747	8,200	11,918	14,346	17,510	25,142	36,634	44,754	50,529	58,289
15,00,000	3,251	5,485	6,094	7,314	8,887	12,919	15,552	18,877	27,105	39,568	48,340	54,577	62,958
20,00,000	3,432	5,792	6,435	7,722	9,384	13,642	16,420	19,931	28,619	41,821	51,091	57,684	66,542

Zone C - Premium by Age Band (in Years)													
Sum Insured	**0-17**	**18-25**	**26-30**	**31-35**	**36-40**	**41-45**	**46-50**	**51-55**	**56-60**	**61-65**	**66-70**	**71-75**	**Above 75**
5,00,000	2,330	3,931	4,368	5,241	6,369	9,258	11,144	13,677	19,637	27,099	33,106	37,378	43,118
10,00,000	2,779	4,690	5,212	6,253	7,600	11,047	13,297	16,229	23,303	33,953	41,479	46,831	54,023
15,00,000	3,013	5,083	5,648	6,779	8,237	11,976	14,414	17,496	25,121	36,672	44,802	50,583	58,350
20,00,000	3,181	5,367	5,964	7,157	8,698	12,645	15,220	18,474	26,525	38,760	47,352	53,463	61,672

***Note for all premium tables**: Premium for ages 46 years and above are applicable only for Renewals.*

II. OPTIONAL COVER PREMIUM RATES (EXCL. GST)

Daily Cash Allowance on Hospitalisation

The rates are irrespective of Zone and Age of Insured Persons.

Daily Allowance (Rs.)	Premium (Rs.)
500	120
1,000	240
2,000	480

III. DISCOUNTS

- **Family Discount:** A discount of 5% is offered on the total premium if a policy is issued on Individual Sum Insured basis and covers more than one person in the family.

- **Direct Channel Discount**:
  - A discount is applicable for fresh policies purchased online through the Company's website or directly from United India's office, without any agent or an intermediary.
  - For renewals, the discount shall be offered provided that both the renewing policy and expiring policy are without any agent or an intermediary. For online renewals of such policies also, this discount is offered.

- **No Claim Rewards (NCR):**
  For every claim free year, the policy holder is entitled for NCR either as a No Claim Discount (max up to 20%) or a Cumulative Bonus (max up to 100%).
  Note: No Claim Rewards is not applicable on Optional Cover premium rates.
  Please refer to policy wordings for details.

- **Floater Discount**: For floater policies, a floater discount is offered on the premium of each and every member of the family as follows:

Family Composition	Floater Discount
1 Adult + any no. of Children	15%
2 Adults	25%
2 Adults + any no. of Children	25%

IV. LOADINGS

We may apply a risk loading on the premium payable (excluding statutory levies & taxes) based upon information declared in the proposal form and the health status of the persons proposed for insurance. Loadings will be applied from Inception Date of the first Policy including subsequent renewal(s).

The loadings are applicable on individual ailments only. In case of loading on two or more ailments, the loadings shall apply in conjunction on additive basis.

Note:

- The application of loading does not mean that the illness/ condition, for which loading has been applied, would be covered from inception. Any waiting period as mentioned in Policy Terms and Conditions shall be applied on illness/condition, as applicable.

Benefit/Premium Illustration

Please note:

1. Premium rates specified in the illustrations below are standard premium rates exclusive of any loadings and GST.
2. Rates shown below are for Zone A of Yuvaan Health Insurance Policy.

ILLUSTRATIONS

Illustration 1: Self, Spouse and 2 Dependent Children

Age of Insured Member	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 family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount, if any	Premium after discount	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater Discount if any	Premium after discount (Rs.)	Sum Insured (Rs.)
36	9,600	10 lakh	9,600	5%	9,120	10 lakh	9,600	25%	7,200	10 lakh
31	7,899	10 lakh	7,899	5%	7,504	10 lakh	7,899		5,925	
10	3,511	10 lakh	3,511	5%	3,335	10 lakh	3,511		2,364	
20	5,924	10 lakh	5,924	5%	5,628	10 lakh	5,924		4,443	
Total Premium for all members of the family is Rs. 26,934/-, when each member is covered separately.			Total Premium for all members of the family is Rs. 25,587/-, when they are covered under a single policy.				Total Premium when policy is opted on floater basis is Rs. 19,932/-			
Sum Insured available for each individual is Rs. 10,00,000/-			Sum Insured available for each individual is Rs. 10,00,000/-				Sum Insured of Rs. 10, 00,000 is available for the entire family.			

Illustration 2: Self and Spouse

Age of Insured Member	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 family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount, if any	Premium after discount	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater Discount if any	Premium after discount (Rs.)	Sum Insured (Rs.)
42	15,972	20 lakh	15,972	5%	15,173	20 lakh	15,972	25%	11,979	20 lakh
38	10,987	20 lakh	10,987	5%	10,438	20 lakh	10,987		8,240	
Total Premium for all members of the family is Rs. 26,959/-, when each member is covered separately.			Total Premium for all members of the family is Rs. 25,611/-, when they are covered under a single policy				Total Premium when policy is opted on floater basis is Rs. 20,219/-			