DID YOU KNOW THAT YOUR HEALTH INSURANCE PREMIUM DEPENDS ON WHERE YOU RESIDE!!

WHAT IS HEALTH INSURANCE AND WHY IS IT NEEDED?

Up to the mid 80's, most of the hospitals in India were Government owned and treatment was free of cost. With the advent of Private Medical Care, the need for Health Insurance was felt and various General Insurance Companies (New India Assurance, National Insurance Company, Oriental Insurance & United Insurance Company) introduced Health (Mediclaim) Insurance as a product.

Health Insurance, also known as medical insurance is a form of insurance which covers the expenses incurred on medical treatment and hospitalisation. It covers the individual and family against any financial constraints arising from medical emergencies. In case of sudden hospitalisation, illness or accident, health insurance takes care of the expenses on medicines, oxygen, ambulance, blood, hospital room, various medical tests and almost all other costs involved. Thus, by insuring one's health, by paying a premium every year according to your age, you ensure that till a certain limit, the medical expenses, would be covered by the insurance company and you will not have to spend it from your own pocket.

Health (Mediclaim) Insurance pays for medical expenses. It is used more broadly to include insurance that covers disability or long-term nursing or custodial care needs. In simple words, if you are covered under Health (Mediclaim) Insurance, you pay some amount of premium every year to an insurance company and if you have an accident or if you have to undergo an operation or a surgery, the insurance company will pay for the medical expenses.

It takes just one visit to a hospital to make you realize how vulnerable you are if you are diagnosed with an illness and need to be hospitalized, no matter if you are rich or poor, male or female, young or old. The list of lifestyle diseases today seems to get longer and more common. . Thankfully there are more specialty hospitals and specialist doctors – but all that comes at a cost. This is where Health Insurance can help you to tide over your problems!

Types of Health (Mediclaim) Insurance

There are mainly 3 types of Health (Mediclaim) Insurance covers which are as follows.

(1) Individual Mediclaim:

This is the simplest form of health insurance covering the hospitalization expenses for an individual up to the sum assured limit. The premium is dependent on the sum assured. It is a cover which takes care of medical expenses following Hospitalization / Domiciliary Hospitalization of the insured in case of sudden illness, accident and any surgery which is required in respect of any disease which has arisen during the policy period. This cover is a hospitalization cover and reimburses the medical expenses incurred in respect of the covered disease / surgery while the insured was admitted in the hospital as an inpatient. The cover also extends to pre- hospitalization and post- hospitalization for periods of 30 days and 60 days respectively.
Example: If a family has 4 members you can take an individual cover of Rs. 2 lakhs each for each member. Each member is now covered for 2 lakhs. If all the 4 members are hospitalized, all 4 of them can get expenses recovered up to Rs 2 lakhs each. All the 4 policies are independent.

(2) Family Floater Policy:

Family Floater Policy is an enhanced version of the mediclaim policy. The policy covers each family member and the entire family's expenses are covered up to the sum assured limit. The family floater plan's premium is less than the separate insurance cover for each family member.
Example: If a family of 4 takes a family floater policy of Rs. 8 lakhs, they can claim medical expenses up to Rs. 8 lakhs in that policy year. If one person is hospitalized and claims Rs. 3 lakhs, it will be paid, but they will be left with only Rs. 5 lakh worth of medical expenses that can be reimbursed in that year. The next year, the policy will start with a fresh Rs. 8 lakhs. So, in many ways the family floater plan offers flexibility in terms of utilizing the overall insurance coverage among the group.

(3) Unit Linked Health Plans:

Health Insurance Companies have introduced Unit Linked Health Plans which combine health insurance with investment and pay back an amount at the end of the insurance term. The returns are dependent on market performance. These plans are new and still in development phase. Only people who can handle market linked products like ULIP and ULPP are recommended to take this plan.
For a number of reasons, it is advisable to stay clear of unit linked health plans. Treat insurance purely as an expense. Opt for an Individual Mediclaim policy if you are single and opt for a Family Floater policy if you have family. Health (Mediclaim) Insurance premiums come under tax exemption under section 80D for a maximum of Rs. 15, 000/-.

What is the Ideal Cover for Health Insurance

The cost of Health Insurance depends on the sum assured, age, current health condition and your previous medical history. The premium will be high if the sum assured is high. So what should be the ideal health insurance cover requirement? There is no standard answer for this.

If health insurance is important, one has to look at one's own lifestyle, health condition, age, family history of illnesses and affordability. Most insurance companies limit the sum assured to a maximum of Rs. 5 lakhs.

Many health insurance policies "provide additional benefits" such as daily allowance, ambulance charges, etc. for hospitalization which are superfluous and a high premium is charged for this. Hence avoid such plans and take something simple and basic.

Health Insurance provided By the Employer

Many employers provide health cover for their employees. There are 3 aspects which need to be considered in such a case

- Is that cover sufficient? Is the insurer good enough?
- What happens if you change your job?
- Health insurance is provided as perk to the employees

So an employee has to understand the policy in detail and check for coverage.

Ask the HR Department for policy details. Get into details and find out what is covered and what is not covered.

Often employees just think that the employer has given them health insurance and are relaxed. Later they find out that it does not cover A and covers B only up to a limit, which can be a painful situation.

Health Insurance for the Aged

Health insurance companies were reluctant to provide cover for the aged till a few years back. But these days, a lot of insurance companies are providing policies for senior citizens. Additional tax exemption of up to Rs. 20, 000/- is provided for the insurance cover paid for a person of age 65 years and above. But the senior citizens have to pay high premium rates. For the employed, another option is to approach the employer to negotiate with the official insurer to provide an option for additional cover to parents. Since the volumes are high, the insurer can provide such added cover at attractive premium rates.

Tax Exemption from Health Insurance Premiums

Sec 80D covers Health Insurance. You can get exemptions of:

(a) Up to Rs. 15,000 paid for self + spouse + children.

(b) Up to Rs 15,000 paid for Parents (Rs 20,000 if parents are senior citizens)

So in total if you pay your health insurance and your parents' health insurance premiums, you can save up to maximum of Rs. 35, 000/-.

Note: If you take Health Insurance riders with Term Insurance like Critical Illness cover, the extra premium paid for that will actually be covered under Sec 80D and not under Sec 80C.

Third Party Administrators (TPAs) – The link between you and the Insurance Company

TPA stands for Third Party Administrator. TPA is a middleman between Insurer and the Customer. At the time of claim, the customer can directly deal with the TPA and the TPA will help them with all the process of claim settlement.

A TPA is a specialized health service provider providing a variety of services like networking with hospitals, arranging for hospitalization and claim processing and settlement. The concept was introduced by the Insurance Regulatory and Development Authority of India (IRDA) for the benefit of both the insured and the insurer. While the insured is benefited by quicker & better health service, insurers are benefited by reduction in their administrative costs, fraudulent claims and ultimately bringing down the claim ratios. An insurance company can have more than one TPA and a TPA can serve more than one insurance company.

Some of the services provided by the TPA are:
(1) Maintaining database of policyholders
(2) Issuing of ID cards to all policyholders
(3) Providing ambulance service
(4) Providing information to policyholders about hospitals
(5) Checking various investigations
(6) Providing cashless service
(7) Processing claims

Health Insurance Claims Settlement Process

In most cases, the Insurance companies appoint a Third Party Administrator (TPA) for claims processing. Once the health insurance policy is sold, the insurer passes on complete details to the TPA. In case of a claim, the insured has to get in touch with the TPA for all verification and formalities to get the claim settled.

Two Ways By Which Health Insurance Claims Are Settled:

(1) Cashless For planned hospitalization at authorized network hospitals, the TPA has to be notified in advance for availing cashless treatment or

within the stipulated time limits for emergencies. The insurance desk at hospitals will generally help with all the paper work. The TPA has to approve the claim amount and the hospital settles the amount with the TPA / Insurer. There will be exclusions which will have to be settled directly at the hospital by the insured.

(2) Reimbursement:

Reimbursement facility can be availed at both the network and non-network hospitals. The hospital bills are directly settled at the hospital after the insured avails the treatment. The insured can then claim reimbursement for hospitalization by submitting relevant bills / documents for the claimed amount to the TPA.

The TPA mode of claims settling has its own problems. The TPA is incentivized to limit insurance claims and they are not the ones who sell the policy. There are many cases where the insured had a tough time to claim for his hospital expenses. So before taking a health insurance policy, check who the TPA is and how good they are when it comes to claims processing. Internet search and a friendly chat with the hospital staff can give you a good insight on the insurer / TPA. There are also some health insurance providers who do not employ TPAs and manage claims settlement directly which is called In-House TPA.

Key Procedures for Filing a Healthcare Insurance Claims

In certain circumstances health insurance claims can be a frustrating process and more so if there is no help from the healthcare provider. Often People are left to fend for themselves while filing a health claim for a medical reimbursement procedure which occurs after hospitalization. In such a situation cashless facility will not be provided by the hospital or nursing home.

The expenses incurred on hospitalization can be claimed only after the patient gets discharged from the hospital or on completion of treatment.

If an individual has to file his own insurance claim, the following points should be borne in mind:

a) **Keep all receipts and arrange them in chronological order**

• You are advised to keep not only all receipts, bills and medical reports as part of the hospitalization but also the ones obtained during 30 days prior to hospitalization and 60 days (only relevant bills) subsequent to hospitalization. The medical services availed during this period as part of the same treatment, are generally applicable to be reimbursed.

• These medical bills, receipts etc. should contain name of the service-provider (establishment), document number, name of the patient, name of the treating consultant, date on which product was purchased, name of the product/services availed, batch number, serial number, quantity, cost

price of the product along with taxes (includes MRP and VAT) and signature of the authorized person.

• Medical reports, bills, receipts, investigation reports, discharge summaries should be arranged in a chronological order.

• It is always preferable to indicate the receipts with a serial number for convenience and quick retrieval of the document, incase it is required.

• While filing the claim, all the receipts, bills, discharge summaries, investigation reports, consultation sheets etc. should be submitted in **original**. In addition, a ***set of Xerox copies*** of the original documents need to be submitted too.

Remember, it is of utmost importance to ***retain a set*** **of Xerox** documents with the claimant, incase the documents are misplaced or lost. This is vital for establishing proof of the medical treatment sought during the illness.

b) Get the claim form from the insurance company

• In order to file your health claim, get the claim form from the insurance company. Alternatively, the claim form can be downloaded from the official website of the insurer (or insurance company).

• Fill in the Claim form which is usually self-explanatory in nature. In this claim form, queries such as the individual's health-insurance cover details, reimbursement of the medical expenses statement details, purpose of hospitalization, personal details, identification proof and similar details are asked from the customer. Relevant and up-to date data must be submitted to avoid a goof-up in the process.

• Claim form will carry additional instruction details which you must read carefully. It must be signed by you or the policyholder and by the treating consultant. The claim form should be stamped with an-official hospital seal for authentication of the claim process.

• After filling the necessary details, it must be accompanied with the relevant documents. These relevant documents can be further classified into 2 groups:

i) Medical Documents

• Discharge Summary from the concerned hospital which contains name of the patient, date of admission, date of discharge, time of admission, time of discharge, main diagnosis and relevant investigations carried out during the hospitalization period.

• All the documents pertaining to the ailment for which the hospitalization was sought which incorporates first detection date of the ailment accompanied with solid/ample proof such as physician's consultation sheets, pharmacy bills or receipts, investigation reports, cash memos and

proper prescriptions.

• Nature of the surgery or operation performed on the individual, information regarding the surgeon's consultation fees, surgery fees, Operation theatre charges accompanied with relevant bills and receipts.

• Certificate from the attending medical practitioner / surgeon that the patient is cured or on the way to recovery.

ii) Policy documents

• Details about the previous policies accompanied with relevant proof of the policy documents, policy product receipts etc.

• Inception (beginning) of the policy-cover document (health-insurance policy) to indicate since when the patient is covered under the policy. The inception date of the policy cover makes it easier for insurance companies to deliver opinion on a particular claim.

• First health-insurance policy inception details must be provided to the concerned TPA (Third Party Administrator) for avoiding customer disputes and grievances. This is an important step in the submission of policy documents and must not be over-looked.

• This claim document must be accompanied with TPA (Third Party Administrator) card for validation and verification purposes.

c) To prepare copies of the original for the purpose of claim submission

• Remember that while submitting the claim documents, they should be in original. In absence of original documents, claims will *not usually* be entertained.
• Along with original documents, an *additional set of Xerox copies* must be submitted along with the claim form.
• Remember that these documents should be in *serialized or chronological* order.
• By doing so, the *errors* occurring in the claim process would be *minimized*. Keep an additional set of Xerox copies for your own file as suggested earlier as proof in case the documents are lost or misplaced.

d) Review and dispatch of documents

• After completing the compilation of the claim to be reimbursed, re-check your documents.

• Verify the documents and see that no document issued during the treatment process is missing. This is necessary to avoid a claim shortfall.

• Check whether all the documents (paperwork) are relevant to the treatment for which the claim is to be submitted.

• Ask the insurance company to which TPA the claim documents have to be submitted.

• Approach your local TPA (in your city or nearby city) where your claim documents are to be submitted.

• Discuss the submission process with the customer-care executive in the local branch of TPA in your city or town.

• Ask the customer care executive to check whether the submission of documents is appropriate or not. In case any modifications are to be made, note it down and follow the instructions as advised by the customer-care executive.

• After completing the pre-requisite formalities, the claim is then submitted to the Customer Care Executive in the concerned TPA.

• Inform the Insurance Company regarding the submission of the claim by sending a set of Xerox-documents to them.

e) Understanding the fine print in the policy document

• Usually all health insurance claims have to be filed within 7 days of completion of treatment or discharge from the hospital.

• Remember that insurance companies will not honor claims in case the documents are not as per their terms and conditions.

• Understand that the entire medical expenses incurred during hospitalization may not be reimbursed to the policyholder.

• Make a note of the deductions or the medical expenses that are not included in the cover. Understand and get a clear picture of the entire process. This is of utmost importance as such expenses incurred as part of the medical treatment will not be reimbursed to the claimant.

Health Insurance Portability

From the 1st of October 2011, India has opened the doors to Health Insurance Portability. Insurance Regulatory and Development Authority (IRDA), the apex regulator of the Insurance Industry released a circular giving guidelines on introduction of portability of Health (Mediclaim) Insurance. Like the name suggests, this allows switching mediclaim policies from one insurer to another, without losing out on coverage due to exclusion.

So, if a customer has a policy and wants to switch to another insurer after one year, he/she will be allowed to do so while retaining the benefit of carrying forward the awaiting period served. This move will mean insurance companies improving their service levels, as they try to retain clients and entice clients from other insurers.

The initiative to bring in a process and guideline to enable portability is a welcome step by IRDA. The circular released displays great intent on the part of the regulator to free the customer from being stuck with the same insurer, fearing loss of benefits of continuity, thus kick starting a competitive health insurance environment.

Before October 1, 2011, if you needed to move to a new health insurance company, you would have to become a new customer for them and lose all the benefits that your existing health insurance policy might have accumulated.

For example, the rules dictate that you need to stick around for 1 to 3 years with an insurer before pre existing illnesses can be covered. In case of switching to a new insurer, you would have lost this benefit completely. Pre-existing illnesses would get covered after the mandatory period is over with the new insurer. This has changed from October 1, 2011

Say, you have covered one year with your present insurance company, and then you have to wait for only 2 more years with the new insurance company before pre-existing illnesses get covered, thanks to health insurance portability.

While this is a great move forward for customers, make sure you do due diligence before changing your insurer. **The premium amount you pay should not be the only reason for you to move.**

Keep in mind the following points when initiating a transfer:

(1) Only individual and family floater policies can be transferred over.

(2) This is applicable only to health insurance policies that are issued by non-life insurance companies.

(3) The process to move to a new insurer needs to be initiated at least 45 days before the premium renewal date of current policy.

(4) Maximum time within which new insurer can ask for more details from you is 7 days.

(5) Maximum time within which existing insurer provides information to new insurer is 7 days.

(6) Maximum time for new insurer to let you know of its decision is 15 days.
At least 45 days before your current policy's premium has to be paid, you can initiate a transfer. The new insurance company will take 15 days to either accept or reject your request. If you do not hear from them in these 15 days, they cannot reject your transfer request. In these 15 days, the new insurer can come and ask for more information either from you or from your exiting insurer.

Remember both the sum assured and accumulated bonus can be transferred. But there is a catch when transferring a policy with bonus.

Suppose the sum assured of your policy is 2 lacs and you were paying a premium of say Rs 5,000 for it and you accumulated a bonus of Rs 25,000 in the previous two years as there were no claims that you made. So the sum assured with your current insurer is actually Rs 2.25 lacs. When you transfer this over to a new health insurer, you might have to pay a premium on Rs 2.25 lacs and not Rs 2 lacs. So your premium will be more than Rs 5,000. **In short, while you can carry over the no claim bonus, the new premium will be calculated on the new cover.**

Note that there is no guarantee that the transfer will necessarily happen for sure at the same premium and at the same sum assured.

The new insurance company has the right to reject your request. Or accept it with an increased premium. If you have had many claims in the past, it is unlikely that new insurance company will accept you in its fold.

When you transfer you will need to accept a different plan from the new company. Not all health insurance policies are same and all of them offer something different, so make sure when you move, you read the policy wordings on your own to understand what you are signing up for. Sometimes you could possibly end up with a higher premium as well.

Remember that using health insurance portability just because your premium is steep or because your insurance company rejected your claims is not a wise idea. You need to move if the new policy is suitable for you.

Health insurance portability is bound to make insurers compete with each other for delivery of better services and to retain existing clients. This could possibly lead to other advantages for customers.

Premium Calculation by Health Insurance Companies

Premiums are calculated based on the insurance product (or plan) purchased by the individual. These insurance products may be packaged in various ways to either provide a general coverage or may meet the needs of a particular age group. To decide on the amount that one would need to shell out, the insurance company takes all costs into considerations. Some of these factors are enlisted below:

a) Personal History:

b) Mortality Rate:
Premiums increase, as you grow older. They increase in relation to hereditary or lifestyle ailments and in principle premiums increase by availing Higher sum assured.

c) Administration and Marketing Expenses: Such expenses are incurred by the organization as part of their operational expenses and are are recovered in the form of premium that a policyholder pays while purchasing an insurance product.
d) Savings Component: This portion of the premium is invested in various public investments approved by the Government of India. based on the guidelines issued by IRDA

e) Medical Underwriting: Underwriting of various insurance products is done to create a balance between an organization and an individual. Medical Underwriting is done with a view to establish eligibility, set premiums or deny coverage. For example premiums can significantly increase in case there is an individual with a past medical history of any chronic ailment or with a long-standing prevailing illness or has had a severe Road Traffic Accident etc.

In case, a group or an organization is involved, medical underwriting is done uniformly for that particular group taking into consideration a host of factors.

f) Adjusted or Modified Community Rating: This factor takes into consideration the geographical location, topography, physical factors of the region, economic factors involved in that region, financial stability, political stability, industrial development, trade activities, lifestyles and other varied factors. For example developed regions have to shell out higher premium in comparison to regions with minimal development, for example a village area...

This means that if you live in metropolitan city like Kolkata, Mumbai, Delhi or Chennai, you have to pay higher premium in comparison to people living in Tier-II and Tier III cities, as your risks are higher of falling sick or being injured in an accident.

In addition, recently another method of calculating premium called **Experienced Rating**. has evolved. In this method, historical data is used to decide upon the rates based on the number of claims and the claim amount made during a given period. As a result, the data that is generated is used to calculate and predict the probability and potential for claims in the future. With extensive data that is now available on Internet, the **experienced rating** method has proved to be a boon for underwriters and the insurance companies. The method uses a comparison of past or historical data which forms the ground-work for analyzing the future premiums.

g) Rating Bands: Under this category, the insurance company fixes a base rate that can be charged for a particular group possessing the same characteristics. The case characteristics include factors such as age, gender, geographical region, family composition, group size, occupation details, industry etc. For example a workforce comprising of healthy employees who are in their youth in the age group of 25-30 years will pay less premium as compared to the workforce who are in the age range of 45-60 years.

We have given only broad guidelines to educate you about how a Health Insurance Company is likely to decide what you will end up paying as premium to insure your health against disease and accidents. Companies that take group insurance are likely to benefit by getting a group discount, depending on the numbers of the staff that they may wish to insure.

The methods involved in calculation of premium can vary from company to company and can change with time.

Some of the conditions for which the insurance company will cover only after a specified period or not cover at all

1. **Thirty Day Cool-off Period:**

Conditions/Ailments first diagnosed in the first 30 days of the policy are not covered under the policy.

2. Exclusion on Specified Surgeries:

The policy opens up cover for the following surgeries from the **3rd** year:

ENT Disorders, Surgery of Hydrocele (male scrotum), Hernia, Arthritis, Cataract, Enlarged Prostrate BPH Surgery, Hysterectomy, Fistula in Anus, Piles, Sinus, Gallbladder surgery, Surgery of the Genito-Urinary System, Pilonidal Sinus, Gout, Rheumatism, Hypertension, Diabetes, Stones, Slipped Disc, Varicose Veins, Joint Replacement, Osteoarthritis, Osteoporosis.

Pre-existing Conditions

All symptoms, diagnosed ailments, health conditions declared/undeclared have a minimum waiting period of 4 years, after which they are covered. In certain conditions there are co-pays after the waiting period. For certain critical ailments the Pre-existing condition could be permanently excluded.

Other than the above waiting periods in the policy, the policy permanently excludes some other treatments.

Permanent Exclusions in the policy:

1. Hospitalization only for evaluation purposes.
2. OPD treatments.
3. Maternity and Childbirth expenses
4. Dental expenses, except for Dental surgery required due to Accidental Surgery.
5. Cosmetic Surgeries.
6. Rehabilitation treatments, which cure by rest, also called "Rest Cure"
7. Unproven treatments like Acupressure etc.
8. Surgery for Correction of Eye Sight – Lasik, is not covered.
9. Accidents caused by hurting own-self, due to alcohol or drug abuse, adventure sports.
10. Treatment for psychosomatic, psychiatric disorders.
11. Treatment of HIV.
12. Sexually transmitted diseases.
13. Circumcision.
14. External Medical Equipment.
15. Genetic Disorders.
16. Treatment of Obesity.
17. Vaccination.
18. Service Charge, Registration Charge in a Hospital.

Most of these treatments are cosmetic, or predictable, and hence, are made to discourage the policy, being bought only to claim for such treatments.

Note, the premium you pay is based on exclusions of such treatments, without which the premium would not have been as affordable as they are.

Finally, your policy could have limits/capping, which could limit how much you could get for your hospital bills:

Room Rent Limits:

Your Policy could have limits on how much you can claim on Room Charges in the Hospital. In some new policies, the limit could also be related to the category of room you can select. Also, note, since almost all expenses in a Hospital are linked to the room category, you will be paid all expenses according to the eligible category of room. For instance if your room rent limit is Rs. 3000, which provides you a Shared Room, all charges would be paid in the claim, as per the Shared room tariff of the hospital. In absence of a tariff, this would be paid proportionately.

Sub Limits on Surgeries:

Some Insurance Companies could apply limits to specific surgeries. For these treatments, the policy would pay only up to this limit.

Co-pay:

Co-pay is the share of the admissible claim, which you are required to pay in the policy. If your policy has a co-pay of 30%, and if your final payable claim amount, as per the policy conditions is Rs. 100, you will be paid Rs. 70/- by the Insurance Company, and you will have to bear Rs. 30 in addition to the amount deducted due to limits and exclusions in the policy.

COMPARATIVE TESTING

Comparative Testing is a formal process by which products & services of different vendors are tested for Quality; the services are tested for compliance to the regulations laid out by the regulatory authorities for services.

CONCERT is undertaking to do this Comparative Testing for South India under a grant from Department of Consumer Affairs, Government of India. In the second year, Concert is testing 7 products and 3 services. One of the services selected for testing is Health Insurance. As part of the testing, the tester tries to provide consumer education on the various features, proper usage and how-to-buy guides for the product/service under test. The major objective of the comparative testing process is to enable the consumer to make informed decision in selecting his service provider.

This study on Health (Mediclaim) Insurance is to compare the service parameters of General Insurance Companies offering Health (Mediclaim) Insurance and Stand-alone Health (Mediclaim) Insurance Companies that are in the field as on **31-03-2012**.

This study would help consumers, at a general level, to understand the companies that are there in the Health (Mediclaim) Insurance market, and enhance their ability to make more informed choice. It will also provide some general knowledge for consumers regarding some fundamentals that govern the working of Health (mediclaim) Insurance companies.

While undertaking this study, we have considered Health (Medical) Insurance sold/issued to individuals only.

Grouping of Insurance Companies for Study

(Group A) Public Sector General Insurance Companies offering Health (Mediclaim) Insurance:

1. National Insurance Co. Ltd.
2. The New India Assurance Co. Ltd.
3. The Oriental Insurance Co. Ltd.
4. United India Insurance Co. Ltd.

(Group B) Stand-alone Health Insurance (Mediclaim) Companies:

1. Star Health and Allied Insurance Company Limited
2. Apollo Munich Health Insurance Company Limited
3. Max Bupa Health Insurance Company Ltd.(February 2010)

(Group C) General Insurance Companies offering Health (Mediclaim) Insurance (Before Dec 2008):

1. Bajaj Allianz General Insurance
2. Bharti AXA General Insurance
3. Cholamandalam MS
4. Future Generali India Insurance
5. HDFC ERGO General Insurance
6. ICICI Lombard
7. IFFCO- TOKIO General Insurance
8. Reliance General Insurance
9. Royal Sundaram

10. Shriram General Insurance
11. Tata AIG General
12. Universal Sompo General Insurance

(Group D) General Insurance Companies offering Health (Mediclaim) Insurance (After Dec 2008):

1. Raheja QBE General Insurance (Dec 2008)
2. SBI General Insurance (December 2009)
3. L & T General Insurance (July 2010)
4. Magma HDI General Insurance Co Ltd (May 2012)

Magma HDI General Insurance Co Ltd (May 2012) has not been considered in this study.

TEST METHODOLOGY

DESK TEST

The Comparative Study is based on information available in public domain as at 31-03-2012 from the published Annual Reports of the IRDA, and the Websites of the Life Insurance Companies.

PARAMETERS TESTED

1. **Solvency Ratio**
2. **Accretion (Gross Premium/Growth Ratio)**
3. **Combined Ratio (%)**
4. **Operating Profit Ratio (%)**
5. **Number of offices**
6. **Grievance Disposal Ratio,**

7. Trend of Claims Settlement

The parameters 1 to 5 are useful for assessing the financial strength of the company.

The parameters 6 and 7 assess the quality of service to the consumer hence more useful to the consumer - the same is tabulated and in detail.

GRIEVANCE DISPOSAL RATIO AND TREND OF CLAIMS SETTLEMENT

Grievance Disposal Ratio will indicate the extent to which the complaints of customers on their grievances are redressed on a time bound manner. Each Company has a separate Grievance Department to look into the issues of customers' various complaints. Redressal of grievances of customers by the Insurer is one of the important areas that is being closely monitored by **IRDA.** A higher ratio indicates that the complaints are being attended promptly.

Trend of Claims Settlement gives information on the number of claims handled, settled, repudiated, and closed during the relevant period.

We have analyzed the information on claims handled/settled/repudiated/closed as submitted by the General Insurance Companies in the IRDA format.

The claims are to be settled within a reasonable time once the Insured submits all required documents. If the claim is not payable as per the terms and conditions of the policy, the claim is repudiated.

If, in spite of various advices by the Insurer to the Insured for submission of documents, the Insurer fails to submit the same, the claims are closed.

We give below the details of Grievance Disposal Ratios and Trend of Claims Settlement handled by these companies as given by theInsurance Companies in their Annual Reports

Name of the Company	Grievance Disposal						Trend of Claims settlement (Health Claims))				
	Opening balance	Additions	Fully accepted	Partial accepted	Rejected	Complaints pending	No of Claims	Settled	Repudiated Denied	Closed	Claims Out standing
National Insurance	297	9640	6350	1933	919	735	184907	121015	12850	17406	33636
The New India Assurance	650	1914	1588	150	525	301	202836	157376	30277	NA	15183
The Oriental Insurance	1052	6020	5583	521	298	670	106771	98368	304	NA	8099
United India Insurance	1100	1942	969	751	986	336	443624	393210	4872	418	45124
Star Health and Allied Insurance	97	625	218	439	51	14	177036	97209	9678	11394	58755
Apollo Munich health Insurance	30	1081	709	57	345	0	94719	81881	7377	1080	4381
Max Bupa Health Insurance	16	198	151	1	53	9	7978	6192	917	0	869
Bajaj Allianz General Insurance	149	5294	5174	0	119	150	25003	19211	1545	NA	5792
Bharti AXA General Insurance	5	1447	1419	0	0	33	11773	7480	579	407	3307
Cholamandalam MS	155	6553	6347	0	300	61	68752	42370	3526	249	22607

Future Generali India Insurance	**17**	**391**	**288**	**1**	**116**	**3**	**10111**	**10459**	**653**	**152**	**1354**
HDFC ERGO General Insurance	**28**	**510**	**460**	**6**	**63**	**9**	**18528**	**12639**	**2878**	**15517**	**3011**
ICICI Lombard General Insurance	**116**	**6059**	**4536**	**0**	**1527**	**112**	**2563733**	**1112886**	**26646**	**14675**	**1450847**
IFFCO TOKIO	**199**	**930**	**940**	**103**	**74**	**12**	**7637**	**3933**	**0**	**1**	**1564**
Reliance General Insurance	**66**	**2440**	**2208**	**90**	**171**	**37**	**242524**	**81338**	**1285**	**1245**	**158656**
Royal Sundaram	**200**	**5880**	**5432**	**343**	**264**	**41**	**36409**	**33884**	**6006**	**NA**	**1573**
Shriram General Insurance	**2**	**53**	**27**	**0**	**28**	**0**	**0**	**0**	**0**	**0**	**0**
Tata AIG General	**232**	**6033**	**5859**	**0**	**315**	**91**	**8369**	**4964**	**1180**	**1921**	**304**
Universal Sompo General Insurance	**32**	**389**	**219**	**0**	**95**	**107**	**16657**	**10590**	**1144**	**3359**	**1564**
Raheja QBE General Insurance (Dec 2008)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
SBI General Insurance (Dec 2009)	**2**	**43**	**29**	**0**	**11**	**5**	**2055**	**2008**	**NA**	**15**	**32**
L & T General Insurance (July 2010)	**1**	**17**	**18**	**0**	**0**	**0**	**4695**	**3360**	**3**	**262**	**1070**

Figures As on 31st March 2012 NA= Not Available

Grievance Disposal Ratio

From **Table** above**,** we find that all the companies have Grievance Disposal Ratio above 90% except Universal Sompo, which was only 74.58%. **In this case they have received 389 complaints during the year and fully accepted 219 complaints and rejected 95 leaving out a balance of 107 cases pending (107 case are pending for more than 15 days).**

Companies like IFFCO TOKIO, Royal Sundaram, Cholamandalam, Reliance General, and Shriram General have around 99% as their Grievance Disposal Ratios. Similarly it can be seen from the Table that Star Health and Allied Insurance and Apollo Munich Health Insurance are also prompt in attending to the Grievances/complaints of their customers. The Grievance Disposal Ratios of above 90% indicate that such General Insurance companies attend to the customer grievances in a time bound manner. As regards Apollo Munich Health Insurance – even though they seem to be prompt in handling grievances – they have rejected 345 complaints out of a total of 1111 complaints handled by them, which seems to be on the high side.

Trend of Claims Settlement

A closer scrutiny of the above Tables, revealed that out of the 4 Public Sector Insurance Companies, three companies namely New India, Oriental, and United India have achieved claim settlement ratio of more than 90% whereas in the case of National Insurance, it is only 82%. The total number of claims repudiated is also on the high side in respect of National Insurance and New India Assurance (12, 850 for National and 30, 277 for New India).

In respect of Private Sector Insurance Companies, only two companies namely Tata AIG and Universal Sompo have settlement ratio of 96% and 91% respectively. However, the numbers of claims repudiated and closed are more as compared to the number of claims handled by them as can be seen from the table below:

Sr. No	Name of Company	No. of Claims Handled	Repudiated Denied	Closed
1	**Tata AIG General**	**8369**	**1180**	**1921**
2	**Universal Sompo General Insurance**	**16657**	**1144**	**3359**

This could be one of the reasons for their settlement ratio to be more than 90% whereas the actual number of claims settled by the was 4964 for Tata AIG and 10590 for Universal Sompo, which are not up to the desired levels.

In respect of Bharti AXA General Insurance and Cholamandalam MS, the settlement ratios are 72% and 67% only. This needs improvement.

As regards Reliance General Insurance the settlement ratio is only 34% and 158, 656 claims are pending as against 241, 524 claims handled by them. Out of 158, 656 claims pending as on 31/03/2012 85, 799 claims are pending for less than 3 months and 72, 780 claims are pending between 3 and 6 months.

Agewise pendency of claims:

ICICI Lombard

Sr. No	Pendency Period	Number of Claims			
1	Less than 3 months	686, 869			
2	3 to 6 months	516, 664			
3	6 months to 1 year	236, 938			
4	More than 1 year	10, 376			

IFFCO TOKIO

Sr. No	Pendency Period	Number of Claims
1	3 to 6 months	225
2	6 months to 1 year	316
3	More than 1 year	321

For both the above companies the pendency of more than 3 months seems to be on the high side.

As regards the stand-alone Health (Mediclaim) Insurance Companies, Star Health was the first company to be formed and they are in business for the last 6 – 7 years (Founded in 2006). Apollo Munich started their operations in August 2008. Apollo Munich Health Insurance Company Limited was previously known as Apollo DKV Insurance Company Limited. In December 2009, Apollo DKV was renamed as Apollo Munich Health Insurance.

MAX Bupa commenced their operations in February 2010 and their figures are not commented on as they are very new entrants.

In respect of Star Health and Apollo Munich, the Claims Settlement ratio works out to 67% and 95% respectively. Star Health was handling Government Health Insurance Schemes of Tamil Nadu and Andhra Pradesh and this could be the reason for handling a total of 177, 036 claims; the ratio of 67% needs improvement.

While collecting data from the websites of these companies, some anomalies were noticed and there appears to be serious mistakes in the Claims Settlement data appearing in their official websites of few companies. Particulars in respect of Number of Claims handled, settled, repudiated, closed and outstanding as on 31/03/2012 in respect of Health Insurance Claims for these companies are given below:

From the above data it is clearly seen that of sum of figures in columns 5+6+7+8 is more than the figure given column 4 and the Claims outstanding as on 31/03/2012 should be equal to the figure in 4 less the total of figures in columns 5+6+7. In view of these anomalies, we are not able to work out the Claims Settlement Ratio as well as the actual Claims closed. Hence we are unable to work out the DT Scoring for this criterion and offer comments with respect to these companies,

In respect of IFFCO TOKIO, even though the total of figures in columns 5+6+7+8 is less than the figure in column 4, the number of claims outstanding as on 31/03/2012 as given in column 8 does not reflect the correct the correct figure as the difference between the figure in column 4 (total claims handled) less the total of figures in columns 5+6+7 should be 2139 and not 1564 as given by the company.

It is quite surprising to see such errors in the figures published in the official websites of these companies; these errors prevent us from offering any comments on the criterion of Claims Settlement that is so important for a customer/consumer.

In respect of ICICI Lombard also there are errors in the published figures for Trend of Claims Settlement in respect of Health Insurance Claims.

In view of the anomalies in the figures for Claims Settlement, we are forced to mention in our Report that these Insurance Companies have not given the correct information in respect of Claims settlement for the Health Insurance (Mediclaim) portfolio.

Health Insurance (Mediclaim) Services Desk Test (DT) Scoring Table

Name of the company	Group	Total Marks (Out of 90)	Solvency Ratio	Accretion of premium for 2012	Combined Ratio	Operating Profit Ratio	Number of Offices	Grievance Disposal Ratio	Trend of Claim Settlement
National Insurance	A	79	10	9	12	12	15	15	6
The Oriental Insurance	A	78	10	5	12	6	15	15	15
United India Insurance	A	75	12	9	12	0	15	12	15
The New India Assurance	A	74	12	9	8	3	15	12	15
Star Health and Allied Insurance	B	49	12	0	8	0	12	15	2
Apollo Munich Health Insurance	B	65	12	9	12	0	6	13	13
Max Bupa health Insurance	B	57	12	5	6	0	6	15	13
Bajaj Allianz General Insurance	C	71	12	7	10	3	9	15	15
ICICI Lombard General Insurance	C	68	10	9	12	0	15	15	7
HDFC ERGO General Insurance	C	*	12	7	12	0	6	15	*
Bharti AXA General Insurance	C	53	12	5	12	0	6	15	3
Future Generali India Insurance	C	*	12	5	12	0	6	15	*
Tata AIG General Insurance	C	60	10	7	12	0	6	15	10
Royal Sundaram General Insurance	C	*	10	5	12	0	6	15	*
Shriram General Insurance	C	*	6	7	12	9	6	15	*
Cholamandalam MS	C	58	10	5	12	3	6	15	7
Universal Sompo	C	52	12	3	12	0	6	9	10
Reliance General Insurance	C	52	10	1	10	0	9	15	7
IFFCO TOKIO General Insurance	C	*	8	1	12	0	6	15	*
L & T General Insurance (July 2010)	D		12	-	12	0	6	-	4
Raheja QBE General Insurance (Dec 2008)	D		12	-	10	0	6	-	
SBI General Insurance (Dec 2009)	D		12	-	12	0	6	12	13

In the **DT Scoring Table** above, seven parameters namely Trend of Claim Settlement, Solvency Ratio, Accretion (Gross premium Growth Rate and Gross premium), Combined Ratio, Operating Profit Ratio, Number of Offices, and Grievance Disposal Ratio are considered for scoring. The parameters Number of offices, Grievance Disposal Ratio, and Trend of Claims Settlement are given **"High"** priority and assigned maximum marks of "**15"** each. Solvency Ratio, Combined ratio, and Operating Profit Ratio were assigned **"Medium"** priority and assigned maximum marks of "**12"** each. Gross premium and Gross premium growth rate were assigned "**third level"** priority, and allotted maximum marks of "**9"** each.

Thus there are three parameters with **"15,"** three with **"12,"** and one with **"9"** marks. The total possible marks for any company considering these seven parameters would be **(3 x 15) + (3 x 12) + (1 x 9) = 90.**

CUSTOMER SURVEY

A customer satisfaction survey from among owners of Health Insurance (Mediclaim) Policies was undertaken to assess the consumer experience of the service parameters of the companies considered. This was done to elicit the views and perceptions of policy holders on the insurance companies they have dealt with, level of customer service rendered by the insurers. The survey was carried out by devising a questionnaire and the policy holders were personally met to complete the questionnaire. A sample size of 5000 was targeted out of which 4706 had finally given their views The parameters were analyzed scored and rated by us.

The survey was carried out in the four Southern states including Puduchery and the details of persons covered are given in the Table below:

	Tamilnadu	Pondicherry	Kerala	Karnataka	Andhra Pradesh
Metro	**550**	**90**	**330**	**375**	**375**
Urban	**220**	**60**	**220**	**250**	**250**
Semi Urban	**220**	**60**	**220**	**250**	**250**
Rural	**110**	**90**	**330**	**375**	**375**
Total	**1100**	**300**	**1100**	**1250**	**1250**

The questionnaire was designed to get information on three areas of importance:

1. Knowledge and insurance awareness of the Public
2. Satisfaction level which includes policy servicing and claims service.
3. Preference of a particular insurance company

While evaluating the questionnaire, the various insurance companies were categorized into four groups as explained in the previous paragraphs.

Scoring Methodology

1. The survey questionnaire has predominantly responses which are **YES/NO.** All **YES** (positive responses) are given a score of **3** and the **NOs** are rated as **0**.

2. The sum of the scores along with the percentage segment wise and for the Insurance Company are indicative of the quality of the service as perceived by the respondents.

3. Where the responses are received on **1** to **5** scale the best perception is given a score of **5** and worst perception a score of **1.** Again the scores are added to compare the performance of the Insurance Companies for the service component tested.

The five point scale **1** – **5** considered has the following ratings:

1. Poor
2. Fair
3. Good
4. Very Good
5. Excellent

The findings of survey are given in **Table** below:

Criteria	Group A	Group B	Group C	Group D
Service Experience of the company/agent	V. Good	V. Good	V. Good	V. Good
Understanding of the important Policy conditions	Good	V. Good	V. Good	Good
Knowledge of the insured	Good	V. Good	V. Good	Good
Service of the TPA	V. Good	V. Good	V. Good	V. Good
Satisfaction with insurance company/service provided	V. Good	V. Good	V. Good	Good

Senior Citizens Policy Coverage in India

With advancing age and limited resources the senior citizens are finding it extremely difficult to cope with the financial burden, which are already weakened by their infirmity and disease.

Most of the Insurance Companies do not issue health insurance policy to senior citizens in India. Bajaj Allianz, National, New India, Star Health, Oriental, United & Max Bupa are issuing policies to those who are above 60 yrs.

Some features of Senior Citizen's policies issued by companies:

1. Max limit of sum assured is fixed

2. Concept of Co pay is introduced. It means that under normal policy if a person of 50 yrs is hospitalized then his full bill will be paid by the insurance Co. But in case he is a senior citizen then he himself will have to pay certain % and is explained below.

3. Limits on Claim amounts are fixed by most of the Companies

Company Name	Bajaj Allianz	National Insurance	New India	Oriental	Star Health	United India	Max Bupa Health Insurance
Policy Name	Silver Health-Health Cover for Seniors	Varistha Mediclaim for Senior Citizens	Senior Citizens Mediclaim Policy	HOPE - HEALTH OF PRIVILEGED ELDER	Senior Citizen Red Carpet (Health Cover for Seniors)	Health Insurance Policy (Silver)	Heart Beat
Max. Sum Insured Available	Rs. 5 Lakhs	Rs. 1 Lakh	Rs .1.5 Lakh	Min. 1 Lakh & Max. 5 Lakhs	Rs. 1 Lakh & Rs. 5 Lakhs	Min. Rs. 1 Lakh, Max. Rs. 3 Lakhs	Min. Rs. 2 Lakhs & Max. 50 Lakhs
Medical Tests	Yes, Pre-acceptance medical tests at the cost of proposer the amount will be paid to client if proposal is accepted.	(1)Blood/ Urine Sugar (2)Blood Pressure (3)Echo-cardiography 4)Eye checkup including Retinoscopy	(1)C.B.C. (2)Blood Sugar(PP & Fasting) (3)SGPT (4)SGOT (5)Cholesterol (6)Triglycerides (7)Serum Creatinine (8)Urine Routine (9)ECG (10)X-Ray Chest PA View (11)Physical Clinical Check up (12)Eye Check up for Cataract & Glaucoma (13)Pap Smear Test	(1)Physical Examination (2)Urine (Microalbumin Urea) 3)Glycocylated Haemoglobin (4)Ultrasonography (Whole Abdomen and Pelvis) (5)X-Ray both Knees (Anteposterior and Latrel) (6)Complete Eye Test including Fundus etc Stress Test (TMT)	(a)Not Required (b)If tests are got done then discount of 10% on premium will be given. (1)Stress Thallium Report (2)BP Report (3)Sugar (Blood & Urine) (4)Blood urea & creatinine Self-Declaration or Certification that surgeries related to Heart / Brain / Cancer has / have not been done in the past.	The following pre-acceptance health check-ups as indicated below at his own cost has to be submitted : (1)Medical Examination (2)CBC & ESR (3)Urine Routine & Microscopic (4)Cholesterol (5)SGPT (6)Sr. Creatinine (7)ECG (8)Stress Test	(1)Diabetes (2)Blood Pressure, (3)Blood / Urine Test, Etc.
Entry Age	46 to 70 Years	60 to 80 Years	60 to 80 Years	60 Years and above (10% loading will be charged for new entrants to the	60 to 69 Years	61 to 80 Years	No Limit

				policy)			
Renewal will be allowed Up to	75 Years	90 Years	Upto age 90 Years	80 & above	Life Long Renewal	Renewal beyond 80 yrs	Life Long Renewal
Conditions of Policy covers/Co Pay	20% of co-pay is applicable in case of treatment taken in other than network hospital. Waiver of co-payment available on payment of additional premium.	Yes it is applicable @ 10 % of claim Amount	Yes it is applicable @ 10% of each & every claim Amount	Yes, 20 % all claims lodged amount	50% for those who didnot go in for medical examination	Co-pay of 80:20 is applicable in respect of all hospitalisation for major illnesses where the charges are as a total package.	Above 65 yrs 20% Co-pay
Room Rent	Not Specified	1 % of Sum Insured per day	Not Specified	1% of Sum Insured per day	1% of Sum Insured subject to Rs. 4000 per day	1% Sum Insured per day	For Rs.2-3 Lakhs-Shared room, For Rs. 5-10 Lakhs-Single room, Above 10 Lakhs - Single room
ICU expenses	Not Specified	2 % of Sum Insured per day overall limit 25% of the Sum Insured per illness/ injury	Up to 2% of Sum Insured per day / Overall limit : 25% of the Sum Insured	2 % of Sum Insured per day	2 % of Sum Insured per day	2 % of Sum Insured per day	No limit
Pre Hospitalisation	3% if Hospitalization exp. will be paid for pre & post hospitalization	30 days	Actual pre-hospitalisation medical charges of up to 30 days period immediately before the insured's admission to hospital for that illness, subject to	30 days	Not Covered	Actual expenses or subject to max. 10% of S.I., whichever is less	30 days (Limit Specified)

			maximum 5% of hospital bill.				
Post Hospitalisation	3% if hopitalization exp. will be paid for pre & post hospitalization	60 days	Actual post-hospitalisation medical charges of up to 60 days period immediately after the insured's discharge from a hospital for that illness or injury, subject to maximum of 10% of hospital bill.	60 days	7% of hospitalization expenses, subject to max. Rs. 5000 @ per occurance	Actual expenses or subject to max. 10% of Sum Insured, whichever is less	60 days (Limit Specified)
Special Condition	Pre-existing covered from 2nd year. The Company's liability an case of any pre-existing illness from the second year of the policy would be restricted to 50% of the limit of indemnity in a policy year.	The company reserve the right to review the premium rate, term & conditions of this policy at the time of renewal		Treatment at Network Hospital Only		Expenses in respect of specified illness viz.Cataract, Hernia, Hysterectomy, Major surgery-Angioplasty and Pre & Post-Hospitalisation treatment is restricted as a percentage of sum insured subject to an overall cap.	2 yrs waiting period for specified illness
Pre existing Diseases	After 1 year but limit would be restricted to 50% of indemnity in a policy year	No claim is payable on pre existing diseases for '1' one year. If the insured intends to cover pre-existing diseases of Hypertensio	After 18 months claim free year. Joint replacement after 4 yrs.	Upto 2 yrs	All are covered but 50% Co payment will have to be made by insured person. However this Policy will not be	Covered after 4 yrs-As defined in the policy	After 4 yrs

		n and/or Diabetes from the inception of the policy he/she has to pay additional premium @10% for either hypertension or diabetes & 20% for hypertension & diabetes for first year of the policy			issued if person to be insured is suffering from Cancer, Chronic Kidney disease, CVA/ Brain Stroke, Alzheimer disease, Parkinson's disease.		
TPA	No	Yes	Yes	Yes	No	Yes	No
Sum Insured	Rs 1 Lakh	Rs 1 Lakh	Rs 1 Lakh	Rs 1 Lakh	Rs 1 Lakh	Rs 1 Lakh	Rs 2 Lakhs *Min Sum Insured
Age Slab	61 to 65	61 to 65	61 to 65	61 to 65	61 to 65	61 to 65	61
Indicative Cost of Medical Tests	Rs. 1000 (approx.) per person	Rs. 1500 (approx.) per person	Rs. 750 (approx.) per person	Rs. 2600 (approx.) per person	Rs. 3000 to 3500	Rs. 3000 to 3500 (approx.) per person	No charge
Doctor fee/surgeon fee/consultants/ anesthetic fee	No Limit	@25% per illness / injury	Overall limit 25% of Sum Insured	No limit	25% of Sum Insured per hospitalization	No Limit	No limit
Ambulance Charge	Rs. 1000 per claim	Rs 1000 in entire policy period will be reimbursed	Subject to a maximum of Rs 1000/-	Actual expenses or per hospitalisation by registered Ambulance subject to limit of 1000 in entire policy period	750 per day & overall limit in a year Rs.1500	Not Covered	Non-Network-Rs.2000, yes covered
Naturopathy Treatment	-	Not payable	-	Not payable	Not Payable	Not payable	Not payable
No Claim Discount	5 % Comulative Bonus, Max. 50%	Specified in the in the policy incepts or manifests	5% Comulative Bonus	No claim Discount at the rate of 5% of the renewal after every	5% per year	The insured shall be entitled for No Claim Discount of	E-vouchers 10% of renewal

		during the first 90 days of the inception of the policy.		claim free year Max. 20%.		5% for every claim free year subject to a maximum of 25%.	premium
Waiting Period	Prostatic hypertrophy, prolapse of genitouninary/ intra - abdominal organs, hernia of all types, hydrocele, fistulae, hemorrhoids, fissure in auns, stones in the urinary and biliary systems; surgery on ears, surgery on skin, internal tumours /cysts/nodules/ polyps; treatment for benign tumors or malignant or condition or for organomegaly, surgery on joints,treatment for prolapsed intervetebtal discs, surgery for gastric or Joint Replacement after 4 yrs	1 yrs Cataract,Benign Prostatic Hypertrophy etc. Pls refer to the policy document	18 Months for Cataract, Hernia etc. Pls refer to the policy document.	2 yrs waiting period for specified diseases like Cataract, Hernia etc.Pls refer to the policy document.	Diseases such as Hernia, Piles, Hydrocele, Congenital Internal disease/ defect, Sinusitis, Gall Stone/Renal Stone removal and Benign Prostrate Hypertrophy and some additional diseases are excluded during the first 2 yrs.	Diseases such as cataract, hernia, hysterectomy and some additional diseases are excluded during the first 2 years of the policy (Ref.Condition no. 4.3).	2 yrs waiting period for specified diseases like Cataract, Hernia etc.Pls refer to the policy document.
Net Premium (Inclusive of Service Tax	Rs. 8057	Rs. 5167 (Included 10% after	Rs. 4758 (Included 10% after	Rs. 5562 (Included 10% after loading)	Rs. 5000 (Without medical tests), Rs.	Rs. 5056	Rs. 14,840 (for Rs. 2

(12.36%) & other loading etc.)		loading)	loading)		4499 (With medical tests)		Lakhs)

Source of Information: http://www.healthinsuranceindia.org/senior-citizens-insurance-policy-coverage-India.asp