EXPOSURE DRAFT

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY (HEALTH INSURANCE) REGULATIONS, 2012

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THE INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY (HEALTH INSURANCE) REGULATIONS, 2012.

F. No. IRDA/Reg/…./2011 dated ….. - *In exercise of the powers conferred under Section 114A of the Insurance Act 1938 and Section 14 read with section 24 of the IRDA Act 199 and in consultation with the Insurance Advisory Committee, the Authority hereby makes the following regulations, namely:-*

CHAPTER 1

1. Short title and commencement.

a.These regulations may be called Insurance Regulatory and Development Authority (Health Insurance) Regulations, 2012

b. They shall come into force from the date of their publication in the Official Gazette by the Central Government.

c. Unless otherwise provided by this regulation, nothing in this regulation shall deem to invalidate the health insurance contracts entered prior to these regulations coming into force.

d. These Regulations are applicable to all life, non life and health insurers, if any conducting health insurance business as defined under these regulations.

1.1 Definitions.

In these Regulations, unless the context otherwise requires,--

a) "*Act*" means the Insurance Act, 1938.

b) "*Agreement*" means an agreement entered into between a Third Party Administrator and an insurance company prescribing the terms and conditions of services, which may be rendered to Insurance Company; or an agreement entered into between a Hospital /Health care provider and an Insurance Company, and may include TPA as a tri-party, prescribing the terms and conditions, which may be rendered to insured persons of the Insurance Company.

c) "*Authority*" means Insurance Regulatory and Development Authority of India established under sub section 1 of section 3 of the IRDA Act 1999.

d) "Break in policy" A break in policy occurs when the premium due on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

e) "Cashless facility" means a facility provided to the insured by an insurer, to make payments of treatment costs directly to the hospital in respect of treatment undergone in a network

provider, to the extent of approval given in the pre-authorization where such treatment is in accordance with the policy terms and conditions.

f) "*Health insurance business*" means the effecting of insurance contracts which provide for sickness benefits or medical, surgical or hospital expense benefits, travel health insurance and personal accident cover ;'

g) "*Health Services" means* all t*he services to* be rendered by a TPA under an agreement with an insurance company in connection with "health insurance business" or 'health cover' as defined in regulation 2(f) of the IRDA (Registration of Indian Insurance Companies) Regulations, 2000, but does not include the business of an insurance company or the soliciting, directly or through an insurance intermediary including an insurance agent, of insurance business.

h) "Health plus Life Combi Products" shall mean the combination of Pure Term Life Insurance cover offered by life insurance companies and Health Insurance cover offered by non life insurance companies.

i) "Network Provider" means hospitals or health care providers which have an agreement with the insurer to settle claims through cashless facility.

j) "Portability" Portability means the right accorded to an individual health insurance policyholder (including family cover) to transfer the credit gained by the insured for pre-existing conditions and time bound exclusions if the policyholder chooses to switch from one insurer to another insurer or from one plan to another plan of the same insurer, provided the previous policy has been maintained without any break.

k) "Senior citizen" means any person who is sixty or more years of age as on the date of commencement of insurance policy.

l) *"Third Party Administrators or TPAs"* means any person who is licensed by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the provision of health services;

m) All words or expressions not defined in these regulations but defined in the Insurance Act 1938 or Insurance Regulatory and Development Authority Act 1999 shall have the same meanings respectively assigned to them in those Acts.

CHAPTER II

Registration of insurance companies who are exclusively doing health insurance business

2. Procedure for Registration

2.1. The Insurance Regulatory and Development Authority (Registration of Indian Insurance Companies) Regulations 2001 shall apply *mutatis mutandis* to all insurance companies who are exclusively doing health insurance business.

2.2. All insurance companies who are exclusively doing health insurance business shall satisfy the capital requirements as specified by the Authority from time to time.

CHAPTER III

Product Design and Related Issues

3.1 Entry and Exit Age

3.1.1. All health insurance policies shall provide for entry age at least up to 65 years, except for those referred in regulation 3.6.

3.1.2. All health insurance policies shall not have an exit age for renewal of the policies, once the proposal is accepted, provided policy is continuously renewed without break.

3.2. Term of health insurance policies

3.2.1. For all products offered to individuals, life insurers shall offer products with policy term of at least 4 years and non-life insurers shall offer products for not more than 3 years

3.2.2. For all products offered as Group Policies, all life insurance companies and non-life insurance companies shall offer only one year Renewable Group Health Insurance Policies.

3.3. Assignment

3.3.1. No assignment of health insurance policies shall be allowed irrespective of whether they are indemnity or benefit based.

3.4. Pan India Access:

3.4.1. All health insurance policies shall allow access for treatment in network provider or in any hospital which is not part of the network provider across pan India except in unauthorised hospitals excluded from providing health care services for health insurance policies.

3.4.2. The insurer shall explicitly state all the terms and conditions with respect to availability and availing of treatment across pan India in the policy document.

3.4.3. If different terms are offered for availing treatment across pan India, this shall be stated explicitly in all the promotion material and shall have suitable provisions built into the proposal form.

3.5. **Travel Medical Insurance Policy**

3.5.1. Travel medical policies may be offered either as

a. a standalone product or

b. an add-on cover to existing health policy as and when existing policyholder travels by charging suitable premium for the add-on cover as approved by the Authority under File And Use Procedure.

3.6. **Option to migrate to suitable health insurance policy:**

3.6.1. In health insurance policies, where the covers offered are specific to a particular age groups like maternity covers, children covered under a family floater policies, cover offered to students etc, insurers shall offer an option to migrate to a suitable health insurance policy, at the renewal of the policy or at the end of the specified exit age, by providing suitable credits for all the previous policy years, provided the policy has been maintained without break.

3.7. **Cumulative bonus:**

3.7.1. In a health insurance policy, insurer may offer cumulative bonus which shall be stated explicitly in the prospectus and the policy document. Such cumulative bonus shall be considered along with the sum insured to arrive at the sub-limits.

3.7.2. If a claim is made in any particular year, the cumulative bonus accrued may be treated as below:

a. May be reduced at the same rate at which it is accrued; or

b. May be utilised to enhance the sum insured by accepting the pro-rate premium to the extent of cumulative bonus to be reduced in that particular year;

3.7.3. Once the insured opts for 3.7.2 (b), it shall not be reduced in the subsequent years.

3.8. **General Provisions**

3.8.1. Any differences in product specifications for different age groups or for different entry ages must be clearly disclosed upfront in prospectus and policy documents.

3.8.2. Insurer shall not compel the insured to migrate to other health insurance products, if it is to the disadvantage of Insured.

3.8.3. 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, proposal form, policy clauses and premium rates inclusive and exclusive of Service Tax as applicable.

3.8.4. Insurers shall individually and collectively take steps for evolving mechanisms for sharing of information among themselves about such persons / hospitals / institutions that are guilty of making or supporting fraudulent claims.

3.9. **Underwriting**

3.9.1. All insurance companies shall obtain all the required information in the proposal form and underwrite the proposals in accordance with the Board approved underwriting policy.

3.9.2. Any proposal for health insurance which is denied on any grounds shall be made in writing with reasons furnished and recorded. Such reasons shall be justifiable, transparent and fair. The insured shall be informed of any loading charged on the premium.

3.9.3. If insurance company intends to call for any further information at subsequent stages of policy with respect to change in occupation or at the time of renewal, the insurance company shall:

a. prescribe standard forms to be filled up by the insured and shall make these forms part of the policy document

b. Clearly state the events which will result in submission of such forms.

c. Clearly state the conditions applicable in such events

3.9.4. Insurers shall devise mechanisms to reward policyholders for early entry, continued renewals, favourable claims experience etc with the same insurer and disclose upfront in prospectus and policy document, as approved under File and Use.

3.9.5. The information that the insurer has already captured at the time of underwriting/accepting the proposal, the terms & conditions offered under the policy based on underwriting and subsequent claims experience emerged during the policy shall form the basis for claim settlement.

3.10. **Cost of pre-insurance health check up**

3.10.1. In case of non-life insurers, where the proposal is accepted and subsequently resulted into a policy, in all such cases, insurers shall reimburse at least 50% of the cost if any, incurred by the insured in pre-insurance medical examination.

Provided, for travel medical insurance policy where the premium levied is less than the costs incurred by the insured in pre-insurance medical examination, the insurer may not reimburse the cost of pre-insurance health check-up.

3.10.2. In case of life insurers, where the proposal is accepted and subsequently resulted into a policy, in all such cases, insurers shall incur the costs and may suitably allow such costs incurred by the insured in pre-insurance medical examination within the premium levied to the policyholder.

3.10.3. Insurers shall enlist or empanel government medical institutions and/or other relevant institutions from which such pre-insurance medical examination reports will be accepted by them.

3.11. **Special Provisions for Insured Persons who are Senior Citizens**

3.11.1. The premium charged for health insurance products offered to senior citizens shall be fair, justified, transparent and duly disclosed upfront. The insured shall be informed of any loading charged on the premium.

3.11.2. All health insurers and TPAs, as the case may be, shall establish a separate channel to address the health insurance related claims and grievances of senior citizens.

3.12. **Pricing of Health Insurance Products**

3.12.1. The premium charged for any health insurance product offered shall be fair, justified, transparent and duly disclosed upfront. The insured shall be informed of any loading charged on the premium.

3.12.2. For calculation of premium for health insurance policies, the completed age of the prospect on the date of commencement of insurance shall only be reckoned.

3.12.3. For the purpose of providing cover under family floater, the premium levied shall take in to account the impact of the multiple incidence rates for all the family members proposed to cover and shall be filed under the File and Use.

3.12.4. The premium for the health insurance products shall be evaluated appropriately after assessing the financial sustainability and viability of the product with respect to the rates, loadings and discounts.

3.12.5. The discounts and loadings offered shall be objective and disclosed upfront in the prospectus and policy document, as approved under the File and Use.

3.12.6. The premiums shall not be allowed to increase for a period of 1 year once the product is cleared by the Authority;

3.12.7. In case of revision of premium rates after completion of such period as stated in 3.12.6, the insurer shall submit under the File and Use Procedure the justification for the revised pricing; the recent three years claims experience on the original pricing along with the expected experience and the reasoning; expected claims experience and the rationale/assumptions for the proposed pricing along with the particulars on how the proposed pricing would meet the adversities experienced, if any.

3.12.8. At the time of filing the product under the File and Use procedure, the insurer shall provide complete pricing details along with all the assumptions, loadings allowed in the premium determination.

3.13**Loading on Renewals**:

3.13.1 If the individual claims experience, for each of the three consecutive policy years other than the current policy year, is more than 500% of the premium under the current policy, the insurer at the time of subsequent renewal may:

a. Apply the malus as referred in the regulation 3.7.2 (a)

b. Load the premium as per the pre-determined table, disclosed at the outset in prospectus and policy document, which is approved as per the File and Use procedure.

c. Accept the renewal at the prevailing premium rates without any loading or malus.

3.14 Free Look Period

3.14.1 Health insurance policies offered by the non-life insurers having duration of three years or more and health insurance policies offered by the life insurers shall have a free look period. The free look period shall be applicable at the inception of the policy and:

a) The insured has a period of 15 days from the date of receipt of the documents to review the terms and conditions of the policy and

b) Where the policy holder disagrees to any terms and conditions, the insured has the option to return the policy stating his reasons for the objections.

c) If the insured has not made any claim during the free look period, the insured shall be entitled to-

i. refund of the premium paid subject only to a deduction of the expenses incurred by the insurer on medical examination of the insured persons and the stamp duty charges or;

ii. where the risk has already commenced and the option of return of the policy is exercised by the policyholder, refund will also be subject to a deduction for proportion risk premium for period on cover or;

iii. Where only a part of the risk has commenced, such proportionate risk premium shall be calculated so as to commensurate with the risk covered during such period.

iv. In respect of unit linked policy, in addition to the deductions in sub-clause(1) of this regulation, the insurer shall also be entitled to repurchase the unit at the price of the units on the date of cancellation.

3.14.2 Non-life insurers may voluntarily provide for free look period even for health insurance policies of duration less than three years. The terms and deductions admissible in the above sub-clause (1) (a) to (1) (c), as relevant, shall apply to such health insurance policies.

3.15 Upper Limit on the Cover Offered:

3.15.1 For any health insurance policy, if the insurer has prescribed any upper limit with respect to the cover offered, the insurer shall not accept any proposal beyond such upper limit.

3.15.2 The insurer shall ensure that the systems in place shall accept proposals only up to the prescribed upper limits.

3.15.3 If any proposal is accepted beyond such upper limit, the insurer shall not deny any claim on the ground that the policy exceeds the upper limit prescribed for that policy.

3.16 Multiple Policies

3.16.1 If two or more policies are taken by an insured during a period from one or more insurers, the contribution clause shall not be applicable for such policies where the cover/benefit offered:

a. is fixed in nature;

b. does not have any relation to the treatment costs;

3.16.2 In case of multiple policies which provide fixed benefits, on happening the event in accordance with the terms and conditions of the policies, the insurer shall make the claim payments independent of payments received under other similar polices.

3.16.3 If two or more policies are taken by an insured during a period from one or more insurers, where the purpose of such policies is to indemnify the treatment costs, the insurer shall not apply the contribution clause, but the policyholder shall have an

option to chose insurer with whom the claim to be settled. In all such cases, the insurer shall be obliged to settle the claim without insisting for contribution clause.

3.17 AYUSH Coverage

3.17.1 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.

3.18 Standard Definition used in health insurance policies

3.18.1 All insurers shall adhere to the stipulated definitions, if any, as issued by the Authority from time to time.

3.19 Standard Nomenclature and Procedures for Critical Illnesses

3.19.1 All Policies offering critical illness coverage shall ensure that definitions of such terms and are in line with the definitions stipulated, if any, by the Authority from time to time.

3.20 Standard List of Excluded Expenses in Hospitalization Indemnity policies

3.20.1 For the purpose of hospitalization indemnity policies, the generally accepted list of excluded items, if any, may be stipulated by the Authority from time to time.

3.20.2 However, Insurers may include these exclusions as part of the cover, if the product design allows for it or if the cover offered includes these as part of hospitalization expenses. Insurers depending on the product design, shall clearly state the list of excluded items for each product out of the list stipulated, if any, by the Authority from time to time and such list shall be annexed to the policy document

3.21 Database for health insurance products:

3.21.1 All insurers filing health insurance products shall complete and submit Database Sheet, if any, as stipulated by the Authority from time to time, as part of file and use procedure.

3.21.2 The Database shall be certified by the Head of Product Development and countersigned by Compliance Officer.

3.22 Withdrawal of Health Insurance Product

3.22.1 To withdraw a health insurance product, the insurer shall take prior approval of the Authority by giving reasons for withdrawal and complete details of the treatment to the existing policyholders**.**

3.22.2 Any product that is being offered in the market by insurance companies shall not be allowed to be withdrawn in respect of the existing customers of the product, unless, the existing customers are given an option to switch to a similar product under specific written consent.

3.22.3 The withdrawn product shall not be offered to the prospective customers.

3.23 **Customer Information Sheet** – Insurer shall provide the customer information sheet to the prospective policyholder. The document shall be:

3.23.1 A one page document in legible font, unless the product is a composite product.

3.23.2 In simple language.

3.23.3 Covering key benefits, exclusions and grievance mechanisms.

3.23.4 A complete document in itself, without any reference made to policy document or any other document.

3.23.5 Insurers shall design Customer Information Sheet as per the format stipulated by the Authority from time to time.

3.23.6 All Insurers shall file the Customer Information Sheet along with policy document at the time of filing product under file and use procedures.

Chapter- IV

Renewability of Health Insurance Policies

4.1 A health insurance policy shall be ordinarily renewable except on grounds of fraud, moral hazards or misrepresentation. The renewal of the health insurance policy sought by the insured shall not be denied arbitrarily. And if denied, shall provide the policyholder with cogent reasons for non-renewal of the health insurance policy.

Explanation I:- the insurer shall not reject the renewal of the health insurance policy on the ground that the insured had made a claim or claims in the previous or earlier years.

4.2 Insurer shall not compel the insured covered under one health insurance product to shift to another health insurance product except in cases where a specific product has been upgraded or discontinued with the prior approval of the Authority.

4.3 Subject to the provisions of these regulations, prospectus of health insurance policy shall contain disclosures about the terms of its renewal.

4.4 The disclosures as aforesaid shall mandatorily contain material information regarding:-

a) coverage and estimated premium for future renewals of the policy

b) disclosure of the maximum age up to when the renewal would be available, if product is offered to specified age groups.

c) any changes in the scope of the cover after certain duration of the policy or after a certain age- such as including but not limited to coverage for pre-existing diseases;

d) whether renewal premium would be guaranteed or subject to revision;

e) the premium being charged at different age slabs;

f) details of specific circumstances where premium could be loaded (or discount withdrawn) by the insurer and also to the extent to which it could be done.

g) Procedure and terms for enhancing the sum insured or scope of cover , if any

4.5 The insurer shall provide for a mechanism to condone delay of renewal up to 30 days from the renewal due date, in line with break in policy.

4.6 For the purpose of this clause, the insurer shall also state, including but not limited to, the fact that coverage would not be available for break in period.

4.7 Notwithstanding anything contained in these regulations, no revision in the premium structure or terms of health insurance policies shall be affected without prior approval of the Authority

4.8 The insurers shall intimate such revision to the policyholders at least three months prior to the date of renewal of the cover. In such cases where the insurer has revised the premiums or the terms and conditions of the policy, the insurer shall send a renewal notice for health insurance policies to the policyholder.

4.9 Where such renewal notice envisages a premium higher than that paid in the previous year, the notice shall explain the reason for the increase in premium and also quantum of the increase in premium which is in accordance with the disclosures earlier made in the prospectus.

4.10 Benefit based policies where policies terminate on happening of the event as per the terms and conditions of the policy; renewability clause shall explicitly state such conditions in the promotion material and the policy document. Ex. Critical illness benefits policies.

Chapter V

Portability of Health Insurance Policies

5.1 A policyholder desirous of porting his policy to another insurance company shall apply to such insurance company at least 45 days before the premium renewal date of his/her existing policy.

5.2 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.

5.3 Portability shall be opted by the policyholder only as stated in 5.1 and not during the currency of the policy.

5.4 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.

5.5 Where the outcome of acceptance of portability is still waiting from the new insurer on the date of renewal

5.5.1 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

5.5.2 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

5.5.3 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.

5.5.4 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.

5.6 In case the policyholder has opted as in 55.1, 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.

5.7 On receipt of such intimation, the insurance company shall furnish the applicant, the Portability Form as set out in Annexure 'I' to these guidelines together with a proposal form and relevant product literature on the various health insurance products which could be offered.

5.8 The policyholder shall fill in the portability form along with proposal form and submit the same to the insurance company.

5.9 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.

5.10 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.

5.11 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.

5.12 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.

5.13 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 the Authority in accordance with clause 6 of IRDA Form R2 of IRDA (Registration of Indian Insurance Companies) Regulations, 2000 and clause 14-15 of F&U Guidelines (circular no. 021/IRDA/F&U/Sep. 06 dated 28th

September 2006), then the insurance company shall not retain the right to reject such proposal and shall have to accept the proposal.

5.14 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.

5.15 No commission shall be payable to any intermediary on the acceptance of a ported policy.

5.16 Portability shall be allowed in the following cases:

5.16.1 All individual health insurance policies issued by non-life insurance companies including family floater policies

5.16.2 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 5.16.1 above.

5.17 For any health insurance policy, waiting period with respect to pre-existing diseases and time bound exclusions shall be taken into account as follows:-

S. No	**No of years of continuous insurance cover with previous insurer (s)**	**Waiting period to be served with new insurer in number of days/years**				
		YY Days	1 Year	2 years	3 years	4 years
I.	XX Days at inception (XX-no of days as per the policy document)	(YY-XX) Days	N/A	N/A	N/A	N/A
II.	***For 1 year period exclusion:***					
	1 year	N/A	Nil	1 Year	2 Years	3 Years
III.	***For 2 year period exclusion:***					
	1 year	N/A	Nil	1 Year	2 Years	3Years
	2 years	N/A	Nil	Nil	1 Year	2 Years
IV.	***For 3 year period exclusion:***					
	1 year	N/A	Nil	1 Year	2 Years	3 Years
	2 years	N/A	Nil	Nil	1 Year	2 Years
	3 years	N/A	Nil	Nil	Nil	1 Year
V.	***For 4 year period exclusion:***					

	1 year	N/A	Nil	1 Year	2 Years	3 Years
	2 years	N/A	Nil	Nil	1 Year	2 Years
	3 years	N/A	Nil	Nil	Nil	1 Year
	4 years	N/A	Nil	Nil	Nil	Nil

Note 1: In case the waiting period for a certain disease or treatment in the new policy is longer than that in the earlier policy for the same disease or treatment, the additional waiting period should be clearly explained to the incoming policy holder in the portability form to be submitted by the porting policyholder.

Note 2: For group health insurance policies, the individual member's shall be given credit as per the table above based on the number of years of continuous insurance cover, irrespective of, whether the previous policy had any pre-existing disease exclusion/time bound exclusions

6.12 The portability shall be applicable to the sum insured under the previous policy and also to an enhanced sum insured, if requested by the insured, to the extent of cumulative bonus acquired from the previous insurer(s) under the previous policies.

For e.g. - If a person had a SI of RS 2lakhs and accrued bonus of Rs 50, 000 with insurer A; when he shifts to insurer B and the proposal is accepted, insurer B has to offer him SI of Rs 2.50lakhs by charging the premium applicable for Rs 2.50lakhs. If insurer B has no product for Rs 2.50lakhs, insurer B would offer the nearest higher slab say Rs 3lakhs to insured by charging premium applicable for Rs 3lakhs SI .However, portability would be available only up to Rs 2.50lakhs.

5.18 Insurers shall clearly draw the attention of the policyholder in the policy contract and the promotional material like prospectus, sales literature or any other documents in any form whatsoever, that:

5.18.1 all health insurance policies are portable;

5.18.2 policyholder should initiate action to approach another insurer, to take advantage of portability, well before the renewal date to avoid any break in the policy coverage due to delays in acceptance of the proposal by the other insurer.

5.19 The insurer shall comply with the "Guidelines on Procedures to Be Adopted by Insurance Companies on Health Insurance Portability" annexed as Annexure II and as amended by the Authority from time to time.

Chapter VI

File and Use Procedure for health insurance products

6.1 All new health insurance products are required to be filed as per the File and Use guidelines and the information shall be furnished in the formats stipulated by the Authority from time to time.

6.2 For any revision or modification of the existing health insurance products, the insurer shall file as per the formats stipulated by the Authority from time to time along with the reasons for the proposed modification.

Chapter VII

Protection of Policyholders' Interest

7.1 The IRDA (Policyholder Protection of Interest) Regulations, 2002 (hereinafter referred as "2002 Regulations" shall be applicable *mutatis mutandis* to all health insurance policies, wherever relevant.

7.2 Unless otherwise inconsistent with this sub-clause, Regulation 8 and 9 of the 2002 Regulations shall apply to all health insurance policies.

7.3 **Settlement of claim:** On receipt of complete documents, an insurer shall within a period of 30 days offer a settlement of the claim to the insured. If the insurer, for any reasons to be recording in writing and communicated to the insured, decides to reject a claim under the policy, it shall do so within a period of 30 days from the receipt of complete documents.

7.4 **Timeline for Submission of claims documents:**

7.4.1 Insurer may stipulate a time limit latest by which the claims documents should be furnished by the policyholder/insured to make a claim.

7.4.2 In case of non submission of timely submission of claims documents, insurers shall not repudiate such claims unless and until the reasons of delay are categorically enquired about, reasons recorded and the insurers sufficiently satisfy that the delayed claims could have otherwise been rejected if reported in time.

7.4.3 All insurers shall develop a sound mechanism of their own to handle such claims with utmost care and caution. The insurers shall incorporate additional wordings in the policy documents, suitably providing insurers' decision to condone delay on merit for

claims which are not submitted in time, but if substantiated by the insured that the delay is beyond his/her control and due to exceptional/ unavoidable circumstances.

Chapter VIII
Health Insurance Policy Servicing

8.1 Administration of Network Provider

a. Subject to the provision of these regulations, the Network Provider may be subject to change from time to time by the insurer.

b. The insurers shall inform the policy holders at all times, the nearest network provider where cashless facility is available and conditions, if any thereof.

c. Insurer shall display and update the list of Network Providers on their website as and when the list of Network providers is modified and inform the insured suitably.

d. 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 for such policy holder as if such hospital continues to be on the Network Provider list.

8.2 For the purpose of claim settlement, insurer shall make direct payments to the Network provider and to the policyholders by integrating their banking system platform with the network provider or the insured, as the case may be.

8.2.1 *Explanation:* - This shall be applicable to claim settlement of all health insurance business. .

8.3 Administration of Health Plus Life Combi Products

8.3.1 The provisions of this regulation shall also be applicable *mutatis mutandis* to Health component of the Health Plus Life Combi Products.

8.3.2 The administration of all *health plus life combi products* shall be in accordance with the **Annexure II, amended from time to time by the Authority.**

8.4 Standard Pre-authorization and Claim form

8.4.1 All insurers shall adhere to the stipulated claim forms prescribed by the Authority, if any from time to time.

8.5 Identity Cards issued to policyholder to avail cashless facility

8.5.1 To avail the benefit of cashless facility, insurers shall issue the Identification card either through a TPA or directly, within 15 days from the date of issue of policy.

8.5.2 The identification card shall carry details of the policyholder and logo of the insurer. The validity of card shall not exceed the term of the policy. In case the policy is renewed, provisions to be established by the insurer to ensure there shall not be any need for re-issue of fresh cards provided there is no change in the details of the policyholder.

Chapter IX
Third Party Administrators

9.1 Health Services:

9.1.1 The insurer shall provide the health services required to the insured to process the claims either directly or may utilize the services of the TPA under an agreement, who are licensed to provide health services in accordance with the IRDA (Third Party Administrators) Regulations, 2002.

9.1.2 The Authority may modify or bring in additional requirements with respect to the provisions of the IRDA (Third Party Administrators) Regulations, 2002 from time to time.

9.2 Bar on Non-insurance healthcare schemes

9.2.1 The TPA shall offer the health services in accordance with the IRDA (Third Party Administrators) Regulations, 2002 only to the insurers registered in India and shall not provide any services directly to non-insurance healthcare schemes or health insurance schemes promoted, sponsored or approved either by any person or by Central or State government.

9.3 **Agreement with insurance company**

9.3.1 A copy of the agreement entered into between the TPA and the insurance company or any modification thereof, shall be filed, within 15 days of its execution or modification, as the case may be, with the Authority.

9.3.2 More than one TPA may be engaged by an insurance company and, similarly, a TPA can serve more than one insurance company.

9.3.3 The parties to the agreement shall agree between themselves on the scope of the contract and the facilities that have to be provided. Such an agreement shall also prescribe the remuneration that may be payable to the TPA by the insurance company.

9.3.4 Insurers who enter into agreement with unlicensed organizations or companies to act as TPA is outside the scope of the provisions of the Act and the regulations and the insurers as well as the organizations who style themselves as service providers would attract penalty under the provisions of the Act or regulations.

9.3.5 The Authority from time to time may prescribe minimum standard clauses to be included in the agreement between insurer and TPA.

9.4 Change of TPAs for servicing of Health Insurance Policies

9.4.1 A change in the TPA by the insurer shall be communicated to the policyholders 30 days before giving effect to the change.

9.4.2 The contact details like helpline numbers, addresses, etc. of the new TPA shall be made immediately available to all the policyholders in case of change of TPA.

9.4.3 The insurers shall take over all the data in respect of the policies serviced by the earlier TPA and make sure that the same is transferred seamlessly to the newly assigned TPA. It shall be ensured that no inconvenience or hardship is caused to the policyholders as a result of the change. In this regard, the following aspects shall receive special attention:

a. Status of cases where pre-authorization has already been issued by existing TPA.

b. Status of cases where claim documents have been submitted to the existing TPA for processing.

c. Status of claims where processing has been completed by the TPA and payment is pending with the insurer/ TPA.

9.4.4 Settlement /denial of claims:

9.4.5 TPA shall, in the correspondence to the policyholder with respect to settlement/denial of the claims, state clearly the following:

"As per the instructions of the insurer <Name of the Insurer>, the claim is being settled/denied for Rs. <amount> on account of <specifics of treatment/grounds of denial>. For any further clarifications, you may contact directly to the insurer."

9.4.6 The above statement shall form the mandatory part of the communication to be sent to the policyholder in case of settlement /denial of the claims.

9.4.7 The insurer shall be responsible to see that proper and prompt service is extended to the policyholders at all times.

Chapter X

10 Contracts between Insurer and Hospitals

10.1 All insurers shall have an agreement directly with the hospitals to establish the list of Network providers. The insurer shall be responsible for carrying out an empanelment process of hospitals or health care providers to provide cashless facility to policyholder.

10.2 The insurer may include the TPA as a tri-party in the agreement with the hospital; however, the entire responsibility lies with the insurer.

10.3 The insurer shall develop a proper system of empanelment of hospitals or health care providers which summarizes the desired infrastructure for inpatient and day care services with respect to hospitals and other health facilities to be empanelled. This process shall be carried out by the insurer directly to ensure that the hospital are equipped with all the necessary infrastructure to enable the insurer to handle the claim in a seamless manner.

10.4 The insurance company shall ensure that adequate number of both public and private providers shall be empanelled. They shall also make efforts that the empanelled providers are spread across different cities of the country and not confined only to metro cities.

10.5 The service agreements between the insurer and empanelled network Providers shall make provisions for the tariff applicable with respect to various kinds of health care services, non-compliance/default clause while signing the same.

10.6 The insured shall have access to all the network providers of an insurer to avail cashless facility as long as the insurer has a service agreement with the network provider and such network providers shall remain unchanged irrespective of change in TPAs.

10.7 Once a hospital or nursing home is empanelled, the insurer shall enter into arrangement with other insurance companies for allowing sharing of network hospitals, transfer of claim & transaction data arising in areas beyond the service area. To ensure this, the insurer shall sign an agreement with other insurers so that beneficiaries can get seamless access of health care services across India.

10.8 The Authority from time to time may prescribe minimum standard clauses to be included in the service agreement between insurer and Network provider.

Chapter IX

Submission of Information through Electronics Returns.

11.1Each insurer shall submit the information regarding health insurance business as specified in the forms in **Annexure III** for the period ending September and March of every financial year, within a period of one month from the last day of the respective month, commencing with the period ending September 30th (non-life insurer) and life insurers commencing from period beginning 1st April

11.2 The information shall be sent to Insurance Regulatory and Development Authority, 3rd Floor, Parisrama Bhavan, Basheer Bagh HYDERABAD 500 004 Andhra Pradesh (INDIA) in a compact disc, meeting the technical requirements as specified in the Data Manual annexed hereto.

11.3The forms in regulation 11.1 may be amended by the Authority from time to time, if required.

CHAPTER X

12 **Valuation of Assets & Liabilities; Preparation of Financial Statements; Solvency Margin of Insurers and Other Issues**

12.1 All insurance companies carrying on health insurance business are required to comply, mutatis mutandis, all relevant regulations, directions, guidelines circulars issued by the Authority from time to time.

Annexure-I
Portability Form

Part-I

1)	Name of the Policyholder / insured (s)	
2)	Date of Birth/Age	
3)	Address of the policyholder/insured	
4)	Details of existing insurer	
	i. Name of the product	
	ii. Sum Insured	
	iii. Cumulative Bonus	
	iv. Add-ons/riders taken	
	v. Policy number	
5)	Details of the proposed insurance	
	i. Name of the product proposed/intend to	

	take	
	ii. Sum Insured Proposed	
	iii. Whether Cumulative Bonus to be converted to an enhanced sum insured	
6)	Reason(s) for portability	
7)	No. of family member to be included I the policy to be ported.	
Enclosure: Photocopy of the existing policy documents		
Date:		Signature of the policyholder

PART –II

1. Whether the PED exclusions / time bound exclusion have longer exclusion period than the existing policy: (Please indicate Yes / NO):
2. If yes, please give written consent to the declaration below:

"I am aware that the waiting period for the following disease(s)/treatment(s) is ..... days/years more than the previous policy terms. I hereby agree to observe the additional waiting period for the following disease(s)/treatment(s)

Signature of the policyholder

ANNEXURE -II
Administration of Health Plus Life Combi Products

1) The product of this class shall be named as '***Health plus Life Combi Products***' referred as '*Combi Products*' hereinafter in these guidelines.
2) These guidelines do not apply to Micro Insurance Products which are governed by IRDA (Micro Insurance) Regulations, 2005.

Guidelines:-

All insurance companies that promote '*Health plus Life Combi products*' shall adhere to the following guidelines

1) Scope of Combi Product Class:

1) The *'Combi Products'* may be promoted by all Life Insurance and Non-Life Insurance Companies.
2) The *'Combi Product'* shall be the combination of Pure Term Life Insurance cover offered by life insurance companies and Health Insurance cover offered by non life insurance companies. Health Insurance for the purpose of this product class means effecting of contracts which exclusively provide sickness benefits or medical, surgical or hospital expense benefits, whether in-patient or out-patient, on an indemnity or reimbursement basis.
3) The Policy Term and Sum Assured limits are as proposed and cleared under File and Use norms.

4) Riders / Add-on covers may be offered subject to File and Use clearance.
5) 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.
6) 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.
7) The integrated premium amount of the 'C*ombi Product'* shall be basis for reckoning the threshold limit / applicability of extant Regulations, guidelines and circulars etc. issued by the Authority or any other statutory body.
8) Commission and Claim payouts in respect of 'C*ombi Products'* shall be by respective insurers only.
9) 'C*ombi product'* shall have a free look option as outlined in IRDA (Health Insurance Regulations) 2010. Free Look option is to be applied to the 'C*ombi Product*' as a whole.
10) The Health portion of the 'C*ombi Product'* shall entitle its renewability at the option of policy holder to have an independent / standalone health insurance policy from Non-Life Insurance Company of the respective 'C*ombi Product'*.

2) **<u>Tie up between insurers:</u>**

1) It is mandatory that insurance companies offering the 'C*ombi Product'* shall have in place a Memorandum of Understanding covering the modus operandi of marketing, policy service and sharing of common expenses.
2) Insurers forming the tie-up shall obtain prior approval of IRDA by duly filing the copy of the agreement entered in this regard. Approval may be obtained by any one of insurers.
3) A tie up is permitted between one life insurer and one non-life insurer only. Thus a life insurer is permitted to tie up with only one non-life insurer and vice-versa.
4) Between these two Insurers any number of 'C*ombi Products'* may be promoted.
5) It is expected that insurance companies would carry out an appropriate due diligence before establishing the business relationship for the purpose of promoting *'Combi Products'*. Insurers are also expected to have a long-term understanding for effective policy service of the proposed 'C*ombi Products'*.

6) Withdrawal from the tie-up is generally not desirable. However, in exceptional cases where insurers desire to withdraw from MOU they shall obtain prior permission of the Authority.
7) There shall be specific time frames / Turn around Times (TAT) to be agreed between the insurance companies as part of MOU for effective policy service, transmission of premiums received etc. at various stages of policy i.e., at pre-sale stage and post-sale stage.

3) **Lead Insurer**:

1) As two insurance companies are involved in offering the 'C*ombi Product'* one of the insurance companies may be mutually agreed to act as a lead insurer in respect of each *'Combi Product'* marketed with agreed terms, conditions and considerations.
2) The Lead Insurer for the purpose of these guidelines is the insurance company mutually agreed by both the insurers to play a critical role in facilitating the policy service as a contact point for rendering various services as required in these guidelines. It is envisaged that the lead insurer would play a major role in facilitating underwriting and policy service.
3) The role of lead insurer shall not deter in relying upon the existing operational infrastructure of the partner-insurance company for effective policy servicing of 'C*ombi Products'*.
4) Either of the insurers are not absolved of their responsibility of proactive settlement of claims.

4) **Underwriting:**

Under the 'C*ombi Product'*, underwriting of respective portion of risk shall be underwritten by respective insurance companies, that is; Life Insurance risk shall be underwritten by Life Insurance Company and the Health Insurance portion of risk to be underwritten by Non-Life Insurance Company.

5) **File and Use:**

1) Both the independent products shall be integrated as a single product and filed with a common brand name.
2) Insurers may also utilize the existing insurance products *'as it is without modifications'* that are already cleared under the extant File and Use norms by the Authority.
3) 'C*ombi Product'* is to be filed at the stage of integrating for getting File and Use approval irrespective of the earlier approval to either of products.
4) '*Combi Product'* filing shall follow the File and Use guidelines in vogue and all such guidelines that would be issued from time to time.
5) *'Combi Product'* is to be filed with Actuarial Department of Authority in File and Use formats that are in vogue.
6) The *Combi Product* shall be approved by the Authority at File and Use.

7) The File and Use application of the *'Combi Product'* shall also specify the following:-

   a. Lead Insurer for the *'Combi Product'* and demarcation of functions between insurers for carrying out activities:-

   b. Procedures proposed for issuance of the premium notices, where applicable and final lapse notices in terms of Section 50 of the Insurance Act, 1938.

   c. Where the servicing is to be necessarily attended by the original insurer, the lead insurer shall facilitate the policy servicing. As far as the policyholder is concerned lead insurer shall be made as the single nodal point for receiving the servicing requests, fulfilling the services and issuing acknowledgements.

   d. Results of feasibility study, if any, in giving a limited access to the policydata base of policies for effecting over-the-counter policy service requests to the lead insurer.

   e. Lead insurer in settlement of claims shall ensure:-

      i) Based on the type of claim, the other insurer shall also take proactive measures for settlement of claims.

      ii) As far as health portion of 'C*ombi Policies'* are concerned, they may be serviced by Third Party Administrators.

      iii) Where the policies are serviceable directly, the lead insurer shall play a facilitative role.

      iv) Lead insurer may not to guarantee the settlement of claim on behalf of the other insurer. The risks accepted by one insurer under *'Combi Product'* shall not affect the business of other insurance company.

      v) The operational procedures proposed to be put in place for timely dispatch of the policy bond of '*Combi Products*'.

   f. Filing the advertisements in accordance with IRDA (Insurance Advertisements and Disclosures) Regulations, 2000 within 30 days from the date of issuing the advertisement with Authority.

   g. Proposed procedures for obtaining the prior approval of IRDA for issuing Joint Sale Advertisements along with the common corporate agents.

   h. The results of the cost benefit analysis carried out by both the insurers.

   i. The *modus operandi* of proposed policy service at various stages of the policy viz., proposal stage, policy servicing, premium collection arrangements and claims service etc.

j. The Information Technology systems put in place for supporting the sale and policy service of the '*Combi Products'*.
k. Agreement on reimbursement of expenses in consideration of common services rendered by each other of insurance companies.
l. Distribution Channel wise maximum commission allowed under the '*Combi Products'*.
m. The manner in which premium is proposed to be collected subject to provisions of Section 64 VB of Insurance Act, 1938.
n. The procedures put in place for expeditious transfer of the portion of premium that pertains to the other insurer of the product.
o. Operational procedures put in place for updating premium on policy data base on a real time basis.
p. Proposal forms to be used for *'Combi Products'*
q. The Terms and Conditions under which the Health portion of the 'C*ombi Product'* entitles its renewability at the option of policy holder to have an independent / standalone health insurance policy from Non-Life Insurance Company of the respective '*Combi Product'*.
r. Options available to policyholders of '*Combi Products*' to discontinue either portion of risk coverage while continuing with the other portion.
s. Copy of proposed common Sales Literature / Sales Illustrations to be issued by both the insurers in respect of '*Combi Products*'.
t. Common Advertisements of *'Combi Products'* shall be restricted to the features, terms and conditions of the '*Combi Product*'.

6) **Distribution Channel**:

1) The sale of 'C*ombi Product'* shall be through:-
   a. Direct Marketing channels
   b. Brokers and
   c. Composite Individual and Corporate Agents, common to both insurers
2) *'Combi Products'* are not allowed to be marketed through 'Bank Referral' arrangements.
3) Insurers shall ensure that the '*Combi Product'* is not marketed by those insurance intermediaries who are not authorized to market either of the products of either of the insurers.

7) **Mandatory Minimum Disclosures:**

1) The mandatory minimum disclosures for a *Combi Product* shall be;

a) The product is jointly offered by *abc insurance company* (specify non-life insurer name) and *xyz insurance company* (specify life insurer name)

b) The risks of this '*Combi Product'* are distinct and are assumed / accepted by respective insurance companies.

c) The liability to settle the claim benefits vests with respective insurers that is for health insurance benefits *abc insurance company* (specify non-life insurer name) and for life insurance benefits *xyz insurance company* (Specify life insurer name)

d) The legal/quasi legal disputes, if any, shall be dealt with the respective insurers for respective benefits

e) The policy holders of the *'Combi Product'* under reference shall be eligible to continue with either part of the policy discontinuing the other during the policy term.

f) Where guaranteed renewability of health insurance plan is allowed, the health insurance portion of this *'Combi Product'* is entitled to that facility

g) Specific Disclosures on the available premium payment options on these *'Combi Products'*.

h) Specific Disclosures about the available Policy Servicing facilities for these *'Combi Products'*.

i) Specific Disclosures about the proposed claims service of these policies under both the risks.

j) Specific Disclosures on the availability of services of '*Third Party Administrators (TPAs)*' for health insurance portion of risk, if available.

k) Specific Disclosures on the available Grievances Redressal Options including particulars of Ombudsman under these *'Combi products'*.

l) Policyholders are to be advised to familiarize themselves with the policy benefits and policy service structure of the *'Combi Product'* before deciding to purchase the policy.

2) Policy documents of *'Combi Products'* shall contain the above referred points c, d, e, f, g, h, i and k as minimum disclosures.

3) Declaration from the prospect shall be obtained and attached to proposal form that he / she has understood the disclosures mentioned at a), b), h) and i) above.

8) In respect of '*Combi Products'* both the insurers shall comply with the provisions Insurance Act, 1938 and Regulations notified there under and other guidelines, circulars that are applicable to health insurance business and life insurance business respectively.

9) For the purpose of these guidelines non-life insurance company includes standalone health insurance Company also.

10) In order to monitor the progress of the penetration of the product class before enlarging the scope of the same all insurance companies that are marketing '*Combi Products*' shall submit the information that is required by the Authority from time to time.

11) The Authority may stipulate such other terms and conditions from time to time for monitoring activities of insurance companies offering *'Combi Products'*.

Annexure-III

Data Format – Life Insurer

All data submitted must be in ASCII format.

HEALTH DATA DICTIONERY					
DATA FIELD	**FIELD HEADING**	**FIELD TYPE**	**FIELD SIZE**	**DATA DICTIONARY REFERENCE**	**Remarks**
1	Txt_TPA_Code	Text	5	150001	Please enter TPA Registration number. Please refer "TPA Master" attached
2	Txt_Insurer_Code	Text	3	150002	Please enter Insurer Registration number. Please refer "Insurer Master" attached
3	Txt_U_W_Office_Code	Text	20	150003	Branch/ Divisional Office Code or Name as available. If Branch/ Division not applicable, enter '0'
4	Txt_Policy_Number	Text	50	150004	Self explanatory
5	Txt_Member_Reference_Key	Text	50	150005	TPAs & Insurers should ensure that the Member Reference Key (MRK) is a unique number denoting each individual member.
6	Date_Of_Birth	Date	10	150006	Date of birth of the insured member dd/mm/yyyy
7	Num_Age_Of_Insured	Numeric	3	150007	Completed years at commencement of policy
8	Date_Policy_Start	Date	10	150008	Date of commencement of policy dd/mm/yyyy
9	Date_Policy_End	Date	10	150009	Date of expiry of policy dd/mm/yyyy
10	Boo_Pre-Existing_Diseases_Covered	Boolean	1	150012	If Pre-Existing Diseases are covered, enter '1', other wise enter '0'

DATA FIELD	FIELD HEADING	FIELD TYPE	FIELD SIZE	DATA DICTIONARY REFERENCE	Remarks
11	Boo_Waiver_Of_1St_Year_ Exclusion	Boolean	1	150013	If this exclusion is waived, enter '1', otherwise enter '0'
12	Boo_Maternity_Cover	Boolean	1	150014	If this cover is given, enter '1', otherwise enter '0'
13	Boo_Baby_Cover_As_Part_ Of_ Maternity	Boolean	1	150015	If this cover is given, enter '1', otherwise enter '0'
14	Boo_Floater_Applicable	Boolean	1	150016	If floater is applicable enter '1', otherwise enter '0'
15	Num_Corporate_Floater_Su m_ Insured	Numeric	16	150017	Buffer amount - (Amount that floats over entire policy) Applicable only for Corporate Floater Policies
16	Num_Group_Size	Numeric	8	150018	Number of members in the group
17	Txt_Gender	Text	1	150019	1-Male, 2- Female, 3- Others
18	Num_Sum_Insured	Numeric	16	150020	Individual Hospitalisation Sum Insured. Specific Sum Insured for the Member excluding any Floater or Bonus Sum Insured.
19	Txt_Relationship_Of_Insured	Text	2	150021	Refer Relationship Master
20	Txt_Occupation	Text	3	150022	Refer Occupation Master
21	Num_Policy_Premium	Numeric	16	150023	Premium on which Service Tax is calculated. For 'Universal Health Type policies, premium will be 'Net Final Premium' inclusive of all subsidies.
22	Num_Individual_Premium	Numeric	16	150024	Individual Premium on which Service Tax is calculated. (If available)
23	Txt_Claim_Number	Text	20	150025	Unique number generated by TPA
24	Txt_Diagnosis_Code_Primary	Text	20	150027	ICD-10 Code applicable for disease - Primary diagnosis.
25	Txt_Procedure_Description_ Primary	Text	50	150028	Description of procedure - Primary procedure
26	Txt_Name_Of_The_Hospital	Text	50	150029	Full Name of Hospital
27	Txt_Registration_Number_Of _ Hospital	Text	20	150030	Registration Number allotted by appropriate authority, if available
28	Txt_Pan_Of_Hospital	Text	20	150031	Income Tax Perrmanent Account Number of hospital
29	Txt_Pin_Code_Of_Hospital	Text	10	150032	6 digit Postal Pin Code. Refer Pincode Master
30	Date_Of_Admission	Date	10	150033	Self explanatory dd/mm/yyyy

DATA FIELD	FIELD HEADING	FIELD TYPE	FIELD SIZE	DATA DICTIONARY REFERENCE	Remarks
31	Date_Of_Discharge	Date	10	150034	Self explanatory dd/mm/yyyy
32	Num_Total_Amount_Claimed	Numeric	16	150035	Total amount claimed for the particular incident without any bifurcation (Include amounts under various subdivisions from 150036 to 150043 and 150085, 150120,150121)
33	Num_Room_&_Nursing_ Charges_ Claimed	Numeric	16	150036	Amount Claimed classified as Room & Nursing Charges incurred between date of admission and discharge. Inclusive of ICU charges, patient diet, HVAC and other room chanrges
34	Num_Surgery_Charges_ Claimed	Numeric	16	150037	Amount Claimed classified as Surgery Charges incurred between date of admission and discharge. including Surgeon/ Asstt. Surgeon/ Anesthestist fees but Excluding OT charges
35	Num_Consultation_Charges _Claimed	Numeric	16	150038	Amount Claimed classified as Consultation Charges incurred between date of admission and discharge, exclusing Surgery Charges.
36	Num_Investigation_Charges _Claimed	Numeric	16	150039	Amount Claimed classified as Investigation Charges incurred between date of admission and discharge.
37	Num_Medicine_Charges_Cl aimed	Numeric	16	150040	Amount Claimed classified as Medicine Charges incurred between date of admission and discharge.
38	Num_Miscellaneous_Charges _Claimed	Numeric	16	150041	All unspecified expenses incurred between date of admission and discharge, other than those claimed above.
39	Num_Pre_Hospitalisation_ Expenses_Included_Under_ 150035_Claimed	Numeric	16	150042	Total amount claimed for pre-hospitalisation treatment without any bifurcation.
40	Num_Post_Hospitalisation_ Expenses_Included_Under_ 150035_Claimed	Numeric	16	150043	Total amount claimed for post-hospitalisation treatment without any bifurcation
41	Num_Total_Claim_Paid	Numeric	16	150046	Total amount of claim paid for the particular incident without any bifurcation (on amounts claimed under various subdivisions from 150036 to 150043, 150085, 150120,150121)

DATA FIELD	FIELD HEADING	FIELD TYPE	FIELD SIZE	DATA DICTIONARY REFERENCE	Remarks
42	Txt_Reason_For_Rejection_ Of_ Claim	Text	3	150047	Refer Rejection/ Reduction Master
43	Num_Floater_Amount	Numeric	16	150048	If 150016 is "1", amount to be filled up in case of "Proposer" or "Employee" only. In all other cases, leave blank.
44	Txt_Remarks_Of_TPA	Text	50	150049	Remarks of TPA
45	Boo_Post_Hospitalization_ Beyond_60_Days_Is_Covered	Boolean	1	150050	If this cover is given, enter '1', otherwise enter '0'
46	Boo_Out_Patient_Cover	Boolean	1	150051	If this cover is given, enter '1', otherwise enter '0'
47	Boo_Baby_Cover_From_ Date_Of_ Birth	Boolean	1	150052	If this cover is given, enter '1', otherwise enter '0'
48	Boo_Ambulance_Cover	Boolean	1	150053	If this cover is given, enter '1', otherwise enter '0'
49	Boo_Health_Check_Up	Boolean	1	150054	If this cover is given, enter '1', otherwise enter '0'
50	Boo_Any_Pre_Existing_ Diseases_ Declared	Boolean	1	150055	If declared, enter '1', otherwise enter '0'
51	Txt_Pre_Existing_Diseases_ Code_ Primary	Text	20	150056	Refer 'Top 20 PED Master' for disease - Primary level
52	Txt_Diagnosis_Code_ Additional	Text	20	150057	ICD-10 Code applicable for disease - additional diagnosis
53	Txt_Procedure_Code_ Additional	Text	50	150059	ICD 10 PCS Codes - additional procedure
54	Txt_Medical_History	Text	255	150061	Medical History - as given in claims documents
55	Txt_Hospital_Code	Text	20	150062	Refer Unique Id for hospital in Hospital Master
56	Boo_Policy_Or_Endorsement	Boolean	1	150063	If Policy, enter '1', if Endorsement enter '0'.
57	Txt_Endorsement_Number	Text	50	150064	Self explanatory
58	Txt_Procedure_Code_Primary	Text	50	150065	ICD 10 PCS Codes - Primary prodcedure
59	Txt_Procedure_Description_ Additional	Text	50	150066	Description of procedure - any additional procedure
60	Txt_Pre_Existing_Diseases_ Code_ Additional	Text	20	150068	Refer 'Top 20 PED Master' for disease - Additional, if any
61	Txt_Reason_For_Reduction _Of_ Claim	Text	3	150072	Refer Rejection/ Reduction Master
62	Txt_Type_Of_Claim_PaymentText		3	150073	Refer Claim Payment Type Master

DATA FIELD	FIELD HEADING	FIELD TYPE	FIELD SIZE	DATA DICTIONARY REFERENCE	Remarks
63	Num_Family_Floater_Sum_ Insured	Numeric	16	150074	Buffer amount - (Amount that floats over entire policy) Applicable only for Family Floater Policies
64	Num_Declaration_Floater_ Sum_ Insured	Numeric	17	150075	Buffer amount - (Amount that floats over entire policy) Applicable only for Declaration Floater Policies
65	Boo_Maternity_Cover_Given _With_A_ Waiting_Period	Boolean	1	150080	If covered with waiting period, enter '1', otherwise enter '0'
66	Txt_Endorsement_Type	Text	3	150081	Refer Endorsement Type Master
67	Boo_Claim_Made_Under_ Alternate_ Medicine	Boolean	1	150082	If claim is under alternate medicine, enter '1', if not enter '0'
68	Txt_System_Of_Medicine_ Used	Text	3	150083	Refer System of Medicine Code Master
69	Boo_Hospital_Is_Networked	Boolean	1	150084	If hospital is networked, enter '1', if not enter '0'
70	Num_Other_Non_Hospital_ Expenses	Numeric	16	150085	All non-hosptital expenses claimed as part of the claim e.g. telephone charges, attendent food etc.
71	Num_Amount_Of_Co_Payme nt_Or_Access_If_Applicable	Numeric	16	150086	If applicable on a lumpsum basis, state amount of co-payment or excess applicable.
72	Num_Opening_Claims_Outs tanding_As_ On_31_3_2008	Numeric	12	150089	Amount of Claims outstanding at the beginning of Financial Year
73	Num_Claims_Paid_During_T he_Period_1- 4-2008_To_ 31_3_2009	Numeric	12	150090	Amount of total of all claims paid during the Financial Year
74	Num_Closing_Claims_Outst anding_As_ On_31_3_2009	Numeric	12	150091	Amount of Claims outstanding at the end of Financial Year
75	Txt_Metro_Nonmetro_Urban _Rural	Text	1	150092	Whether policy holder location is 1=Metro, 2=Urban other than metro and 3=Rural. Metros are 4 metros including Banglore and Hyderabad.
76	Date_Of_Payment	Date	10	150093	Date of cheque issued/cash paid to the insured in dd/mm/yyyy
77	Txt_Payment_Reference_ Number	Text	25	150094	Payment Reference Number allotted by TPA/Insurer
78	Boo_Policy_Having_Co-Insurance	Boolean	1	150095	If Policy is with Co-Insurance, enter '1' otherwise enter '0'
79	Num_Your_Co_Insurance_ Share	Numeric	6	150096	If Co-Insurance is there, mention your share in percentage (nnn.nn). If no Co-Insurance, mention 100.

DATA FIELD	FIELD HEADING	FIELD TYPE	FIELD SIZE	DATA DICTIONARY REFERENCE	Remarks
80	Date_Member_Entry	Date	10	150097	Member's entry date into policy dd/mm/yyyy
81	Date_Member_Exit	Date	10	150098	Member's exit date from policy dd/mm/yyyy
82	Date_Claim_Intimation	Date	10	150099	Date on which claim is intimated
83	Num_Bonus_Sum_Insured	Numeric	16	150100	Sum Insured added as Bonus.
84	Txt_Unq_Product_Code	Text	20	150101	Give File & Use Product Code issued by IRDA
85	Txt_Coverage_Scope	Text	30	150102	Refer Coverage Scope Master
86	Txt_Payout_Basis	Text	3	150103	Refer Payout Basis Master
87	Txt_Insured_Type	Text	3	150104	Refer Insured Type Master
88	Txt_Policy_Term	Text	3	150105	Enter Policy period in years
89	Txt_Contract_Acceptance_ Special_ Term	Text	255	150106	Mention contract acceptance terms of the product and policy type
90	Boo_Type_Of_Premium	Boolean	1	150107	If 1st time premium, enter '1' else enter '0' for Renewal premium.
91	Txt_Other_Co-Insurance_ Share	Text	50	150108	Provide name of Co-Insurer and their share in free text
92	Num_Premium_Discount	Numeric	16	150109	Mention discount amount on premium
93	Boo_Whether_Sub_Standard _Cases	Boolean	1	150110	Not Coverable as a normal case/rates, but covered as a special case. If Sub_Standard Case, enter '1', otherwise enter '0'.
94	Txt_Sub_Standard_Cases	Text	50	150111	If 150110 is '1' then Mention substandard cases details
95	Txt_If _Ped_Code_Is_99_ Description	Text	50	150112	If PED code is 99 i.e. others, provide description of the pre-existing disease
96	Txt_Reason_For_ Hospitalisation	Text	3	150113	Enter 1 for Illness, 2 for Injury and 3 for Maternity
97	Txt_Reason_For_Injury	Text	3	150114	If field 150113 is Injury, Enter '1' for Alcohal Consumption or 2 ro Sabstance Abyse.
98	Txt_Master_Claim_Id	Text	20	150115	Provide master claim id/no. In case of multiple payments made under of single incident of claim, a master id should be given and subsequent payments should contain child number.

DATA FIELD	FIELD HEADING	FIELD TYPE	FIELD SIZE	DATA DICTIONARY REFERENCE	Remarks
99	Txt_Child_Claim_Id	Text	20	150116	Provide child claim id/no. under master claim id/no. above
100	Txt_Treating_Doctor_ Registration_ Number	Text	50	150117	Provide Registration number of the Medical Practitioner caring for the patient during hospitalisation
101	Txt_Type_Of_Admission	Text	3	150118	Enter 1 for emergency, 2 for Planned, 3 for Day Care
102	Txt_Details_Of_Lumpsum_ Or_Cash_ Benefit_Claimed	Text	3	150119	Enter 1 - Hospital Daily Cash, 2 for Surgical Cash, 3 for Critical Illness benefit, 4 for Covalescence, 5 for Pre/Post Hospitalisation Lumpsum Benefit and 99 for Others.
103	Txt_Room_Category_ Occupied	Text	3	150120	Enter 1 for Single bed, 2 for Twin Sharing, 3 for three or more beds and 4 Day care
104	Num_Professional_Charges _Claimed	Numeric	16	150121	This field will contain Surgeon/ Asstt. Surgeon/ Anaesthesist Charges Claimed
105	Num_ot_Charges_Claimed	Numeric	16	150122	Amount Claimed classified as Operation Theatre Charges incurred between date of admission and discharge.
106	Num_Surgical_Implant Charges_Claimed	Numeric	16	150123	Amount Claimed classified as Surgical Implant Charges incurred between date of admission and discharge.
107	Num_Room_&_Nursing_ Charges_ Paid	Numeric	16	150124	Claim amount paid classified as Room & Nursing Charges between date of admission and discharge.Inclusive of ICU charges, patient diet, HVAC and other room chanrges
108	Num_Surgery_Charges_ Paid	Numeric	16	150125	Claim amount paid classified as Surgery Charges incurred between date of admission and discharge. including Surgeon/ Asstt. Surgeon/ Anesthestist fees but Excluding OT charges
109	Num_Professional_Charges _Paid	Numeric	16	150126	This field will contain Surgeon/ Asstt. Surgeon/ Anaesthesist Charges Paid
110	Num_Consultation_Charges _Paid	Numeric	16	150127	Claim amount paid classified as Consultation Charges between date of admission and discharge., exclusing Surgery Charges.
111	Num_Investigation_Charges _Paid	Numeric	16	150128	Claim amount paid classified as Investigation Charges between date of admission and discharge.

DATA FIELD	FIELD HEADING	FIELD TYPE	FIELD SIZE	DATA DICTIONARY REFERENCE	Remarks
112	Num_ot_Charges_Paid	Numeric	16	150129	Claim amount paid classified as Operation Theatre Charges between date of admission and discharge.
113	Num_Medicine_Charges_Paid	Numeric	16	150130	Claim amount paid classified as Medicine Charges between date of admission and discharge.
114	Num_Surgical_Implant_ Charges_Paid	Numeric	16	150131	Claim amount paid classified as Surgical Implant Charges between date of admission and discharge.
115	Num_Miscellaneous_Charges _Paid	Numeric	16	150132	All unspecified expenses paid between date of admission and discharge, other than those paid above.
116	Num_Pre_Hospitalisation_E xpenses_Included_Under_1 50046_Paid	Numeric	16	150133	Total amount paid for pre-hospitalisation treatment without any bifurcation.
117	Num_Post_Hospitalisation_ Expenses_Included_Under_ 150046_Paid	Numeric	16	150134	Total amount paid for post-hospitalisation treatment without any bifurcation
118	Num_Co_Payment_ Dedcuctible	Numeric	16	150135	Provide Co-Payment Dedcuctible Amount.
119	Date_of_Receipt_Of _Complete_Claim_Document	Date	10	150136	Enter Date on which full claim documents are received.
120	Boo_Whether_Claim_Paid_ for_ PED	Boolean	1	150137	If claim paid is for Pre_Existing_Diseases, Enter '1', if not enter'0'.
121	Txt_If_Yes_PED_Code	Text	3	150138	If field 150134 is '1', enter PED code from PED Master.

HEALTH L1 - POLICY FORMAT					
DATA FIELD	FIELD HEADING	FIELD TYPE	FIELD SIZE	DATA DICTIONARY REFERENCE	REMARKS
1	Txt_TPA_Code	Text	5	150001	Please enter TPA Registration number. Please refer "TPA Master" attached
2	Txt_Insurer_Code	Text	3	150002	Please enter Insurer Registration number. Please refer "Insurer Master" attached
3	Txt_U_W_Office_Code	Text	20	150003	Branch/ Divisional Office Code or Name as available. If Branch/ Division not applicable, enter '0'
4	Txt_Policy_Number	Text	50	150004	Self explanatory
5	Txt_Unq_Product_Code	Text	20	150101	Give File & Use Product Code issued by IRDA
6	Date_Policy_Start	Date	10	150008	Date of commencement of policy dd/mm/yyyy

7	Date_Policy_End	Date	10	150009	Date of expiry of policy dd/mm/yyyy
8	Txt_Coverage_Scope	Text	30	150102	Refer Coverage Scope Master
9	Txt_Payout_Basis	Text	3	150103	Refer Payout Basis Master
10	Txt_Insured_Type	Text	3	150104	Refer Insured Type Master
11	Txt_Policy_Term	Text	3	150105	Enter Policy period in years
12	Txt_Contract_Acceptance_ Special_Term	Text	25 5	150106	Mention contract acceptance terms of the product and policy type
13	Boo_Type_of_Premium	Boolean	1	150107	If 1st time premium, enter '1' else enter '0' for Renewal premium.
14	Num_Policy_Premium	Numeric	16	150023	Premium on which Service Tax is calculated. For 'Universal Health Type policies, premium will be 'Net Final Premium' inclusive of all subsidies.
15	Boo_Post_Hospitalization_ beyond_ 60_days_is_Covered	Boolean	1	150050	If this cover is given, enter '1', otherwise enter '0'
16	Boo_Out_patient_cover	Boolean	1	150051	If this cover is given, enter '1', otherwise enter '0'
17	Boo_Baby_Cover_from_Date_of _Birth	Boolean	1	150052	If this cover is given, enter '1', otherwise enter '0'
18	Boo_Ambulance_Cover	Boolean	1	150053	If this cover is given, enter '1', otherwise enter '0'
19	Boo_Health_Check_Up	Boolean	1	150054	If this cover is given, enter '1', otherwise enter '0'
20	Boo_Policy_or_Endorsement	Boolean	1	150063	If Policy, enter '1', if Endorsement enter '0'.
21	Txt_Endorsement_Number	Text	50	150064	Self explanatory
22	Txt_Endorsement_Type	Text	3	150081	Refer Endorsement Type Master
23	Boo_Policy_having_Co- Insurance	Boolean	1	150095	If Policy is with Co-Insurance, enter '1' otherwise enter '0'
24	Num_Your_Co_Insurance_Share	Numeric	6	150096	If Co-Insurance is there, mention your share in percentage (nnn.nn). If no Co-Insurance, mention 100.
25	Txt_Other_Co-Insurance_Share	Text	50	150108	Provide name of Co-Insurer and their share in free text

HEALTH L2 - MEMBER FORMAT

DATA FIELD	FIELD HEADING	FIELD TYPE	FIELD SIZE	DATA DICTIONARY REFERENCE	Remarks
1	Txt_TPA_Code	Text	5	150001	Please enter TPA Registration number. Please refer "TPA Master" attached
2	Txt_Insurer_Code	Text	3	150002	Please enter Insurer Registration number. Please refer "Insurer Master" attached
3	Txt_U_W_Office_Code	Text	20	150003	Branch/ Divisional Office Code or Name as available. If Branch/ Division not applicable, enter'0'
4	Txt_Policy_Number	Text	50	150004	Self explanatory
5	Txt_Unq_Product_Code	Text	20	150101	Give File & Use Product Code issued by IRDA
6	Date_Policy_Start	Date	10	150008	Date of commencement of policy

					dd/mm/yyyy
7	Date_Policy_End	Date	10	150009	Date of expiry of policy dd/mm/yyyy
8	Txt_Endorsement_Number	Text	50	150064	Self explanatory
9	Txt_Member_Reference_Key	Text	50	150005	TPAs & Insurers should ensure that the Member Reference Key (MRK) is a unique number denoting each individual member.
10	Date_of_Birth	Date	10	150006	Date of birth of the insured member dd/mm/yyyy
11	Num_Age_of_Insured	Numeric	3	150007	Completed years at commencement of policy
12	Boo_Pre-existing_Diseases_ Covered	Boolean	1	150012	If Pre-Existing Diseases are covered, enter '1', otherwise enter '0'
13	Boo_Waiver_of_1st_Year_ Exclusion	Boolean	1	150013	If this exclusion is waived, enter '1', otherwise enter '0'
14	Boo_Maternity_Cover	Boolean	1	150014	If this cover is given, enter '1', otherwise enter '0'
15	Boo_Baby_Cover_as_Part_of_ Maternity	Boolean	1	150015	If this cover is given, enter '1', otherwise enter '0'
16	Boo_Floater_Applicable	Boolean	1	150016	If floater is applicable enter '1', otherwise enter '0'
17	Num_Corporate_Floater_Sum_ Insured	Numeric	16	150017	Buffer amount - (Amount that floats over entire policy) Applicable only for Corporate Floater Policies
18	Num_Group_Size	Numeric	8	150018	Number of members in the group
19	Txt_Gender	Text	1	150019	1-Male, 2- Female, 3- Others
20	Num_Sum_Insured	Numeric	16	150020	Individual Hospitalisation Sum Insured. Specific Sum Insured for the Member excluding any Floater or Bonus Sum Insured.
21	Txt_Relationship_of_Insured	Text	2	150021	Refer Relationship Master
22	Txt_Occupation	Text	3	150022	Refer Occupation Master

Data Format-Non life Insurer

All data submitted must be in ASCII format.

HEALTH DATA DICTIONERY

DATA FIELD	FIELD HEADING	FIELD TYPE	FIELD SIZE	DATA DICTIONARY REFERENCE	REMARKS
1	Txt_TPA_Code	Text	5	150001	Please enter TPA Registration number. Please refer "TPA Master" attached
2	Txt_Insurer_Code	Text	3	150002	Please enter Insurer Registration number. Please refer "Insurer Master" attached
3	Txt_U_W_Office_Code	Text	20	150003	Branch/ Divisional Office Code or Name as available. If Branch/ Division not applicable, enter '0'
4	Txt_Policy_Number	Text	50	150004	Self explanatory
5	Txt_Member_Reference_ Key	Text	50	150005	TPAs & Insurers should ensure that the Member Reference Key (MRK) is a unique number denoting each individual member.

DATA FIELD	FIELD HEADING	FIELD TYPE	FIELD SIZE	DATA DICTIONARY REFERENCE	REMARKS
6	Date_of_Birth	Date	10	150006	Date of birth of the insured member as dd/mm/yyyy
7	Num_Age_of_Insured	Numeric	3	150007	Completed years at commencement of policy
8	Date_Policy_Start	Date	10	150008	Date of commencement of policy as dd/mm/yyyy
9	Date_Policy_End	Date	10	150009	Date of expiry of policy as dd/mm/yyyy
10	Txt_Product_Type	Text	3	150010	Refer Product Type Master
11	Txt_Type_of_Policy	Text	3	150011	Refer Policy Type Master
12	Boo_Pre-existing_Diseases _Covered	Boolean	1	150012	If Pre-Existing Diseases are covered, enter '1', other wise enter '0'
13	Boo_Waiver_of_1st_Year_ Exclusion	Boolean	1	150013	If this exclusion is waived, enter '1', otherwise enter '0'
14	Boo_Maternity_Cover	Boolean	1	150014	If this cover is given, enter '1', otherwise enter '0'
15	Boo_Baby_cover_as_part_of _ Maternity	Boolean	1	150015	If this cover is given, enter '1', otherwise enter '0'
16	Boo_Floater_applicable	Boolean	1	150016	If floater is applicable enter '1', otherwise enter '0'
17	Num_Corporate_Floater_ Sum_ Insured	Numeric	16	150017	Buffer amount - (Amount that floats over entire policy) Applicable only for Corporate Floater Policies
18	Num_Group_Size	Numeric	8	150018	Number of members in the group
19	Txt_Gender	Text	1	150019	1-Male, 2- Female, 3- Others
20	Num_Sum_Insured	Numeric	16	150020	Individual Hospitalisation Sum Insured. Specific Sum Insured for the Member excluding any Floater or Bonus Sum Insured.
21	Txt_Relationship_of_Insured	Text	20	150021	Refer Relationship Master
22	Txt_Occupation	Text	20	150022	Refer Occupation Master
23	Num_Policy_Premium	Numeric	16	150023	Premium on which Service Tax is calculated. For 'Universal Health Type policies, premium will be 'Net Final Premium' inclusive of all subsidies.
24	Num_Individual_Premium	Numeric	16	150024	Individual Premium on which Service Tax is calculated. (If available)
25	Txt_Claim_Number	Text	20	150025	Unique number generated by TPA
27	Txt_Diagnosis_Code_ Level _I	Text	20	150027	ICD-10 Code applicable for disease - Primary level.
28	Txt_Procedure_Code_ Level_I	Text	50	150065	ICD 10 PCS Codes - Primary level
29	Txt_Name_of_the_Hospital	Text	50	150029	Full Name of Hospital
30	Txt_Registration_Number_of _ Hospital	Text	20	150030	Registration Number allotted by appropriate authority, if available
31	Txt_PAN_of_Hospital	Text	20	150031	Income Tax Permanent Account Number of hospital, if available
32	Txt_Pin_Code_of_Hospital	Text	10	150032	6 digit Postal Pin Code. Refer Pin code Master
33	Date_of_Admission	Date	10	150033	Self explanatory as dd/mm/yyyy
34	Date_of_Discharge	Date	10	150034	Self explanatory as dd/mm/yyyy