CHAPTER 19

HEALTH INSURANCE PRODUCTS

Chapter Introduction

This chapter will give you an overall insight into the various health insurance products offered by insurance companies in India. From just one product – Mediclaim to hundreds of products of different kinds, the customer has a wide range to choose appropriate cover. The chapter explains the features of various health products that can cover individuals, family and group.

Learning Outcomes

A. Classification of health insurance products
B. IRDA guidelines on Standardization in health insurance
C. Hospitalization indemnity product
D. Top-up covers or high deductible insurance plans
E. Senior citizen policy
F. Fixed benefit covers – Hospital cash, critical illness
G. Long term care product
H. Combi-products
I. Package policies
J. Micro insurance and health insurance for poorer sections
K. Rashtriya Swasthya Bima Yojana
L. Pradhan Mantri Suraksha Bima Yojana
M. Pradhan Mantri Jan Dhan Yojana
N. Personal accident and disability cover
O. Overseas travel insurance
P. Group health cover
Q. Special products
R. Key terms in health policies

After studying this chapter, you should be able to:

a) Explain the various classes of health insurance
b) Describe the IRDAI guidelines on standardization in health insurance
c) Discuss the various types of health products available in the Indian market today
d) Explain Personal Accident insurance
e) Discuss overseas travel insurance
f) Understand key terms and clauses in health policies

A. Classification of health insurance products

1. Introduction to health insurance products

The Health Insurance Regulations of IRDA define health cover as follows

Definition

"Health insurance business" or "health cover" means the effecting of insurance contracts which provide for sickness benefits or medical, surgical or hospital expense benefits, including assured benefits and long-term care, travel insurance and personal accident cover.

Health insurance products available in the Indian market are mostly in the nature of **hospitalization products.** These products cover the expenses incurred by an individual during hospitalization. Again, these types of expenses are very high and mostly beyond the reach of the common man due to increasing cost of healthcare, surgical procedures, new and more expensive technology coming in the market and cost of newer generation of medicines. In fact, it is becoming very difficult for an individual even if he is financially sound to bear such high expenses without any health insurance.

Therefore, health insurance is important mainly for two reasons:

- ✓ **Providing financial assistance to pay for medical facilities** in case of any illness.
- ✓ **Preserving the savings of an individual** which may otherwise be wiped out due to illness.

The first retail health insurance product covering hospitalization costs – Mediclaim - was introduced by the 4 public sector insurers in 1986. These companies also introduced a couple of other covers like Bhavishya Arogya Policy covering proposers at a young age for their post-retirement medical costs, the Overseas Mediclaim policy offering travel insurance and Jana Arogya Bima policy for the poorer people.

Later insurance sector was opened up to the private sector players, which led to many more companies entering including the health insurance market. With that came greater spread of this business, a number of variations in these covers and also a few new covers too.

Today, the health insurance segment has developed to a large extent, with hundreds of products offered by almost all general Insurance companies stand along health insurers and life insurers. However, the basic benefit structure of the Mediclaim policy i.e. cover against hospitalization expenses still remains the most popular form of insurance.

As per Insurance Regulatory and Development Authority (Health Insurance) Regulations, **2016**

1. 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.
2. 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.

3. In Order to Facilitate the Offering of Innovative Covers by Insurers, **'Pilot-Products'** may be Designed and Filed for Approval of the Authority, in accordance with the Product-Filing Guide-Lines, Specified by the Authority. Pilot-Products, referred herein, can be offered, Only by General-Insurers and Health-Insurers, for Policy-Tenure of **1 Year**. Every Pilot-Product may be offered Up To a Period, Not Exceeding **5 Years**. After 5 Years of Launch of the Pilot-Product, the Product needs to get converted into a Regular Product, or Based on Valid Reasons, may be Withdrawn, Subject to the Insured, Being Given an Option, to Migrate to Another Product, Subject to the Portability-Conditions. The Authority may specify the Guide-Lines for Pilot-Products, From-Time-To-Time. Where, a Pilot-Product gets converted into a Regular Product, Any Exception made in these Regulations, for Pilot-Products, shall, No Longer Apply; and the Insurer shall Ensure the Compliance with All the Provisions of these Regulations.

***Pilot-Product** is a Close-Ended Product, with a Policy-Term of **1 Year**, that may be Offered-for-Sale, by General-Insurers or Health-Insurers, for a Period, Not Exceeding **5 Years**, From the Date of Launch of the Product, with a View to Giving a Scope to Innovation, for Covering the Risks, that Have Not Been Offered Hitherto or Stand-Excluded in the Extant-Products.*

2. Features of health policies

Health insurance basically deals with sickness and therefore expenses incurred due to sickness. Sometimes, the disease contracted by a person could be chronic or long lasting, lifelong or critical in terms of impact on day to day living activities. Expenses could also be incurred due to accidental injuries or due to disablement arising out of accident.

Various customers with different life styles, paying capacity and health status would have different requirements which need to be considered while designing suitable products to be offered to each customer segment. Customers also desire comprehensive cover while buying health insurance which would cover all their needs. At the same time, to achieve greater acceptability and bigger

volume, health insurance products need to be kept affordable, they should also be easy to understand for the customer and also for the sales team to market them.

These are some of the desirable features of health insurance products which the insurance companies try to achieve in different forms for the customer.

3. Broad classification of health insurance products

Whatever be the product design, health insurance products can be broadly classified into 3 categories:

a) Indemnity covers

These products constitute the bulk of the health insurance market and pay for actual medical expenses incurred due to hospitalization.

b) Fixed benefit covers

Also called as 'hospital cash', these products pay for a fixed sum per day for the period of hospitalization. Some products also have a fixed graded surgery benefit incorporated in the product.

c) Critical illness covers

This is a fixed benefit plan for payout on occurrence of a pre-defined critical illness like heart attack, stroke, cancer etc.

The world over health and disability insurance go together but in India, **personal accident cover** has traditionally been sold independent of health insurance.
Also health insurance usually does not include expenses incurred whilst outside India. For this purpose, another product – **overseas health insurance or travel insurance** - needs to be purchased. Only in recent times, a few high end health insurance products of private insurers include overseas insurance cover as part of regular health insurance cover, subject to certain terms and conditions.

4. Classification based on customer segment

Products are also designed keeping in mind the target customer segment. The benefit structure, pricing, underwriting and marketing for each segment is quite distinct. Products classified based on customer segments are:

a) **Individual cover** offered to retail customers and their family members

b) **Group cover** offered to corporate clients, covering employees and groups, covering their members

c) **Mass policies** for government schemes like RSBY covering very poor sections of the population.

B. **IRDA Guidelines on Standardization in health insurance**

With so many insurers providing numerous varied products and with different definitions of various terms and exclusions, confusion arose in the market. It became difficult for the customer to compare products and for third party administrators to pay claims against products of individual companies. Moreover, in critical illness policies, there was no clear understanding as to what was a critical illness and what was not. Maintaining electronic data for the health insurance industry was also becoming difficult.

To remove the confusion among insurers, service providers, TPAs and hospitals and the grievances of the insuring public, various organizations like IRDA, service providers, hospitals, Health Advisory Committee of the Federation of Chambers of Commerce and Industry got together to provide some kind of standardization in health insurance. Based on a common understanding, IRDA issued Guidelines on standardization in health insurance in 2016.
The guidelines now provide for standardization of:

1. definitions of commonly used insurance terms
2. definitions of critical illnesses
3. list of excluded items of expenses in hospitalization indemnity policies
4. claim forms and pre-authorization forms
5. billing formats
6. discharge summary of hospitals
7. standard contracts between TPAs, insurers and hospitals
8. standard File and Use format for getting IRDAI for new policies

This has been a big step to improve the quality of service of the health providers and the insurance industry and will also help in collection of meaningful health and health insurance data.

C. Hospitalization indemnity product

An indemnity based health insurance policy is the most common and highest sold health insurance product in India. The **Mediclaim policy** introduced in the eighties by the PSU insurers was the earliest standard health product and was the only product available in the market for a long time. Though this product, with a few changes, is marketed by different insurers under different brand names, Mediclaim continues to be the largest selling health insurance in the country.

Hospitalization indemnity products protect individuals from the expenditure they may need to incur in the event of hospitalisation. In most of the cases, they also cover a specific number of days before and after hospitalisation, but exclude any expenses not involving hospitalisation.

Such a cover is provided on an **'indemnity' basis**, that is, by making good part or all of the expenses incurred or amount spent during hospitalisation. This may be contrasted with the insurance coverage on **'benefit' basis**, where the amount that will be paid on the occurrence of a certain event (like hospitalisation, diagnosis of critical illness or each day of admission) is as stated in the insurance policy and is not related to the actual expenditure incurred.

Example

Raghu has a small family consisting of his wife and a 14 year old son. He has taken a Mediclaim policy, covering each member of his family, from a health insurance company, for an individual cover of Rs. 1 lakh each. Each of them could get recovery of medical expenses up to Rs. 1 lakh in case of hospitalisation.

Raghu was hospitalised due to heart attack and required surgery. The medical bill raised was Rs. 1.25 lakhs. The insurance company paid Rs 1 lakh according to the plan coverage and Raghu had to pay the remaining amount of Rs. 25,000 from his own pocket.

The main features of the indemnity based Mediclaim policy are detailed below, **though variations in limits of cover, additional exclusions or benefits or some add-ons may apply to products marketed by each insurer**. The student is advised that the following is only a broad idea about the product and he should acquaint himself with the product of the particular insurer he wishes to know more about. He also **needs to educate himself about some of the medical terms that may be used.**

1. Inpatient hospitalization expenses

An indemnity policy pays the insured the cost of hospitalization expenses incurred on account of illness / accident.

All expenses may not be payable and most products define the expenses covered which normally include:

i. Room, boarding and nursing expenses as provided by the hospital / nursing home. This includes nursing care, RMO charges, IV fluids / blood transfusion / injection administration charges and similar expenses

ii. Intensive Care Unit (ICU) expenses

iii. Surgeon, anesthetist, medical practitioner, consultants, specialists fees

iv. Anesthetic, blood, oxygen, operation theatre charges, surgical appliances,

v. Medicines and drugs,

vi. Dialysis, chemotherapy, radiotherapy

vii. Cost of prosthetic devices implanted during surgical procedure like pacemaker, orthopedic implants, infra cardiac valve replacements, vascular stents

viii. Relevant laboratory / diagnostic tests and other medical expenses related to the treatment

ix. Hospitalization expenses (excluding cost of organ) incurred on donor in respect of organ transplant to the insured

A regular hospitalization indemnity policy covers expenses only if the duration of stay in hospital is for 24 hours or more. However with advancements in medical technologies, treatment procedures for many surgeries do not require hospitalization. Now as daycare procedures, they can be conducted at specialized daycare centers or hospitals as the case may be. Treatments such as eye surgeries, chemotherapy; dialysis etc. can be classified under daycare surgeries and the list is ever growing. These are also covered under the policy.

Coverage of outpatient expenses is still very limited in India, with very few such products offering OPD covers. However there are some plans that cover treatment as outpatient and also related health care expenses associated with doctor visits, regular medical tests, dental and pharmacy costs.

2. Pre and post hospitalization expenses

i. Pre hospitalization expenses

Hospitalization could be either emergency hospitalization or planned. If a patient goes in for a planned surgery, there would be expenses incurred by him prior to the hospitalization.

Definition

IRDA Health Insurance Standardization guidelines define Pre-hospital expenses as:

Medical expenses incurred immediately before the insured person is hospitalized, provided that:

a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

b) The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

Pre hospitalization expenses could be in the form of tests, medicines, doctors' fees etc. Such expenses relevant and pertaining to the hospitalization are covered under the health policies.

ii. Post hospitalization expenses

After stay in the hospital, in most cases there would be expenses related to recovery and follow-up.

Definition

Medical Expenses incurred immediately after the Insured Person is dischared from hospital, provided that:

a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
b) The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

Post hospitalization expenses would be relevant medical expenses incurred during period up to the defined number of days after hospitalization and will be considered as part of claim.

Post hospitalization expenses could be in the form of medicines, drugs, review by doctors etc. after discharge from hospital. Such expenses have to be related to the treatment taken in hospital and are covered under the health policies.

Though the duration of cover for pre and post hospitalization expenses would vary from insurer to insurer and is defined in the policy, the most common cover is for **thirty days pre and sixty days post hospitalization**.

Pre and post-hospitalization expenses form part of the overall sum insured for which cover is granted under the policy.

a) DOMICILIARY HOSPITALIZATION

Although this benefit is not commonly used by policyholders, an individual health policy also has a provision to take care of expenses incurred for medical treatment taken at home without being admitted to a hospital. However, the condition is that though the illness requires attention at a hospital, the condition of the patient is such that he cannot be moved to a hospital or there is lack of accommodation in hospitals.

This cover usually carries an **excess clause of three to five days** meaning that treatment costs for the first three to five days have to be borne by the insured. The cover also excludes domiciliary treatments for certain chronic or common oilments such as Asthma, Bronchitis, Chronic Nephritis and Nephritic Syndrome, Diarrhoea and all type of Dysenteries including Gastroenteritis, Diabetes Mellitus Epilepsy, Hypertension, Influenza, Cough and Cold, fevers.

b) COMMON EXCLUSIONS

Some of the usual exclusions under hospitalization indemnity policies are given below. These are based on the suggested exclusions detailed in the Guidelines on Standardization in Health Insurance issued by IRDAI particularly Annexure IV. The student is advised to acquaint himself with the guidelines available on the IRDAI website.

It must be noted that if any of the exclusions are waived or any additional exclusions are imposed as per File and Use approved terms, these must be stated separately in the Customer Information Sheet and the policy.

1. Pre-existing diseases

This is almost always excluded under individual health plans since otherwise it would mean covering a certainty and poses a high risk to the insurer. One of the important disclosures required at the time of taking a health policy is regarding previous history of ailments / injuries of each insured person covered. This will enable the insurer to decide on accepting the proposal for insurance.

Definition

The IRDA guidelines on standardisation define Pre-existing as
"Any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and/or were diagnosed, and/or received medical advice/treatment within 48 months prior to the first policy issued by the insurer."

The exclusion is: Any pre-existing condition(s) as defined in the policy, until 48 months of continuous coverage of such insured person have elapsed, since inception of his / her first policy with the company.

2. Weight control programs/ supplies/ services
3. Cost of spectacles/ contact lenses/ hearing aids etc.
4. Dental treatment expenses that do not require hospitalisation
5. Hormone replacement
6. Home visit charges
7. Infertility/ subfertility/ assisted conception procedure
8. Obesity (including morbid obesity) treatment
9. Psychiatric & psychosomatic disorders
10. Corrective surgery for refractive error
11. Treatment of sexually transmitted diseases
12. Donor screening charges
13. Admission/registration charges
14. Hospitalisation for evaluation/ diagnostic purpose
15. Expenses for investigation/ treatment irrelevant to the disease for which admitted or diagnosed
16. Any expenses when the patient is diagnosed with retro virus and/or suffering from HIV/ AIDS etc. is detected directly or indirectly
17. Stem cell implantation/ surgery and storage
18. War and nuclear related causes
19. All non-medical items such as registration charges, admission fees, telephone, television charges, toiletries, etc.
20. A waiting period of 30 days from inception of policy is normally applicable in most policies for making any claim. This however will not be applied for hospitalization due to an accident.

Example

Mira had taken a health insurance policy for coverage of expenses in the event of hospitalisation. The policy had a clause for initial waiting period of 30 days.

Unfortunately, 20 days after she took the policy, Mira contracted malaria and was hospitalised for 5 days. She had to pay heavy hospital bills.

When she asked for reimbursement from the insurance company, they denied payment of the claim because the event of hospitalization occurred within the waiting period of 30 days from taking the policy.

i. **Waiting periods:** This is applicable for diseases for which typically treatment can be delayed and planned. Depending on the product,

waiting periods of one / two / four years apply for diseases such as Cataract, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Congenital internal disease, Fistula in anus, piles, Sinusitis and related disorders, Gall Bladder Stone removal, Gout and Rheumatism, Calculus Diseases, gout and rheumatism, age related osteoarthritis, osteoporosis.

c) COVERAGE OPTIONS AVAILABLE

i. Individual coverage

An individual insured can cover himself along with family members such as spouse, dependent children, dependent parents, dependent parents in law, dependent siblings etc. Some insurers do not have a restriction on the dependents who can be covered. It is possible to cover each of such dependent insureds under a single policy with a separate sum insured chosen for each insured person. In such covers, each person insured under the policy can claim upto the maximum amount of his sum insured during the currency of the policy. Premium will be charged for each individual insured according to his age and sum insured chosen and any other rating factor.

ii. Family floater

In the variant known as a family floater policy, the family consisting of spouse, dependent children and dependent parents are offered a single sum insured which floats over the entire family.

Example

If a floater policy of Rs. 5 lacs is taken for a family of four, it means that during the policy period, it will pay for claims related to more than one family member or multiple claims of a single member of the family. All these together cannot exceed the total coverage of Rs. 5 lacs. Premium will normally be charged based on the age of the oldest member of the family proposed for insurance.

The covers and exclusions under both these policies would be the same. Family floater policies are getting popular in the market as the entire family gets coverage for an overall sum insured which can be chosen at a higher level at a reasonable premium.

d) SPECIAL FEATURES

A number of changes to existing coverages and new value added features have been added to the basic indemnity cover offered under the earlier Mediclaim product. We shall discuss some of these changes. It is to be noted that not all products carry all the below mentioned features, and they may vary from insurer to insurer and product to product.

i. Sub limits and Disease specific capping

Some of the products have disease specific capping e.g. cataract. A few also have sub limits on room rent linked to sum insured e.g. per day room rent restricted to 1% of sum insured and ICU charges to 2% of sum insured. As expenses under other heads such as ICU charges, OT charges and even surgeon's fees are linked to the type of room opted for, room rent capping helps in restricting expenses under other heads also and hence the overall hospitalization expenses.

ii. Co-payment (popularly called Co-pay)

A co-payment is a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.

This ensures that the insured exercises caution in selecting his options and thus reduces his overall hospitalization expenses voluntarily.

iii. Deductible

Deductible is a cost-sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

Insurers are to define whether the deductible is applicable per year, per life or per event and the specific deductible to be applied.

iv. New exclusions have been introduced and later standardized by IRDAI:

- ✓ Genetic disorders and stem cell implantation / surgery.
- ✓ External and or durable Medical / Non-medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Infusion pump etc., ambulatory devices i.e. walker, crutches, belts, collars, caps, splints, slings, braces, stockings etc. of any kind, diabetic foot wear, glucometer / thermometer and similar related items etc. and also any medical equipment which is subsequently used at home etc.
- ✓ Any kind of Service charges, Surcharges, Admission fees / Registration charges etc. levied by the hospital
- ✓ Doctor's home visit charges, Attendant / Nursing charges during pre and post hospitalization period

v. Zone wise premium

Normally, the premium would depend on the age of the insured person and the sum insured selected. Premium differential has been introduced in certain zones with higher claims cost e.g. Delhi and Mumbai form part of highest premium zone for certain products by some insurers.

vi. Coverage of pre-existing diseases

In view of regulatory requirement, pre-existing diseases which were excluded earlier are specifically mentioned with a waiting period of four years. Few high end products by some insurance companies have reduced the period to 2 and 3 years.

vii. Renewability

Lifelong renewability was introduced by few insurers. Now, this has been made compulsory by IRDAI for all policies.

viii. Coverage for Day care procedure

Advancement of medical science has seen inclusion of large number of procedures under day care category. Earlier only seven procedures were specifically mentioned under daycare - Cataract, D and C, Dialysis, Chemotherapy, Radiotherapy, Lithotripsy and Tonsillectomy. Now, more than 150 procedures are covered and the list keeps growing.

ix. Cost of pre policy check up

Cost of medical examination was earlier borne by prospective clients. Now insurer reimburses the cost, provided the proposal is accepted for underwriting, the reimbursement varying from 50% to 100%. Now this has also been mandated by IRDAI that insurer would bear at least 50% of health checkup expenses.

x. Duration of pre and post hospital cover

Duration of pre and post hospital coverage is extended to 60 days and 90 days by most insurers especially in their high end product. Few insurers have also capped these expenses linked to certain percentage of claim amount, subject to a maximum limit.

xi. Add on covers

Various new additional covers called Add-on covers have been introduced by some of the insurers. Some of them are:

- ✓ **Maternity cover:** Maternity was not offered earlier under retail policies but is now offered by most insurers, with varying waiting periods.

- ✓ **Critical illness cover:** Available as an option under the high end version products for certain ailments which are life threatening and entail expensive treatment.

- ✓ **Reinstatement of sum insured:** After payment of claim, the sum insured (which gets reduced on payment of a claim) can be restored to the original limit by paying extra premium.

- ✓ **Coverage for AYUSH – Ayurvedic – Yoga - Unani – Siddha – Homeopath:** Few policies cover expenses towards AYUSH treatment up to a certain percentage of the hospitalization expenses.

xii. Value added covers

Few indemnity products include value added covers as listed below. The benefits are payable up to the limit of sum insured specified against each cover in the schedule of the policy, not exceeding the overall sum insured.

- ✓ **Outpatient cover:** As we know health insurance products in India mostly cover only in-patient hospitalization expenses. Few companies now offer limited cover for out-patient expenses under some of the high-end plans.

- ✓ **Hospital cash:** This provides for fixed lump sum payment for each day of hospitalization for a specified period. Normally the period is granted for 7 days excluding the policies deductible of 2/3 days. Thus, the benefit would trigger only if hospitalization period is beyond the deductible period. This is in addition to the hospitalization claim but within the overall sum insured of the policy or may be with a separate sub-limit.

- ✓ **Recovery benefit:** Lump sum benefit is paid if the total period of stay in hospital due to sickness and/or accident is not less than 10 days.

- ✓ **Donor's expenses:** The policy provides for reimbursement of expenses towards donor in case of major organ transplant as per the terms and condition defined in the policy.

- ✓ **Reimbursement of ambulance:** Expenses incurred towards ambulance by Insured/insured person are reimbursed up to a certain limit specified in the schedule of the policy.

- ✓ **Expenses for accompanying person:** This is intended to cover the expenses incurred by accompanying person towards food, transportation whilst attending to insured patient during the period of hospitalization. Lump sum payment or reimbursement payment as per the policy terms is paid, up to the limit specified in the schedule of the policy.

- ✓ **Family definition:** Definition of family has undergone changes in few health products. Earlier, primary insured, spouse, dependent children

were granted cover. Now there are policies where parents and in-laws can also be granted cover under the same policy.

D. Top-up covers or high deductible insurance plans

A top-up cover is also known as a high deductible policy. Most people in the international markets buy top-up covers in addition to high co-pay policies or uncovered diseases or treatment. However in India, the key reason for introduction of top-up cover initially seems to be lack of high sum insured products, though the same is no longer the case. The maximum amount of cover under a health policy remained at Rs 5,00,000 for a very long time. Anyone wanting a higher cover was forced to buy two policies paying double the premium. This led to the development of the Top-Up policies by insurers, which offers cover for high sums insured over and above a specified amount (called threshold).

This policy works along with a basic health cover having a low sum insured and comes at a comparatively reasonable premium. For example, Individuals covered by their employers can also opt for a top-up cover for additional protection (keeping the sum insured of the first policy as the threshold). This can be for self and family, which comes in handy in the unfortunate event of high cost treatment.

To be eligible to receive a claim under the top-up policy, the medical costs must be greater than the deductible (or threshold) level chosen under the plan and the reimbursement under the high deductible plan would be the amount of expense incurred i.e. greater than the deductible

Example

An individual is covered for a sum insured of Rs. 3 lacs by his employer. He could opt for a top-up policy of Rs. 10 lacs in excess of Rs. three lacs.

If the cost of a single hospitalization is Rs. 5 lacs, the basic policy would cover up to Rs. three lacs only. With the top-up cover, the balance sum of Rs. two lacs would be paid out by the top-up policy.

Top-up policies come cheap and the cost of a single Rs. 10 lacs policy would be far higher than the top-up policy of Rs. 10 lacs in excess of Rs. three lacs.

These covers are available on individual basis and family basis. Individual sum insured for each family member covered or a single sum insured floating over the family are offered in the market today.

In case the top-up plan requires the deductible amount to be crossed at every single event of hospitalization, the plan is known as a **Catastrophe based** high deductible plan. This means that to be payable, in the example given above, each and every claim must cross Rs. 3 lacs

However top-up plans that allow the deductible to be crossed post a series of hospitalizations during the policy period are known as **Aggregate based** high deductible plans **or Super top-up** cover as known in the Indian market. This means that, in the example given above, each and every claim is added and when this crosses Rs. 3 lacs, the Top-up cover would start paying claims.

Most of the standard terms, conditions and exclusions of a hospital indemnity policy apply to these products. In some markets, where basic health cover is provided by the Government, insurers mostly deal only with granting the Top-Up covers.

E. Senior citizen policy

These plans are designed to offer cover to elderly people who often were denied coverage after certain age (e.g. people over 60 years of age). The structure of the coverage and exclusions are much like a hospitalization policy.

Special attention is paid to diseases of the elderly in setting coverage and waiting period. Entry age is mostly after 60 years and renewable lifelong. Sum insured range from Rs. 50,000 to Rs. 5,00,000. There is variation of waiting period applicable to certain ailments. Example: Cataract may have 1 year waiting for one insurer and 2 year waiting period for some other insurer.

Also certain ailments may not have waiting period for a particular insurer where as another may have. Example: Sinusitis does not fall in waiting period clause of some insurers but few others include it in their waiting period clause.

Pre-existing disease has either a waiting period or capping in some policies. Pre-post hospital expenses are either paid as a percentage of hospital claims or a sub limit whichever is higher. In some policies they follow the typical indemnity plans such as expenses falling within specified period of 30/60 days or 60/90 days.

IRDAI has mandated special provisions for insured persons who are Senior Citizens:

1. The premium charged for health insurance products offered to senior citizens shall be fair, justified, transparent and duly disclosed upfront.
2. The insured shall be informed in writing of any underwriting loading charged over and above the premium and the specific consent of the policyholder for such loadings shall be obtained before issuance of a policy.
3. All health insurers and TPAs shall establish a separate channel to address the health insurance related claims and grievances of senior citizens.

F. Fixed benefit covers - Hospital cash, critical illness

The greatest risk to an insurer in a health insurance policy is unnecessary and unreasonable use of the policy benefits. Knowing that the patient is covered under a health policy, doctors, surgeons and hospitals tend to over treat him. They prolong the length of stay in the hospital, carry out unnecessary diagnostic and laboratory tests and thus inflate the cost of treatment beyond the necessary amount. Another major impact on insurer's costs is the constant rise in medical costs, usually higher than the increase in premium rates.

The answer to this is the Fixed Benefit cover. While providing adequate protection to the insured persons, the fixed benefits cover also help the insurer to effectively price his policy for a reasonable duration. In this product, commonly occurring treatments are listed under each system such as ENT, Ophthalmology, Obstetrics and Gynaecology, etc. and the maximum pay out for each of these is spelt out in the policy.

The insured also gets a fixed sum as claim amount irrespective of the amount spent by him for the named treatment. The package charges payable for each of these treatments is generally based on a study of the reasonable cost that would be needed for treating the condition.

The package charges would include all components of the cost such as:

a) Room rent,
b) Professional fees,
c) Diagnostics,
d) Drugs,
e) Pre and post hospitalization expenses etc.

The package charges could even include diet, transport, ambulance charges etc. depending on the product.

These policies are simple to administer as only proof of hospitalization and coverage of ailment under the policy are sufficient to process the claim.

Some products package a daily cash benefit along with the fixed benefit cover. The list of treatments covered could vary from around 75 to about 200 depending on the definitions of the treatments in the product.

A provision is made to pay a fixed sum for surgeries / treatment which do not find a place in the list named in the policy. Multiple claims for different treatments are possible during the policy period. However the claims are finally limited by the sum insured chosen under the policy.

Some of the fixed benefit insurance plans are:

- ✓ Hospital daily cash insurance plans
- ✓ Critical illness insurance plans

1. HOSPITAL DAILY CASH POLICY

a) Per day amount limit

Hospital cash coverage provides a fixed sum to the insured person for each day of hospitalization. Per day cash coverage could vary from (for example) Rs. 1,500 per day to Rs. 5,000 or even more per day. An upper limit is provided on the daily cash payout per illness as well as for the duration of the policy, which is usually an annual policy.

b) Number of payment days

In some of the variants of this policy, the number of days of daily cash allowed is linked to the disease for which treatment is being taken. A detailed list of treatments and duration of stay for each is stipulated which limits the daily cash benefit allowed for each type of procedure/ illness.

c) Standalone cover or add-on cover

The hospital daily cash policy is available as a standalone policy as offered by some insurers while, in other cases, it is an add-on cover to a regular indemnity policy. These policies help the insured to cover incidental expenses as the payout is a fixed sum and not related to the actual cost of treatment. This also allows the payout under the policy to be provided in addition to any cover received under an indemnity based health insurance plan.

d) Supplementary cover

These policies could supplement a regular hospital expenses policy as it is cost effective and provides compensation for incidental expenses and also expenses not payable under the indemnity policy such as exclusions, co-pay etc.

e) Other advantages of the cover

From the insurer's point of view, this plan has several advantages as it is easy to explain to a customer and hence can be sold more easily. It beats medical inflation as a fixed sum per day is paid for the duration of hospitalization whatever may be the actual expense. Also, acceptance of such insurance covers and claims settlements are really simplified.

2. CRITICAL ILLNESS POLICY

This product is also known as the **dreaded disease cover** or a **trauma care cover.**

With advancement in medical science, people are surviving some of the major diseases like cancer, strokes and heart attack etc. which in earlier times would have resulted in death. Again, life expectancy has increased considerably after surviving such major illnesses. However surviving a major illness entails huge expense for treatment as well as for living expenses post treatment. Thus onset of critical illness threatens financial security of a person

a) Critical illness policy is a benefit policy with a provision to pay a lump sum amount on diagnosis of certain named critical illness.

b) It is sold:
   - ✓ As a standalone policy or
   - ✓ As an add-on cover to a few health policies or
   - ✓ As an add-on cover in some life insurance policies

In India, critical illness benefits are most commonly sold by life insurers as riders to life policies and two forms of cover are offered by them – accelerated CI benefit plan and standalone CI benefit plan. Precise definition of the covered illnesses and good underwriting are extremely important when this benefit is sold. To avoid confusion, the definitions of 20 most common critical illnesses have been standardized under IRDA Health Insurance Standardization guidelines. (Please refer to the Annexure at the end).

However, the chance for adverse selection (whereby mostly those people most likely to be affected take this insurance) at issuance stage is quite high and it is important to determine health status of the proposers. Due to lack of sufficient data, currently pricing of critical illness plans is being supported through reinsurers' data.

c) Critical illnesses are major illnesses that could not only lead to very high hospitalization costs, but could also cause disability, loss of limbs, loss of earning etc. and may require prolonged care post hospitalization.

d) A critical illness policy is often recommended to be taken in addition to a hospital indemnity policy, so that the compensation under the policy could help in overcoming the financial burden of a family whose member is affected by such illness.

e) The critical illnesses covered vary across insurers and products, but the common ones include:
   - ✓ Cancers of specified severity
   - ✓ Acute myocardial infarction
   - ✓ Coronary artery surgery
   - ✓ Heart valve replacement
   - ✓ Coma of specified severity
   - ✓ Renal failure
   - ✓ Stroke resulting in permanent symptoms
   - ✓ Major organ / bone marrow transplant
   - ✓ Multiple sclerosis

- ✓ Motor Neuron disease
- ✓ Permanent paralysis of limbs
- ✓ Permanent disability due to major accidents

The list of critical illnesses is not static and keeps evolving. In a few international markets insurers classify conditions into 'core' and 'additional', even covering conditions like Alzheimer's disease. Sometimes 'terminal illness' is also included for coverage though premium would obviously be very high.

f) While most critical illness policies provide for a lump sum payment on diagnosis of illness, there are a few policies which provide hospitalization expenses cover only in the form of reimbursement of expenses. Few products offer combination of both covers i.e. indemnity for in patient hospitalization expenses and lump sum payment upon diagnosis of major diseases named in the policy.

g) Critical illness policies are usually available for persons in the age group of 21 years to 65 years.

h) The sum insured offered under these policies is quite high as the primary reason of such a policy would be to provide for the financial burden of long term care associated with such diseases.

i) Under these policies generally 100% of the sum insured is paid on diagnosis of a critical illness. In some cases compensation could vary from 25% to 100% of sum insured depending on the policy terms and conditions and severity of illness.

j) A standard condition seen in all critical illness policies is the waiting period of 90 days from inception of policy for any benefit to become payable under the policy and the survival clause of 30 days after diagnosis of the illness. The survival clause has been included as this benefit must not be confused with a "death benefit" but more interpreted as a "survival (living) benefit" i.e. the benefit provided to overcome the hardships that may follow a critical illness.

k) Rigorous medical examinations are to be undergone for persons especially over 45 years of age who wish to take the critical illness policy. Standard exclusions are quite similar to those found in health insurance products, failure to seek or follow medical advice, or delaying medical treatment in order to dodge the waiting period is also specifically excluded.

l) The insurer may compensate the insured only once for any one or more of the covered diseases of the policy or offer multiple payouts but up to a certain limited number. The policy terminates, once compensation is paid under the policy in respect of any of the insured person.

m) The critical illness policy is also offered to groups especially corporates who take policies for their employees.

G. Long term care insurance

Today, with increasing life expectancy, the population of aged people in the world is going up. With an ageing population, the world over, long term care insurance is also gaining importance. Elderly people require long term care and also those people suffering from any kind of disability. Long term care means all forms of continuing personal or nursing care for people who are unable to look after themselves without a degree of support and whose health is not going to get better in future.

There are two types of plans for long term care:

a) Pre-funded plans which are purchased by healthy insured to take care of their future medical expenses and

b) Immediate need plans which are purchased by a lump sum premium when the insured is requiring long term care.

The severity of disability (and expected survival period) decides the quantum of benefit. Long term care products are yet to be developed in Indian market.

Bhavishya Arogya policy

The first pre-funded insurance plan was the Bhavishya Arogya policy marketed by the four public sector general insurance companies. Introduced in the year 1990, the policy is basically meant to take care of the healthcare needs of an insured person after his retirement, while he pays premium during his productive life. It is similar to taking a life insurance policy except that it covers future medical expenses rather than death.

a) Deferred Mediclaim

The policy is a sort of deferred or future Mediclaim policy and provides cover similar to the Mediclaim policy. The proposer can join the scheme any time between the age of 25 and 55 years.

b) Retirement age

He can choose a retirement age between 55 and 60 years with a condition that there should be a clear gap of 4 years between the date of joining and the retirement age chosen. The policy retirement age means the age selected by the insured at the time of signing the proposal and specified in the schedule for the purpose of start of benefit under the policy. This age cannot be advanced.

c) Pre-retirement period

The pre-retirement period means the period starting from the date of acceptance of the proposal and ending with the policy retirement age specified in the schedule. During this period the insured shall be paying installment/single premium amount as applicable. The insured has the option of paying either one lump-sum premium or in installments.

d) Withdrawal

In case, the insured dies or wishes to withdraw from the scheme either before the retirement age or after retirement age chosen, then appropriate refund of premium would be allowed subject to no claim having occurred under the policy. There is a provision of grace period of 7 days for payment of premium in the event of satisfactory reason for delay in renewal.

e) Assignment

The scheme provides for assignment.

f) Exclusions

The policy does not have exclusion of pre-existing diseases, 30 days waiting period and first year exclusion for specified diseases as in Mediclaim. Since it is a future Mediclaim policy, this is quite logical.

g) Group insurance variant

Policy can also be availed of on group basis in which case, facility of group discount is available.

H. **Combi-products**

Sometimes, products pertaining to life insurance are combined with health insurance products. This is a good way of promoting more products in a packaged way through two insurers coming together and entering into an understanding.

Health plus Life Combi Products therefore mean products which offer the combination of a life insurance cover of a life insurance company and a health insurance cover offered by non-life and/or standalone health insurance company.

The products are jointly designed by the two insurers and marketed through the distribution channels of both insurers. Obviously, this would entail a tie-up between two companies and as per current guidelines, such tie-up is permitted only between one life insurer and one non-life insurer at any time. A Memorandum of Understanding between such companies must be in place for the way marketing, policy servicing and sharing of common expenses will be carried out and also policy servicing parameters and transmission of premium. Approval of IRDAI for the tie-up may be sought by any one of the insurers. The agreement should be of a long term nature and withdrawal from the tie-up will not be permitted except under exceptional circumstances and to the satisfaction of the IRDAI.

One of the insurance companies may be mutually agreed to act as a lead insurer to play a critical role in facilitating the policy service as a contact point for rendering various services as required for combi products. The lead insurer may play a major role in facilitating underwriting and policy service. However, the claims and commission payouts are handled by the respective insurers depending on which section of the policy is affected.

'Combi Product' filing shall follow the File and Use guidelines issued from time to time and individually cleared. The premium components of both risks are to be separately identifiable and disclosed to the policyholders at both pre-sale stage and post-sale stage and in all documents like policy document, sales literature etc.

The product may be offered both as individual insurance policy and on group insurance basis. However in respect of health insurance floater policies, the pure term life insurance coverage is allowed on the life of one of the earning members of the family who is also the proposer on health insurance policy subject to insurable interest and other applicable underwriting norms of respective insurers.

Free Look option is available to the insured and is to be applied to the 'Combi Product' as a whole. However, the Health portion of the 'Combi Product' shall entitle its renewability at the option of policyholder from the respective Non-Life/standalone health Insurance Company.

Marketing of Combi Products can be done through Direct marketing channels, Brokers and Composite Individual and Corporate Agents common to both insurers but not through Bank referral arrangements. However, they cannot be intermediaries who are not authorized to market either of the products of either of the insurers.

Specific disclosures have to be made in the proposal and sales literature especially features like there are two insurers involved, that each risk is distinct from the other, who will settle claims, matters relating to renewability of both or only one of the covers at the option of the insured, servicing facilities etc.

The IT system to service this business must be robust and seamless as it means a lot of integration of data between the two insurers and data generation to IRDAI as required.

I. Package policies

Package or umbrella covers give, under a single document, a combination of covers.

For instance in other classes of business, there are covers such as Householder's Policy, Shopkeeper's Policy, Office Package Policy etc. that, under one policy, seek to cover various physical assets including buildings, contents etc. Such policies may also include certain personal lines or liability covers.

Examples of package policy in health insurance include combining Critical illness cover benefits with indemnity policies and even life insurance policies and hospital daily cash benefits with indemnity policies.

In the case of travel insurance, the policy offered is also a package policy covering not only health insurance but also accidental death / disability benefits along with Medical expenses due to illness / accident, Loss of or delay in arrival of checked in baggage, Loss of passport and documents, Third party liability for property / personal damages, Cancellation of trips and even Hijack cover.

J. Micro insurance and health insurance for poorer sections

Micro-insurance products are specifically designed to aim for the protection of low income people from rural and informal sectors. The low income people form a sizable part of our population and usually don't have any health security cover. Therefore, this low value product, with an affordable premium and benefit package, is initiated to help these people to cope with and recover from common risks. Micro insurance is governed by the IRDA Micro Insurance Regulations, 2005.

These products come with a small premium and typically, the sum insured is below Rs.30,000, as required vide the IRDA micro-insurance regulations, 2005. Such covers are mostly taken on a group basis by various community organizations or non-governmental organizations (NGOs) for their members. The IRDA's rural and social sector obligations also require that insurers should sell a defined proportion of their policies as micro-insurance products, to enable wider reach of insurance.

Two policies particularly created by PSUs to cater to the poorer sections of society are described below:

1. Jan Arogya Bima Policy

Following are the features of Jan Arogya Bima Policy:

a. This policy is designed to provide cheap medical insurance to poorer sections of the society.

b. The coverage is along the lines of the individual Mediclaim policy. Cumulative bonus and medical check-up benefits are not included.

c. The policy is available to individuals and family members.

d. The age limit is five to 70 years.

e. Children between the age of three months and five years can be covered provided one or both parents are covered concurrently.

f. The sum insured per insured person is restricted to Rs.5,000 and the premium payable as per the following table.

Table 2.1

Age of the person insured	Up to 46 years	46-55	56-65	66-70
Head of the family	70	100	120	140
Spouse	70	100	120	140
Dependent child up to 25 years	50	50	50	50
For family of 2+1 dependent child	190	250	290	330
For family of 2+2 dependent	240	300	340	380

children				

- Premium qualifies for tax benefit under Section 80D of the Income Tax Act.
- Service tax is not applicable to the policy.

2. Universal Health Insurance Scheme (UHIS)

This policy is available to groups of 100 or more families. In recent times even individual UHIS Policies were made available to the public.

Benefits
Following is the list of benefits of universal health insurance scheme:

- **Medical reimbursement**
  The policy provides reimbursement of hospitalization expenses up to Rs.30,000 to an individual / family subject to the following sub limits.

Table 2.2

Particulars	Limit
Room, boarding expenses	Up to Rs.150/- per day
If admitted in ICU	Up to Rs.300/- per day
Surgeon, Anaesthetist, Consultant, Specialists fees, Nursing expenses	Up to Rs.4,500/- per illness/ injury
Anaesthesia, Blood, Oxygen, OT charges, Medicines, Diagnostic material and X-Ray, Dialysis, Radiotherapy, Chemotherapy, Cost of pacemaker, Artificial limb, etc.	Up to Rs.4,500/- per illness/ injury
Total expenses incurred for any one illness	Up to Rs. 15,000/-

- **Personal accident cover**
  Coverage for death of the earning head of the family (as named in the schedule) due to accident: Rs.25,000/-.
- **Disability cover**
  If the earning head of the family is hospitalised due to an accident / illness compensation of Rs. 50/- per day will be paid per day of hospitalisation up to a maximum of 15 days after a waiting period of three days.
- **Premium**

Table 2.3

Entity	**Premium**
For an individual	Rs.365/- per annum
For a family up to five (including the first three children)	Rs.548/- per annum
For a family up to seven (including the first three children and dependent parents)	Rs.730/- per annum
Premium subsidy for BPL families	For families below the poverty line the Government will provide a premium subsidy.

K. **Rashtriya Swasthya Bima Yojana**

The government has also launched various health schemes, some of them applicable to particular states. To extend the reach of health benefits to the masses, it has implemented the Rashtriya Swasthya Bima Yojana in association with insurance companies. RSBY has been launched by the Ministry of Labour and Employment, Government of India, to provide health insurance coverage for the below poverty line (BPL) families.

Following are the features of Rashtriya Swasthya Bima Yojana:

a. Total sum insured of Rs. 30,000 per BPL family on a family floater basis.

b. Pre-existing diseases to be covered.

c. Coverage of health services related to hospitalization and services of surgical nature which can be provided on a day-care basis.

d. Cashless coverage of all eligible health services.

e. Provision of smart card.

f. Provision of pre and post hospitalization expenses.

g. Transport allowance of Rs.100/- per visit.

h. The Central and State Government pays the premium to the insurer.

i. Insurers are selected by the State Government on the basis of a competitive bidding.

j. Choice to the beneficiary between public and private hospitals.

k. Premium to be borne by the Central and State governments in the proportion of 3:1. Central Government to contribute a maximum amount of Rs. 565/- per family.

l. Contribution by the State Governments: 25 percent of the annual premium and any additional premium beyond Rs 750.

m. Beneficiary to pay Rs. 30/- per annum as registration fee/ renewal fee.

n. Administrative cost to be borne by the State Government.

o. Cost of smart card additional amount of Rs. 60/- per beneficiary would be available for this purpose.

p. The scheme shall commence operation from the first of the month after the next month from the date of issue of smart card. Thus, if the initial smart cards are issued anytime during the month of February in a particular district, the scheme will commence from 1st of April.

q. The scheme will last for one year till 31st March of next year. This would be the terminal date of the scheme in that particular district. Thus, cards issued during the intervening period will also have the terminal date as 31st March of the following year.

Claim settlement to be done through TPA's mentioned in the schedule or by the insurance company. The settlement is to be made cashless as far as possible through listed hospitals.

Any one illness will be deemed to mean continuous period of illness and it includes relapse within 60 days from the date of last consultation with the hospital.

L. Pradhan Mantri Suraksha Bima Yojana

The recently announced PMSBY covering personal accident death and disability cover insurance has attracted lot of interest and the scheme details are as under:

Scope of coverage: All savings bank account holders in the age 18 to 70 years in participating banks are entitled to join. Participating banks must tie up with any approved non-life insurer who will offer a Master Policy to such bank for the cover. Any person would be eligible to join the scheme through one savings bank account only and if he enrols in more than one bank, he gets no extra benefit and the extra premium paid will stand forfeited. Aadhar would be the primary KYC for the bank account.

Enrollment Modality / Period: The cover shall be for the one year period from 1st June to 31st May for which option to join / pay by auto-debit from the designated savings bank account on the prescribed forms will be required to be given by 31st May of every year, extendable up to 31st August 2015 in the initial year. Initially on launch, the period for joining may be extended by Govt. of India for another three months, i.e. up to 30th of November, 2015.

Joining subsequently on payment of full annual premium may be possible on specified terms. Applicants may give an indefinite / longer option for enrolment / auto-debit, subject to continuation of the scheme with terms as may be revised on the basis of past experience. Individuals who exit the scheme at any point may re-join the scheme in future years through the above modality. New entrants into the eligible category from year to year or currently eligible individuals who did not join earlier shall be able to join in future years while the scheme is continuing.

Benefits under the insurance are as follows:

Table of Benefits	**Sum Insured**
Death	Rs. 2 Lakh
Total and irrecoverable loss of both eyes or loss of use of both hands or feet or loss of sight of one eye and loss of use of hand or foot	Rs. 2 Lakh
Total and irrecoverable loss of sight of one eye or loss of use of one hand or foot	Rs. 1 Lakh

Joining and Nomination facility is available by sms, email or personal visit.

Premium: Rs.12/- per annum per member. The premium will be deducted from the account holder's savings bank account through 'auto debit' facility in one instalment on or before 1st June of each annual coverage period.

However, in cases where auto debit takes place after 1st June, the cover shall commence from the first day of the month following the auto debit. Participating banks will deduct the premium amount in the same month when the auto debit option is given, preferably in May of every year, and remit the amount due to the Insurance Company in that month itself.

The premium would be reviewed based on annual claims experience but efforts would be made to ensure that there is no upward revision of premium in the first three years.

Termination of cover: The accident cover for the member shall terminate:

1. On member attaining the age of 70 years (age nearest birth day) or
2. Closure of account with the Bank or insufficiency of balance to keep the insurance in force or
3. In case a member is covered through more than one account, insurance cover will be restricted to one only and the other cover will terminate while the premium shall be forfeited.

If the insurance cover is ceased due to any technical reasons such as insufficient balance on due date or due to any administrative issues, the same can be reinstated on receipt of full annual premium, subject to conditions that may be laid down. During this period, the risk cover will be suspended and reinstatement of risk cover will be at the sole discretion of Insurance Company.

M. **Pradhan Mantri Jan Dhan Yojana**

This financial inclusion campaign for Indian citizens in Banking Savings & Deposit Accounts, Remittance, Credit, Insurance and Pension in an affordable manner was launched by the Prime Minister of India, Narendra Modi on 28 August 2014 as announced on his first Independence Day speech on 15 August 2014. This scheme has set a world record in bank account opening during any one week. Aimed at including maximum number of people in the banking mainstream

An account can be opened in any bank branch or Business Correspondent (Bank Mitra) outlet. PMJDY accounts are being opened with Zero balance. However, if the account-holder wishes to get cheque book, he/she will have to fulfill minimum balance criteria.

Special Benefits under PMJDY Scheme

1. Interest on deposit.
2. Accidental insurance cover of Rs.1.00 lac
3. No minimum balance required.
4. Life insurance cover of Rs.30,000/-
5. Easy Transfer of money across India
6. Beneficiaries of Government Schemes will get Direct Benefit Transfer in these accounts.
7. After satisfactory operation of the account for 6 months, an overdraft facility will be permitted
8. Access to Pension, insurance products.
9. Accidental Insurance Cover
10. RuPay Debit Card which must be used at least once in 45 days.
11. Overdraft facility upto Rs.5000/- is available in only one account per household, preferably lady of the household.

As on 13th May 2015, a record 15.59 Crore accounts have been opened with a balance in account of Rs. 16,918.91 Crores. Of these, 8.50 Crore accounts have been opened with zero balance.

N. Personal Accident and disability cover

A **Personal Accident (PA) Cover** provides compensation due to death and disability in the event of unforeseen accident. Often these policies provide some form of medical cover along with the accident benefit.

In a PA policy, while the death benefit is payment of 100% of the sum insured, in the event of disability, compensation varies from a fixed percentage of the sum insured in the case of permanent disability to weekly compensation for temporary disablement.

Weekly compensation means payment of a fixed sum per week of disablement subject to a maximum limit in terms of number of weeks for which the compensation would be payable.

1. Types of disability covered

Types of disability which are normally covered under the policy are:

i. **Permanent total disability (PTD):** means becoming totally disabled for lifetime viz. paralysis of all four limbs, comatose condition, loss of both eyes/ both hands/ both limbs or one hand and one eye or one eye and one leg or one hand and one leg,

ii. **Permanent partial disability (PPD):** means becoming partially disabled for lifetime viz. loss of fingers, toes, phalanges etc.

iii. **Temporary total disability (TTD):** means becoming totally disabled for a temporary period of time. This section of cover is intended to cover the loss of income during the disability period.

The client has choice to select only death cover or death plus permanent disablement of Or Death plus permanent disablement and also temporary total disablement.

2. Sum insured

Sums insured for PA policies are usually decided on the basis of gross monthly income. Typically, it is 60 times of the gross monthly income. However, some insurers also offer on fixed plan basis without considering the income level. In such policies sum insured for each section of cover varies as per the plan opted.

3. Benefit plan

Being a benefit plan, PA policies do not attract contribution. Thus, if a person has more than one policy with different insurers, in the event of accidental death, PTD or PPD, claims would be paid under all the policies.

4. Scope of cover

These policies are often extended to cover medical expenses, which reimburses the hospitalization and other medical costs incurred following the accident. Today we have health policies which are issued to cover medical/ hospitalization expenses incurred consequent to an accident. Such policies do not cover diseases and their treatment and instead cover only accident related medical costs.

5. Value added benefits

Along with personal accident, many insurers also offer value added benefits like hospital cash on account of hospitalization due to accident, cost of transportation of mortal remains, education benefit for a fixed sum and ambulance charges on the basis of actual or fixed limit whichever is lower.

6. Exclusions

Common exclusions under personal accident cover are:

i. Any existing disability prior to the inception of policy

ii. Death or disability due to mental disorders or any sickness

iii. Directly or indirectly caused by venereal disease, sexually transmitted diseases, AIDS or insanity.

iv. Death or disability caused by radiation, infection, poisoning except where these arise from an accident.

v. Any injury arising or resulting from the Insured or any of his family members committing any breach of law with criminal intent.

vi. Death or disability or Injury due to accidental injury arising out of or directly or indirectly connected with or traceable to war, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrests, restraints and detainments.

vii. In the event the insured person is a victim of culpable homicide, i.e. murder. However, in most policies, in case of murder where the insured is not himself involved in criminal activity, it is treated as an accident and covered under the policy.

viii. Death/Disablement/Hospitalization resulting, directly or indirectly, caused by, contributed to or aggravated or prolonged by child birth or from pregnancy or in consequence thereof.

ix. While the Insured/Insured Person is participating or training for any sport as a professional, serving in any branch of the Military or Armed Forces of any country, whether in peace or war.

x. Intentional self-injury, suicide or attempted suicide (whether sane or insane)

xi. abuse of intoxicants or drugs and alcohol

xii. whilst engaging in aviation or ballooning, whilst mounting into, dismounting from or travelling in any aircraft or balloon other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world

Certain policies also exclude loss arising out of driving any vehicle without a valid driving license.

PA policies are offered to individuals, family and also to groups.

Family Package Cover

Family package cover may be granted on the following pattern:

- **Earning member (Persons Insured) and Spouse, if earning:** Independent capital sum insured for each, as desired, within usual limitations as in individual.

- **Spouse (if not earning member):** usually 50 percent of the capital sum insured of the earning member. This may be limited to a specified upper limit e.g. Rs.1,00,000 or Rs. 3,00,000.

- **Children (between the age of 5 years and 25 years):** usually 25 percent of the capital sum insured of the earning parent subject to a specified upper limit e.g. Rs. 50,000 per child.

Group Personal Accident Policies

Group Personal Accident Policies are usually annual policies only renewal being allowed on anniversary. However, 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.

Following are different types of group policies:

- **Employer and Employee relationship**

  These policies are granted to firms, association etc. to cover:

  - Named employees

- Unnamed employees

- **Non Employer-Employee relationship**

  These policies are granted to associations, societies, clubs, etc. to cover:

  - Named members
  - Members not identified by name

  (Note: Employees may be covered separately)

Broken bone policy and compensation for loss of daily activities

This is a specialised PA policy. This policy is designed to provide cover against listed fractures.

i. Fixed benefit or percentage of sum insured mentioned against each fracture is paid at the time of claim.

ii. Quantum of benefit depends on the type of bone covered and nature of fracture sustained.

iii. To illustrate further, compound fracture would have higher percentage of benefit than simple fracture. Again, percentage of benefit for femur bone (thigh bone) would have higher percentage over benefit of finger bone.

iv. The policy also covers fixed benefit defined in the policy for loss of daily activities viz. eating, toileting, dressing, continence (ability to hold urine or stools) or immobility so that insured can take care of cost associated to maintain his/her life.

v. It also covers hospital cash benefit and accidental death cover. Different plans are available with varying sums insured and benefit payout.

O. Overseas travel insurance

1. Need for the policy

An Indian citizen travelling outside India for business, holidays or studies is exposed to the risk of accident, injury and sickness during his stay overseas. The cost of medical care, especially in countries such as USA and Canada, is very high and could cause major financial problems if a person travelling to these countries were to meet with an unfortunate accident/ illness. To protect against such unfortunate events, travel policies or overseas health and accident policies are available.

2. Scope of coverage

Such policies are primarily meant for accident and sickness benefits, but most products available in the market package a range of covers within one product. The covers offered are:

i. Accidental death / disability
ii. Medical expenses due to illness / accident
iii. Loss of checked in baggage
iv. Delay in arrival of checked in baggage
v. Loss of passport and documents
vi. Third party liability for property / personal damages
vii. Cancellation of trips
viii. Hijack cover

3. Types of plans

The popular policies are the Business and Holiday Plans, the Study Plans and the Employment Plans.

4. Who can provide this insurance

Overseas or Domestic Travel Insurance policies may only be offered by non-life and standalone health insurance companies, either as a standalone product or as an add-on cover to an existing health policy, provided that the premium for the add-on cover is approved by the Authority under File And Use Procedure.

5. Who can take the policy

An Indian citizen travelling abroad on business, holiday or for studies can avail this policy. Employees of Indian employers sent on contracts abroad can also be covered.

6. Sum insured and premiums

The cover is granted in US Dollars and generally varies from USD 100,000 to USD 500,000. For the section covering medical expenses evacuation, repariation, which is the main section. For other sections the S.I. is lower, expect for the liability cover. Premiums can be paid in Indian rupees except in the case of the employment plan where premium has to be paid in dollars. The plans are usually of two types:

- ✓ World-wide excluding USA / Canada
- ✓ World-wide including USA / Canada

Some products provide for cover in Asian countries only, Schengen countries only etc.

1. Corporate frequent travellers plans

This is an annual policy whereby a corporate/employer takes individual policies for its executives who frequently make trips outside India. This cover can also be taken by individuals who fly overseas many times during a year. There are limits on the maximum duration of each trip and also the maximum number of trips that can be availed in a year.

An increasingly popular cover today is an annual declaration policy whereby an advance premium is paid based on the estimated man days of travel in a year by a company's employees.

Declarations are made weekly / fortnightly on the number of days of travel employee wise and premium is adjusted against the advance. Provision is also given for increase in the number of man days during the currency of the policy, as it gets exhausted on payment of additional advance premium.

The above policies are granted only for business and holiday travels.

Common exclusions under the OMP include pre-existing diseases. Persons with existing ailments cannot obtain cover for taking treatment abroad.

The health related claims under these policies are totally cashless wherein each insurer ties up with an international service provider with network in major countries who service the policies abroad.

P. Group health cover

1. GROUP POLICIES

As explained earlier in the chapter a group policy is taken by a group owner who could be an employer, an association, a bank's credit card division, where a single policy covers the entire group of individuals.

Group Health Insurance Policies may be offered by any insurance company, provided that all such products shall only be one year renewable contracts.

Features of group policies- Hospitalisation benefit covers.

1. Scope of coverage

The most common form of group health insurance is the policy taken by employers covering employees and their families including dependent spouse, children and parents / parents in law.

2. Tailor-made cover

Group policies are often tailor-made covers to suit the requirements of the group. Thus, in group policies, one will find several standard exclusions of the individual policy being covered under the group policy.

3. Maternity cover

One of the most common extensions in a group policy is the maternity cover. This is now being offered by some insurers under individual policies, but with a waiting period of two to three years. In a group policy, it normally has a waiting period of nine months only and in some cases, even this is waived. Maternity cover would provide for the expenses incurred in hospitalization for delivery of child and includes C- section delivery. This cover is generally restricted to Rs. 25,000 to Rs. 50,000 within the overall sum insured of the family.

4. Child cover

Children are normally covered from the age of three months only in individual health policies. In group policies, coverage is given to babies from day one, sometimes restricted to the maternity cover limit and sometimes extended to include the full sum insured of the family.

5. Pre-existing diseases covered, waiting period waived off

Several exclusions such as the pre-existing disease exclusion, thirty days waiting period, two years waiting period, congenital diseases may be covered in a tailor-made group policy.

6. Premium calculation

The premium charged for a group policy is based on the age profile of the group members, the size of the group and most importantly the claims experience of the group. As the premium varies year on year based on experience, additional covers as mentioned above are freely given to the groups, as it is in the interest of the group policyholder to manage his claims within the premiums paid.

7. Non-employer employee groups

In India, regulatory provisions strictly prohibit formation of groups primarily for the purpose of taking out a group insurance cover. When group policies are given to other than employers, it is important to determine the relation of the group owner to its members.

Example

A bank taking a policy for its saving bank account holders or credit card holders constitutes a homogenous group, whereby a large group is able to benefit by a tailor-made policy designed to suit their requirements.

Here the premium collected from each individual account holder may be quite low, but as a group the premium obtained by the insurer would be substantial and the bank offers a value add to its customers in the form of a superior policy and at better premium rates.

8. Pricing

In group policies, there is provision for discount on premium based on size of the group as also the claims experience of the group. Group insurance reduces the risk of adverse selection, as the entire group is covered in a policy and enables the group holder to bargain for better terms. However, in recent years, this segment has seen high loss ratios, primarily due to underpricing of premium due to competition. While, this has led to some to review of premium and cover by insurers, it is still difficult to declare that the situation has since been corrected.

9. Premium payment

The premiums could be either totally paid by the employer or group owner, but it is usually on a contribution basis by the employees or group members. However it is a single contract with the insurer, with the employer/group owner collecting the premium and paying the premium covering all the members.

10. Add-on benefits

Tailor-made group policies offer covers such as dental care, vision care, and cost of health checkup and sometimes, critical illness cover too at additional premiums or as complimentary benefits.

Notes:

IRDAI has laid down conditions for granting of group accident and health covers. This protects individuals from being misled by fraudsters into joining invalid and money making group policy schemes.

Recently introduced government health insurance schemes and mass products can also be classified as group health covers since the policies are purchased for an entire segment of the population by the government.

Definition

Group definition could be summarized as below:

a) A group should consist of persons with a commonality of purpose, and the group organizer should have the mandate from a majority of the members of the group to arrange insurance on their behalf.

b) No group should be formed with the main purpose of availing insurance.

c) The premium charged and benefits available should be clearly indicated in the group policy issued to individual members.

d) Group discounts should be passed on to individual members and premium charged should not be more than that given to the insurance company.

2. CORPORATE BUFFER OR FLOATER COVER

In most group policies, each family is covered for a defined sum insured, varying from Rs. One lac to five lacs and sometimes more. There arise situations where the sum insured of the family is exhausted, especially in the case of major illness of a family member. In such situations, the buffer cover brings relief, whereby the excess expenses over and above the family sum insured are met from this buffer amount.

In short the buffer cover would have a sum insured varying from Rs. ten lacs to a crore or more. Amounts are drawn from the buffer, once a family's sum insured is exhausted. However this utilization is usually restricted to major illness / critical illness expenses where a single hospitalization exhausts the sum insured.

The amount that could be utilized by each member from this buffer is also capped, often up to the original sum insured. Such buffer covers should be given for medium sized policies and a prudent underwriter would not provide this cover for low sum insured policies.

Q. Special Products

1. Disease covers

In recent years, disease specific covers like cancer, diabetes have been introduced in the Indian market, mostly by life insurance companies. The cover is long term - 5 years to 20 years and a wellness benefit is also included – a regular health check-up paid for by the insurer. There is incentive for better control of factors like blood glucose, LDL, blood pressure etc. in the form of reduced premiums from second year of policy onwards. On the other hand, a higher premium would be chargeable for poor control.

2. Product designed to cover diabetic persons

This policy can be taken by persons between 26 and 65 years and is renewable up to 70 years. Sum Insured ranges from Rs. 50,000 to Rs. 5,00,000. Capping on Room rent is applicable. Product is aimed to cover hospitalization complications of diabetes like diabetic retinopathy (eye), kidney, diabetic foot, kidney transplant including donor expenses.

Test Yourself 8

Though the duration of cover for pre-hospitalization expenses would vary from insurer to insurer and is defined in the policy, the most common cover is for _____ pre-hospitalization.

I. Fifteen days
II. Thirty days
III. Forty Five days
IV. Sixty days

R. Key terms in health policies

1. Network Provider

Network provider refers to a hospital/nursing home/day care center which is under tie-up with an insurer/TPA for providing cashless treatment to insured patients. Insurers / TPAs normally negotiate favourable discounts on charges and fees from such providers who also guarantee a good level of service. Patients are free to go to out-of-network providers but there they are generally charged much higher fees.

2. Preferred provider network (PPN)

An insurer has the option to create a preferred network of hospitals to ensure quality treatment and at best rates. When this group is limited to only a select few by the insurer based on experience, utilization and cost of providing care, then we have what is known as the preferred provider network.

3. Cashless service

Experience has shown that one of the causes of debt is borrowing for treatment of illness. A cashless service enables the insured to avail of the treatment up to the limit of cover without any payment to the hospitals. All that the insured has to do is approach a network hospital and present his medical card as proof of insurance. The insurer facilitates a cashless access to the health service and directly makes payment to the network provider for the admissible amount. However, the insured has to make payment for amounts beyond the policy limits and for expenses not payable as per policy conditions.

4. Third party administrator (TPA)

A major development in the field of health insurance is the introduction of the third party administrator or TPA. Several insurers across the world utilize the services of independent organizations for managing health insurance claims. These agencies are known as the TPAs.

In India, a TPA is engaged by an insurer for provision of health services which includes among other things:

i. Providing an identity card to the policyholder which is proof of his insurance policy and can be used for admission into a hospital
ii. Providing a cashless service at network hospitals
iii. Processing of claims

TPAs are independent entities who are appointed by insurers for processing and finalizing health claims. TPAs service health policyholders starting from issuance of unique identity cards for hospital admissions up to settlement of claims either on cashless basis or reimbursement basis.

Third party administrators were introduced in the year 2001. They are licensed and regulated by IRDAI and mandated to provide health services. The minimum capital and other stipulations to qualify as a TPA are prescribed by IRDAI.

Thus health claims servicing are now outsourced by the insurers to the TPAs, at a remuneration of five-six percent of the premium collected.

Third party administrators enter into an MOU with hospitals or health service providers and ensure that any person who undergoes treatment in the network hospitals is given a cashless service. They are the intermediaries between the insurer(s) and the insured(s), who co-ordinate with the hospitals and finalize health claims.

5. Hospital

A hospital means any institution established for in-patient care and day care treatment of sickness and / or injuries and which has been registered as a hospital with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:

a) has at least 10 inpatient beds in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;
b) has qualified nursing staff under its employment round the clock;
c) has qualified medical practitioner(s) in charge round the clock;
d) has a fully equipped operation theatre of its own where surgical procedures are carried out;
e) maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

6. Medical practitioner

A Medical practitioner is a person who holds a valid registration from the medical council of any state of India and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license. However, insurance companies are free to make a restriction that the registered practitioner should not be the insured or any close family member.

7. Qualified nurse

Qualified nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

8. Reasonable and necessary expenses

A health insurance policy always contains this clause as the policy provides for compensation of expenses that would be deemed to be reasonable for treatment of a particular ailment and in a particular geographical area.

A common meaning would be the charges incurred that are medically necessary to treat the condition, does not exceed the usual level of charges for similar treatment in the locality in which it is incurred and does not include charges that would not have been made if no insurance existed.

IRDAI defines Reasonable Charges as the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved .

This clause provides protection to the insurer against inflation of bills by the provider and also prevents insured from going in for high end hospitals for treatment of common ailments, which could be otherwise done at reasonably low costs.

9. Notice of claim

Every insurance policy provides for immediate intimation of claim and specified time limits for document submission. In health insurance policies, wherever cashless facility is desired by the customer, intimations are given well before the hospitalization. However in cases of reimbursement claims, the insured sometimes does not bother to intimate insurers of the claim and submits the documents after a lapse of several days / months. Delay in submission of bills could lead to inflation of bills, frauds by insured / hospital, etc. It also affects making proper provisions for claims by the insurance company. Hence insurance companies usually insist on immediate intimation of claims. The time limit for submission of claim documents is normally fixed at 15 days from the date of discharge. This enables quick and accurate reporting of claims, and also enables the insurer to carry out investigations wherever required.

IRDA guidelines stipulate that claim intimation/paper submission beyond stipulated time should be considered if there is a justifiable reason for the same.

10. Free health check

In individual health policies, a provision is generally available to give some form of incentive to a claim free policyholder. Many policies provide for reimbursement of the cost of health check-up at the end of four continuous, claim free policy periods. This is normally capped at 1% of the average sum insured of the preceding three years.

11. Cumulative bonus

Another form of encouraging a claim free policyholder is providing a cumulative bonus on the sum insured for every claim free year. This means that the sum insured gets increased on renewal by a fixed percentage say 5% annually and is allowed up to a maximum of 50% for ten claim-free renewals. The insured pays the premium for the original sum insured and enjoys a higher cover.

As per IRDAI guidelines, cumulative bonus can be provided only on indemnity based health insurance policies and not benefit policies (except PA policies). The operation of cumulative bonus should be stated explicitly in the prospectus and the policy document. Moreover, if a claim is made in any particular year, the cumulative bonus accrued can only be reduced at the same rate at which it is accrued.

Example

A person takes a policy for Rs. 3 lacs at a premium of Rs. 5,000. In the second year, in case of no claims in the first year, he gets a sum insured of Rs. 3.15 lacs (5% more than the previous year) at the same premium of Rs. 5,000. This could go up to Rs. 4.5 lacs over a ten year claim free renewal.

12. Malus/ Bonus

Just as there is an incentive to keep the health policy free of claims, the opposite is called a malus. Here, if the claims under a policy are very high, a malus or loading of premium is collected at renewal.

Keeping in view that health policy is a social benefit policy, so far malus is not charged on individual health policies.

However, in case of group policies, the malus is charged by way of loading the overall premium suitably to keep the claim ratio within reasonable limits. On the other hand if experience is good a discount in premium rate is allowed which is turned as Bonus.

13. No claim discount

Some products provide for a discount on premium for every claim free year instead of a bonus on sum insured.

14. Co-payment

Co-payment is the concept of the insured bearing a portion of each and every claim under a health policy. These could be compulsory or voluntary depending on the product. Co-payment brings in a certain discipline among the insured to avoid unnecessary hospitalizations.

Some products in the market have co-payment clauses in respect of certain diseases only, such as major surgeries, or commonly occurring surgeries, or for persons above a certain age.