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CONSUMER BULLETIN

Health Insurance Policies

Insurance Development and Regulatory Authority (IRDA) has framed regulations named **Insurance Regulatory and Development Authority (Health Insurance) Regulation 2013.** These regulations have become effective since 16th February 2013**.**

Salient points:

a) Life Insurance Companies may offer long term health products but the premium for such products shall remain unchanged for at least a period of every block of three years, thereafter the premium may be reviewed and modified as necessary.

b) Non-Life and Standalone Health insurance companies may offer individual health products with a minimum tenure of one year and a maximum tenure of three years, provided that the premium shall remain unchanged for the tenure.

c) Group Health Insurance Policies may be offered by any insurance company, provided that all such products shall only be one year renewable contracts. However, the non-life and standalone health insurers may offer group personal accident products with term less than one year also to provide coverage to any specific events.

Health Insurance Products

1. No health insurance product shall be marketed by any insurer unless it has the prior clearance of IRDA accorded as per the File and Use Procedure.
2. Any subsequent revision or modification of any approved health insurance product shall also require the prior clearance of the Authority as per the guidelines issued from time to time.
3. Any revision or modification in a policy which is approved by the IRDA shall be notified to each policy holder at least three months prior to the date when such revision or modification comes into effect. The notice shall set out the reasons for such revision or modification, in particular the reason for an increase in premium and the quantum of such increase.
4. The possibility for a revision or modification of the terms of the policy including the premium must be disclosed in the prospectus
5. To withdraw a health insurance product, the insurer shall take prior approval of IRDA by giving reasons for withdrawal and complete details of the treatment to the existing policy holders.
6. The policy document shall clearly indicate the possibility of withdrawal of the products in the future and the options that would be available to the policyholder on withdrawal of the products.
7. If the existing customer does not respond to the insurer's intimation, the policy shall be withdrawn on the renewal date and the insured shall have to take a new policy available with the insurer, subject to portability conditions.
8. Insurer shall not compel the insured to migrate to other health insurance products, if it is to the disadvantage of insured.

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9. Insurers shall ensure adequate dissemination of product information on all their health insurance products on their websites. This information shall include a description of the product, copies of the prospectus as approved under the File and Use Procedure, proposal form, policy document wordings and premium rates inclusive and exclusive of Service Tax as applicable.
10. No assignment of health insurance policies shall be allowed irrespective of whether the coverage provided under such policies are indemnity based or benefit based. Provided that, in Life-Health Combi products, assignment may be allowed only for the life insurance component of the product.
11. All health insurance policies shall ordinarily provide for an entry age of at least up to 65 years.
12. Once a proposal is accepted and a policy is issued which is thereafter renewed periodically without any break, further renewal shall not be denied on grounds of the age of the insured.
13. A health insurance policy shall ordinarily be renewable except on grounds of fraud, moral hazard or misrepresentation or non-cooperation by the insured.
14. The renewal of a health insurance policy sought by the insured shall not be denied arbitrarily. If denied, the insurer shall provide the policyholder with reasons for such denial of renewal.
15. A insurer shall not deny the renewal of a health insurance policy on the ground that the insured had made a claim or claims in the previous or earlier years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy like critical illness policy following payment of the critical illness benefit, the policy terminates.
16. The insurer shall provide for a mechanism to condone a delay in renewal up to 30 days from the due date of renewal without deeming such condonation as a break in policy. However coverage need not be available for such period.
17. The promotion material and the policy document shall explicitly state the conditions under which a policy terminates, such as on the payment of the benefit in case of critical illness benefits policies.

Free Look Period

1. All Health insurance Policies shall have a free look period. The free look period shall be applicable at the inception of the policy and:
2. The insured will be allowed a period of at least 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable.
3. If the insured has not made any claim during the free look period, the insured shall be entitled to:

a) A refund of the premium paid less any expenses incurred by the insurer on medical examination of the insured persons and the stamp duty charges or;
b) Where the risk has already commenced and the option of return of the policy is exercised by the policyholder, a deduction towards the proportionate risk premium for period on cover or;
c) Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.
d) In respect of unit linked policy, in addition to the above deductions, the insurer shall also be entitled to repurchase the unit at the price of the units as on the date of the return of the policy.

Cost of pre-insurance health check-up

1. The cost of any pre-insurance medical examination shall generally form part of the expenses allowed in arriving at the premium. However in case of products with term of one year and less, if such cost is to be incurred by the insured, not less than 50% of such cost shall be borne by the insurer once the proposal is accepted, except in travel insurance policies where such costs need not be reimbursed.
2. Insurers may provide coverage to non-allopathic treatments provided the treatment has been undergone in a government hospital or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health or any other suitable institutions.
3. The insurer shall establish necessary systems, procedures, offices and infrastructure to enable efficient issuance of pre-authorizations on a 24 hour basis and the prompt settlement of claims and grievances.

Settlement/Rejection of claim by insurer:

1. An insurer shall settle claims, including its rejection, within thirty days of the receipt of the last 'necessary' document.
2. Except in cases where a fraud is suspected, ordinarily any document not listed in the terms and conditions of the policy shall be deemed **'necessary'**. The insurer shall ensure that all the documents required for claims processing are called for at one time and shall not call for the documents in a piece meal manner.
3. The information that the insurer has captured in the proposal form at the time of accepting the proposal, the terms & conditions offered under the policy, the medical history as revealed by earlier claims, if any, and the prior claims experience shall all be maintained by the insurer as an electronic record and shall not be called for again from the policyholder/insured at the time of subsequent claim settlements. If called, for such information will not be deemed 'necessary.'
4. If the claim event falls within two policy periods, the claims shall be paid taking into consideration the available sum insured in the two policy periods, including the deductibles for each policy period. Such eligible claim amount to be payable to the insured shall be reduced to the extent of premium to be received for the renewal/due date of premium of health insurance policy, if not received earlier.

5. Insurer may stipulate a period within which all necessary claim documents should be furnished by the policy holder/ insured to make a claim. However, claims filed even beyond such period should be considered if there are valid reasons for any delay.

Administration of Health Policies

1. Subject to the terms of a policy, insurers shall extend to all policy holders a cashless facility for treatment at specified establishments or the reimbursement of the costs of medical and health treatments or services availed at any medical establishment.
2. Cashless facility shall be offered only at establishments which have entered into an Agreement with the insurer to extend such services. Such establishments will be termed as Network Providers. Reimbursement shall be allowed at any medical establishment. All such establishments must be licensed or registered as may be required by any Local, State or National Law as applicable.
3. The administration of all health plus life-combi products shall be in accordance with the provisions of Schedule II to this Regulation as may be amended from time to time by the Authority.
4. Except in emergencies a cashless facility may require a Pre-Authorisation to be issued by the Insurer or an appointed TPA to the Network Provider where the treatment is to be undergone. The Authority may prescribe a Standard Pre-Authorisation form and standard reimbursement claims forms which shall be used for this purpose, as applicable.
5. To avail the benefit of cashless facility, insurers shall issue an Identification Card to the insured within 15 days from the date of issue of a policy, either through a TPA or directly.
6. The identification card shall, at the minimum, carry details of the policyholder and the logo of the insurer. The validity of card shall coincide with the term of the policy and mayas renewed from time to time. Insures may issue a Smart Card instead of an Identity Card.
7. Where a policyholder has been issued a pre-authorisation for the conduct of a given procedure in a given hospital or if the policyholder is already undergoing such treatment at a hospital, and such hospital is proposed to be removed from the list of Network Provider, then insurers shall provide the benefits of cashless facility to such policy holder as if such hospital continues to be on the Network Provider list
8. Insurer shall keep the insured informed of the list of Network Providers and display the same on their website and the appointed TPA's office. Such list shall be updated as and when there is any change in the Network providers.
9. The insured shall have access to all the Network Providers of an insurer to avail cashless facility as long as the insurer has a valid service agreement with the Network Provider and such Network Providers shall remain unchanged irrespective of change in TPAs.
10. An insurance company may enter into arrangement with other insurance companies for sharing of Network Providers, transfer of claim & transaction data arising in areas beyond their service areas.

Portability of Health Insurance Policies offered by Life and General Insurers:

1. A policyholder desirous of porting his policy to another insurance company shall apply to such insurance company, to port the entire policy along with all the members of the family, if any, at least 45 days before the premium renewal date of his/her existing policy.
2. Insurer may not be liable to offer portability if policyholder fails to approach the new insurer at least 45 days before the premium renewal date.
3. Portability shall be opted by the policyholder only as stated above and not during the currency of the policy.
4. In case insurer is willing to consider the proposal for portability even if the policyholder fails to approach insurer at least 45 days before the renewal date, it may be free to do so.
5. Where the outcome of acceptance of portability is still waiting from the new insurer on the date of renewal
   a) the existing policy shall be allowed to extend, if requested by the policyholder, for the short period by accepting a pro- rate premium for such short period, which shall be of at least one month and
   b) shall not cancel existing policy until such time a confirmed policy from new insurer is received or at the specific written request of the insured
   c) the new insurer, in all such cases, shall reckon the date of the commencement of risk to match with date of expiry of the short period, wherever relevant.
   d) if for any reason the insured intends to continue the policy further with the existing insurer, it shall be allowed to continue by charging a regular premium and without imposing any new condition.
6. In case the policyholder has opted as in 5 (a), and there is a claim, then existing insurer may charge the balance premium for remaining part of the policy year provided the claims is accepted by the existing insurer. In such cases, policyholder shall be liable to pay the premium for the balance period and continue with existing insurer for that policy year.
7. On receipt of such intimation, the insurance company shall furnish the applicant, the Portability Form together with a proposal form and relevant product literature on the various health insurance products which could be offered.

8. The policyholder shall fill in the portability form along with proposal form and submit the same to the insurance company.
9. On receipt of the Portability Form, the insurance company shall address the existing insurance company seeking necessary details of medical history and claim history of the concerned policyholder. This shall be done through the web portal of the IRDA.
10. The insurance company receiving such a request on portability shall furnish the requisite data in the data format for porting insurance policies prescribed in the web portal of IRDA within 7 working days of the receipt of the request.
11. In case the existing insurer fails to provide the requisite data in the data format to the new insurance company within the specified time frame, it shall be viewed as violation of directions issued by the IRDA and the insurer shall be subject to penal provisions under the Insurance Act, 1938.
12. On receipt of the data from the existing insurance company, the new insurance company may underwrite the proposal and convey its decision to the policyholder in accordance with the **Regulation 4 (6)** of the **IRDA (Protection of Policyholders' interest) Regulations, 2002.**
13. If on receipt of data within the above time frame, the insurance company does not communicate its decision to the requesting policyholder within 15 days in accordance with its underwriting policy as filed by the company with IRDA, then the insurance company shall not retain the right to reject such proposal and shall have to accept the proposal.
14. In order to accept a policy which is porting-in, insurer shall not levy any additional loading or charges exclusively for the purpose of porting.
15. No commission shall be payable to any intermediary on the acceptance of a ported policy.
16. Portability shall be allowed in the following cases:
    a) All individual health insurance policies issued by non-life insurance companies including family floater policies
    b) Individual members, including the family members covered under any group health insurance policy of a non-life insurance company shall have the right to migrate from such a group policy to an individual health insurance policy or a family floater policy with the same insurer. Thereafter, he/she shall be accorded the right mentioned in 1 above.

Set Top Box and Dish now available on rental scheme

In order to provide an easy exit option to the subscribers, ensure availability of Customer Premises Equipment (CPEs) like set top box, dish and remote etc. at reasonable price and terms and conditions, Telecom Regulatory Authority of India (TRAI) has mandated through issue of tariff order prescribing standard tariff package for offering STB/CPE on rental basis. This would ensure that the subscribers would now have an easy migration from one operator to another without re-investing in new CPE. The following are standard tariff package for supply of STB/CPE to subscribers:

Refund of Security Deposit	DAS		DTH	
	Security Deposit (Rs.)	Monthly Rent (Rs.) (Excluding taxes)	Security Deposit (Rs.)	Monthly Rent (Rs.) (Excluding taxes)
Security deposit refundable after 3 years or on surrender of STB/CPE within three years	400	55.66	500	71.75
	800	50.66	1000	65.50
The security deposit adjustable over 3 years. If STB/CPE is surrendered within 3 years, the unadjusted portions of the security deposit will be refundable.	400	46.80	500	60.66
	800	32.93	1000	43.33

Consumer Alerts

- **The customer of health insurance are advised to read the policy document before they buy it. They are also advised to check about the things that their policy covers or does not cover. It may happen that the claim for illnesses that the policy does not cover and they claim for illness that the policy does not cover which leads to disappointment later. It is important to discuss all the terms and conditions very carefully with the insurer at the time of purchase.**
- **For availing cashless insurance facility, where an insurer pays directly to the hospital for the expenses incurred by the insured person, it is important to check the list of empanelled hospitals as well. It is also advice to check whether the cashless hospitals are within reach of their locality to insure that the emergency treatments are available on immediate basis to the insured without wasting time to reach the hospital.**
- **The plan should offer a premium versus benefit comparison. Even if the sum insured is the same, there are other benefits to check, such as critical illnesses covered, OPD cover, ambulance service and insurance against pre-existing diseases.**