HEALTH INSURANCE

HEALTH POLICY

- Health Policy - Indemnity Policy

- Health combined with Critical Illness Policy – Indemnity cum Benefit Policy

Health Insurance Policy covers Hospitalisation in India

Overseas Mediclaim Policy covers Hospitalisation outside India

Personal Accident Policy covers Worldwide

Certain Health Policy covers foreign visits also as option under overseas Mediclaim on payment of additional premium

HEALTH POLICY

- **Retail - Individual Health Policy**
- **Group -**

  Employee-Employer Relationship

  Non-Employer – Non-Employee Relationship – Ex.Association, Clubs, Resorts,

- **Government Schemes - Govt pays the premium**

Health Policy COVERS

- Room, Boarding and Nursing expenses
- ICU/NICU, CCU.
- Surgeon, Anesthetist, Consultants, Specialist and other Doctor fees associated with treatment.
- Medicines, Implants and consumables
- Hospitalisation expenses of Donors subject to availability of Sum Insured.
- Cost of Organ is not covers - it is illegal and cost cannot be predicted.
- Pre-hospitalisation 30 days prior to admission date and Post-hospitalisation 60 days from the date of discharge.

COVERS

- What is the minimum period for hospitalisation ?
- 24 hours
- Day Care Procedures - Whether admission is required ?
- No
- Domiciliary Expenses –
- Condition of patient is such that he is not in a condition to be
- removed to hospital
- Non-availability of room in the hospital
- Home-Care treatment

COVERS

AYUSH - Ayurvedic, Yoga and Naturopathy, Unani, Siddha and Homeopathic

Covered if taken in Government Hospital or in any Institute recognised by the Government and/or accredited by QCI (Quality Council of India)/NABH

(National Accreditation Board on Health)

Government is making AYUSH coverage compulsory in all health policies

MTMAT - MODERN TREATMENT METHODS & ADVANCEMENT IN TECHNOLOGIES - with limits

TYPE OF HOSPITALS

Tertiary Care Hospital - High end hospitals where all types of treatments are carried out.

Secondary care Hospital - Single Speciality or Surgeries of any specific in nature is carried out.

Primary Care Hospital - Where consultation is carried out and basic level of treatment is performed.

HOSPITAL

	REGULAR	AYUSH
REGISTRATION	Registered as Hospital with local authorities or	Recognised or registered with local authorities or
TYPE	Registered	Govt/Teaching hospital attached to Ayush Hospital,
MINIMUM BEDS	**10 lakhs10 in towns having less than 15 in all other places**	**“5”**
Medical Prac.	Mandatory	Ayush Medical Practitioner
Qualified Nurse	Mandatory	---
Operation Theatre	Compulsory if performed	Theraphy sections
Daily Records	Mandatory	Mandatory

DEFINITION AND EXCLUSIONS

- Standard Definition - All Policy related viz.Age, Policy period, etc.
- Specific Definitions - Psychiatric, Epidemic, Age, etc. - All specific defences which relates to particular type of policies

- Waiting Period Exclusions - Time bound exclusions and covered after the particular time is over.
- Permanent Exclusions - Permanently excluded throughout the policy coverage under the product type.
- Specific Permanent Exclusions - Any exclusions which is specifically included under the particular product type.

WAITING PERIOD EXCLUSIONS

- **Pre-existing diseases - 36 months**

  Any disease for which treatment is rendered or well-known to insured person at the time of first policy.

- **First 30 days - No illness is covered EXCEPT accident**
- **Two years/Four years exclusion – eg. Cataract, Hysterectomy, Hernia, Arthritis, Osteoporosis**

PERMANENT EXCLUSIONS

- Circumcision/Inoculation/Plastic surgery
- Cost of spectacles, contact lenses and hearing aids
- Vitamins and tonics - Covered if it is part of treatment

- Pregnancy, childbirth except ectopic pregnancy **provided it is supported by USG report and certificate of Gynae that it is life threatening.**

- Devices – **CPAP, Belts, collar, stockings, diabetic footwear, Glucometer/Thermometer, alpha/water bed**

PERMANENT EXCLUSIONS

- Genetic disorders and stem cell implantation
- Change of treatment from one system of medicine to another – unless recommended by the consultant/hosp.
- ARMD, RFQMR – Rotational Field Quantum Magnetic Resonance, EECP- Enhanced External Counter Pulsation –

  Why these are not covered ?
- Non-Medical expenses
- Admission/Registration, service, surcharges.

ANY ONE ILLNESS AND GRACE PERIOD

Any One illness – Continue period of illness and relapse within 45 days from the date of last consultation

Grace Period - 30 days for Quarterly/Half-yearly/YEARLY premium.

15days where premium is paid in monthly instalments.

Claim payable even if claim fall under grace period IN CASE OF grace periods falling under instalment premium.

Not applicable for grace period at renewals.

NETWORK VS.PPN

- Network - Empaneled hospitals - where cashless facility is provided - Between TPA and Hospital - Different TPAs have different rates with Hospital for same procedure

- PPN - Preferred Provider Network - Between TPA, Insurance company and Hospital - effective in 12 cities - Same rate across all Hospitals and across all PSUs.

FACTORS

Age and Sum Insured - Health Policy

Age, No.of days and Sum Insured - OMP

Age, Occupation, No of days and Sum Insured

OPTIONAL COVERS

- Daily Cash Allowance
- Critical Illness
- Overseas Hospitalisation
- Road and Air Ambulance
- Reinstatement of Sum Insured (In-built also)
- List of Excluded Items.

RENEWAL

Can be denied only on

- **Fraud**
- **Non-Disclosure.**
- **Misrepresentation**

Cannot be denied

- **Claim in preceding years.**
- **Resort to fresh underwriting unless there is an enhancement of Sum Insured.**

Cancellation

Can cancel the policy on

- Fraud
- Misrepresentation
- Non-disclosure of material fact
- Non-cooperation by the insured

Period of Notice - Fifteen days in writing by Registered A/D

If Insured cancel ; - 7 days notice in writing. Refund proportionate premium for unexpired policy period and if no claim is made.

Enhancement of Sum Insured

- Can be considered – ? Yes
- When ? - Only during renewal

- Waiting Period clause in the policy - applicable for enhanced sum insured

MID-TERM ADDITION

- Newly married spouse
- New Born Baby

Reinstatement of Sum Insured

- Some Policies offer
- SI reinstated as soon as the entire SI is exhausted or during claim.
- Premium added or inbuilt at the commencement of risk.
- Mid-term cannot be included.
- Reinstated SI can be utilised for illness other than for which the SI is exhausted.
- Reinstated SI can be utilized by other persons also subject to availability of SI.

FREE LOOK PERIOD

- 30 days from the date of receipt of policy
- Available for policies with term of one year or more
- Applicable at the inception of first policy
- Proportionate risk premium to be deducted for period of cover
- Refund of the premium paid less any expenses incurred by the insurer on medical examination provided no claim is made.

On acceptance, Pre-acceptance health check-up paid - Rs.400/-

Premium collected - Rs.3,650/- 1-1-2024 to 31-12-2024

Policy delivered on 15-1-2024

Policy returned on 09-02-2024

Can we refund ?

TIMELINES

Intimation OF claim - Immediate -

Emergency cases - within 24 hours

Submission of documents – 15 days from the date of discharge

Settlement of claims – 15 days from the date of receipt of last documents

No claim shall be rejected or closed for want of documents or for delayed intimation.

PRE-ACCEPTANCE HEALTH CHECK-UP

Test differs from Policy to Policy.

Not less than 50% of the cost involved for the required test to be refunded subject acceptance of risk.

COST OF HEALTH CHECK-UP

1% of the average sum insured for the preceding four claim free years

(Book reference)

Some policy has three years and some have four years

Would not be considered as a claim and will not affect the cumulative bonus or discount accrued during the previous years.

PRE-EXISTING DEFINITION

Pre-existing disease means any condition, ailment or injury or disease:

a. That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the insurer OR

b. For which medical advice or treatment was recommended by, or received from, a physician within 36 months prior to the effective date of the policy or its reinstatement

MIGRATION

- Within the Company.
- Migration to suitable health product at the time of exit age or at the time of withdrawal of existing product.
- SI, NCB,PED, Specific Waiting Period, Moratorium
- Allow all suitable credits in the previous policy years provided policy maintained without any break.
- Not applicable for Travel and PA Policies.

PORTABILITY

- Credit gained with previous insurance for PED and time-bound exclusions
- Policy holder to apply at least 30 days before but not earlier than 60 days from the due date of renewal.
- Existing Insurer to provide the information sought by Acquiring Insurer immediately but not more than 72 hours of receipt of request through IIB.
- Acquiring Insurer to communicate on the proposal but not more than 5 days of receipt of information from Existing insurer.
- No commission for port-in policy.

MORATORIUM PERIOD

If the insured is with us for 60 months of continuous coverage, there is no question of look back.

Except for established fraud.

Ported or migrated period to be counted for purpose of calculating the Moratorium period.

NO CLAIM BONUS

Reward for policyholders who do not make a claim –

Cumulative Bonus – Addition in Sum Insured

Or

Discount in renewal premium

MULTIPLE POLICIES

- Each insurer deal with the claims independently.
- It is the privilege of the Insured to claim under any policy.
- Has right to claim the balance amount/deductibles/co-pay from the other insurer subject to the limits and terms of the policy.
- The first settler will hold the claim documents and the second settler shall settle the claim based on the certified documents obtained from the first settler.
- In case of Benefit Policy - ?????????????

THIRD PARTY ADMINISTRATOR

ROLE

ID Card issuance / Processing of claims

Whether TPA can approve the claim ? No

Whether TPA settle the claim ? No

Whether TPA can repudiate the claim - No

As soon as the claim is settled, the file to returned to UW office and documents to be digitally transferred.

IRDAI REGULATIONS

IRDA (Health Insurance) Regulations 2013 - 01-10-2013

IRDAI (Health Insurance) regulations 2016 - 12-07-2016

Includes Health, Personal Accident and Travel policies

MASTER CIRCULAR ISSUED ON 29-05-2024 TO COMPLY WITH BEFORE 30-09-2024

IRDAI REGULATIONS

- Shall not be denied renewal – No age limit for renewal
- Cumulative Bonus accrued – reduce at the same rate at which it has accrued
- Cannot seek Medical examination or fresh proposal form if same sum insured is maintained on renewal.

IRDAI REGULATIONS

- Documents submitted beyond certain period – can claim be denied ? No
- Whether TPA can be changed ? Yes – 30 days Notice
- No commission payable for Portability policy.
- Combi products – Combination of What ? Health and life
- UIN - ? Unique Identification Number
- PMC – ? Product Management Committee
- Can Life Insurance provide health cover - ? (5>) Yes
- Minimum Group size - 7
- Can devise mechanism to reward policyholders

RECENT AMENDMENTS

In compliance with -

Provision for insurance of Mental Illness as good as physical illness - Mental Healthcare Act 2017 came into force 29-05-2018

HIV and AIDS (Prevention and Control) ACT 2017 w.e.f.10-9-2018 - No person to be discriminated.

Rights of persons with disabilities act 2016

Surrogacy act, 2021

Transgender persons act, 2019

ROHINI MASTER - Registrar of Hospitals in network of Insurance. Maintained by IIB.

LATEST GUIDELINES

- Revised cis – w.e.f.01-01-2024 – Local language if reqd., font size 12 and above, (arial).
- SURROGACY ACT – COVERAGE FOR SURROGATE MOTHER FOR 36 MONTHS
- Intending couple or woman CAN TAKE health insurance FOR oocyte donor for a period of 12 months.
- NOMINATION COMPULSORY FOR THE PURPOSE OF PAYMENT OF CLAIMS. Can be changed any time during the policy period.

- With specific consent from customer, ayushman bharat health account (abha) to be created for hassle-free method of accessing and sharing health records digitally.

IRDAI MASTER CIRCULAR

- Entry age – all ages
- All medical conditions
- ALL TYPE OF TREATMENTS TO BE COVERED
- ALL TYPE OF PERSONS TO BE COVERED WITHOUT ANY DISCRIMINATION. ?????
- ALL TYPE OF HOSPITALS/HEALTH CARE PROVIDERS TO BE COVERED.

- INSURERS FREE TO CUSTOMISE THEIR PRODUCT DEPENDING ON CUSTOMER'S REQUIREMENTS.

IRDAI MASTER CIRCULAR

- PRODUCTS TO COVER MTMAT – INSURERS TO COMPULSORY COVER ALL SORTS OF ADVANCEMENTS
- CUSTOMER INFORMATION SHEET IS COMPULSORY – INDEX OF CONTENTS OF POLICY. Demand in local language ?????
- Whether required for Group Policies ?
- 100% cashless to policyholders.
- Empaneled hospitals to be available in website.
- National health claim payments for speedy settlement.

LATEST GUIDELINES

- Cashless decision immediately but not more than **one hour** of receipt of request
- Digital mode of pre-authorization is appreciated
- Final authorization within **three hours of receipt of discharge authorization request from the hospital**. If delayed beyond ????????
- In case of death, immediate process to be done to get the mortal remains released from hospital.
- No claim to be repudiated without the approval of PMC or a three member sub-group of PMC called the CRC - Claims Review Committee.
- Disallowed amount to be shared with specific T & C of policy

LATEST GUIDELINES

- If withdrawn, one-time option to be given to renew under existing terms if the policy expires within 90 days of withdrawal
- Existing policy to continue till its expiry.
- Senior Citizen Premium – Cannot be revised more than 10% per annum
- IRDAI to be consulted prior to taking decision on –

If the premium is revised beyond 10%.

Withdrawal of any products affecting Senior citizen.

LATEST GUIDELINES

- Reply to Grievance to contain the complete address of Insurance Ombudsman to whom the applicant can approach if dis-satisfied with the reply.
- Ombudsman award to be complied with within 30 days failing which Rs.5,000/- per day to be payable to the complainant as penalty.

LATEST GUIDELINES

- Board approved Underwriting Policy.
- Standards and Benchmarks for empanelment of Hospitals.
- Proposal form in simple language and CIS in specified format
- Well defined claim settlement process, TATs, Servicing of Policy.
- Onboard Health care providers on NHCX.
- Monitoring performance of TPAs.

LATEST GUIDELINES - PMC

- PMC AT ALL INSURERS - MEMBERS OF CUO, AA, CMO, CIO, CTO, CCO.
- QUORUM OF PMC IS 3 MEMBERS IN ADDITION TO AA.
- Overall responsibility rests with CEO.
- DUE DILIGENCE PROCESS IS IN PLACE TO MITIGATE RISKS
- PMC APPROVES THE PRODUCT AND NECESSARY SUBMISSION MADE TO IRDAI.
- USE AND FILE PROCEDURE IS COMPLETE, CORRECT AND IN COMPLIANCE WITH THE EXTANT APPLICABLE

LATEST - PMC

- If Product not launched within 30 days of generation of UIN, approval or modification afresh to be obtained from PMC.
- Decision of withdrawal shall be taken by PMC with clearly documenting the reason for the same.
- IRDAI TO BE INFORMED WITHIN 30 DAYS OF WITHDRAWAL
- Withdrawn product not to be offered to new customer.
- One time option to be given to renew if renewal falls within 90 days from the date of withdrawal.
- Migration permitted as per insured's choice.
- Premium received for product withdrawn and policy not issued - REFUNDED & NOT ADJUSTED

OTHER REGULATIONS

- IRDAI (Third party Administrators – Health Services) regulations 2016
- IRDA (Protection of Policyholders' Interest) Regulations2002 – Penal interest – Regulation 9(6) – Revised in 2017 – 22-06-2017
- 1. 2% over the bank rate from the date of last received documents till settlement if claim is not settled within 30 days of last received documents.

IMP DESCRIPTIONS

ABHA - AYUSHMAN BHARAT HEALTH ACCOUNT

To receive and access digital lab reports, prescriptions and diagnosis

Specific consent of claimant is required to create this account and at every instance required.

ABDM – AYUSHMAN BHARAT DIGITAL MISSION

- INTEGRATED DIGITAL HEALTH SYSTEM DEVELOPED TO BRIDGE THE GAP BETWEEN DIFFERENT STAKEHOLDERS OF HEALTHCARE ECO SYSTEM.

14 DIGIT NUMBER – PROVIDES THE HEALTH RECORDS OF PERSON

CUSTODIAN OF ABHA – GOVERNMENT OF INDIA

NHCX – NATIONAL HEALTH CLAIMS EXCHANGE – EXCHANGING THE HEALTH CLAIMS DATA FOR USE OF THE STAKEHOLDERS.

FHIR - Fast Healthcare Interoperability Resources Standard

IMP DESCRIPTIONS

CPR - CARDIOPULMONARY RESUSCITATION

BMI - BODY MASS INDEX

NICU - Neo-natal intensive care unit

CCU - critical care unit

HDL & LDL - high density lipoprotein and low density lipoprotein

AMBULATORY CHARGES - services rendered after surgery otherwise called outpatient charges

DME - durable medical equipments

HCPC - HEALTHCARE PROCEDURE CODING

ICD - INTERNATIONAL CLASSIFICATION OF DISEASES

AYUSHMAN BHARAT

- Health and Wellness Centre (HWC) and Pradhan Mantri Jan Arogya Yojana (PMJAY).
- Primary Health care – More than 150,000 centres
- Sum Insured – Rs.5 lakhs per family per year – for Secondary and Tertiary Care Hospitals.
- More than 12 Crores family covered and more than 55 Crores individual beneficiaries
- Occupational Criteria based on Socio-Economic Caste census 2011 (SECC) for rural and urban areas.
- Erstwhile Rashtriya Swasthya Bima Yojana and National health protection Scheme.
- Worlds - ??????????

AYUSHMAN BHARAT

- No restriction on Family size, age or gender
- Pre-existing covered from day one.
- Pre-hospitalization – 3 days and Post-hospitalization – 15 days.
- Unique feature is beneficiary can avail treatment anywhere in India.
- Both Public and Private Hospitals are empaneled.
- Around 1929 Packages have been covered under this scheme for a fixed amount.
- Whether Ragpickers/Beggars/Sanitation worker/Chowkidar ?????
- Assurance Mode/Trust Mode - ??????? (Implementation Support Agency) - Rate - ?????
- Insurance Mode - ??????????? Premium - ????????

AYUSHMAN BHARAT

- Administrative cost - Not to exceed _____ ?
- If surplus amount after claims+cost - What action ?
- Categorised under A and B States - Union Territories comes under Category A
- ICR above 120% - What action ?
- 60:40 for all States other than North-eastern States and three Himalayan States and Union Territories with legislature
- 90:10 for North eastern States and three Himalayan states.
- 100% for Union Territories without legislature
- ESIS Card holders – Can also use PM-Jay benefits

AROGYA SANJEEVANI

- Common Product across all General Insurers
- Only premium rate differs
- Room rent, Nursing – 2% per day subject to max. of Rs.5,000/- per day
- ICU – 5% per day subject to max.of Rs.10,000/- per day
- Cataract – 25% of SI or Rs.40,000/- whichever is less
- Pre-hospitalisation – 30 days
- Post-hospitalisation – 60 days
- Modern methods introduced with 50% limit of SI.

AROGYA SANJEEVANI

- Cumulative bonus 5% upto 50% and shall reduced in the same manner if claim is reported
- All exclusions are defined and common across all insurers.
- Copayment of 5% - If the claim amount exceed SI ?
- Payment of premium on instalment basis permitted with 30 days grace time for making the payment
- Nomination mandatory.
- No loading to apply in case of claims experience.
- Sum Insured ranging from Rs.50,000 to Rs.10 lakhs
- Both on Individual basis and Floater basis
- Family - self, spouse, children and parents/in-laws

CORONA KAVACH

- Individual and Floater basis
- Hospitalisation, Home-care treatment, Pre and Post
- SI ranging from rs.50,000 to Rs.5 lacs
- Policy period – 3 ½, 6 ½ and 9 ½ months - Why ?
- Home-care with certain conditions – Maximum upto 14 days treatment
- First fifteen days
- Health care discount (for those who are working in Health care) – 5%
- Rural – 10%
- Cancellation – 7 days Notice

OVERSEAS MEDICLAIM POLICY

- For travelling abroad.
- Medical expenses and Repatriation
- Personal Accident
- Loss of checked in Baggage (Property Irregularity report
- Delay in checked in Baggage - Only on outbound flights
- Loss of Passport
- Personal Liability – Legal liability arising out of insured.
- Policy issued for max.180 days – One extension upto 180
- Age, No.of days and Sum Insured

OVERSEAS MEDICLAIM POLICY

- ✓ Against Medical Advice.
- ✓ Deductibles
- ✓ Cosmetic surgery
- ✓ Pregnancy
- ✓ Treatment in India
- ✓ Pre-existing - ????????????

- ✓ CORPORATE FREQUENT TRAVELLERS
- ✓ For frequently travelling public.
- ✓ Subject to any one trip not exceeding 60 days and aggregate 180 days during the policy period.

CRITICAL ILLNESS BENEFIT POLICY

- ✓ Benefit policy for covering Critical Illness contracted.
- ✓ Designed to take care of the future medical expenses
- ✓ Full Sum Insured is payable on contracting the critical illness for the first time.
- ✓ Waiting period is first 90 days of the first policy
- ✓ Survival period is 30 days from the date of diagnosis.
- ✓ Illnesses differs from policy to policy.
- ✓ Policy ceases as soon as the claim is paid.

QUESTIONS

TWO POLICIES

Policy period - 1-1-2018 to 31-12-2018 - Rs.2 lakhs

Renewed - 1-1-2019 to 31-12-2019 - Rs.2 lakhs

Admitted on 25-12-2018 and discharged on 06-01-2019

Claimed amount - Rs.3.25 lakhs

Non-Medical expenses - Rs.0.54 lakhs

How much claim payable ?

Claimed amount	**-**	**Rs.3.25 lakhs**
Less : Non-Medical Exp	**-**	**Rs.0.54 lakhs**
Admissible amount	**-**	**Rs.2.71 lakhs**

Claim payable is - Rs.2.71 lakhs / Rs.2 lakhs / proprionately paid and si reduced.

Ans : ????

COPAY

Policy period - 1-1-2018 to 31-12-2018 - Rs.3 lakhs

Policy renewed on 20-01-2019-19-01-2020 - rs.3 lakhs

Policy carry copay of 10% on all claims

Admitted on 25-12-2018 and discharged on 06-01-2019

Claimed amount - Rs.4.20 lakhs

Non-Medical expenses - Rs.0.20 lakhs

How much claim payable ?

- **Claimed amount - Rs.4.20 lakhs**
- **Less : Non-Medical expenses Rs.0.20 lakhs Rs.4.00 lakhs**
- **Less : 10% copay on admissible claims Rs.0.40 lakhs**
- **Admissible claim amount Rs.3.60 lakhs**
- **Claim payable - Rs.4.20 L / Rs.2.70 L / Rs.3 L / prop.share only**

Ans : ????????

COPAY

Policy period - 1-1-2018 to 31-12-2018 - Rs.3 lakhs

<u>Policy carry copay of 10% on all claims</u>

Admitted on 25-12-2018 and discharged on 06-01-2019

Claimed amount - Rs.3.50 lakhs

Non-Medical expenses - Rs.0.20 lakhs

How much claim payable ?

- ✓ **Claimed amount - Rs.3.50 lakhs**
- ✓ **Less : Non-Medical expenses Rs.0.20 lakhs Rs.3.30 lakhs**
- ✓ **Less : 10% copay on admissible claims Rs.0.33 lakhs**
- ✓ **Admissible claim amount Rs.2.97 lakhs**
- ✓ **Claim payable - ???????**

Single policy

Policy period - 1-1-2018 to 31-12-2018 - Rs.3 lakhs

Not renewed due to certain reasons

Admitted on 29-12-2018 and discharged on 06-01-2019

Claimed amount - Rs.4.20 lakhs

Non-Medical expenses - Rs.0.20 lakhs

How much claim payable ? -

TWO POLICIES

UIIC Policy period - 1-1-2019 to 31-12-2019 - Rs.3 lakhs

NIA Policy period – 01-07-2018 to 30-06-2019 – Rs.5 lakhs

Admitted on 01-02-2019 and discharged on 16-02-2019

Claimed amount - Rs.3.80 lakhs

Non-Medical expenses - Rs.0.20 lakhs

From where the insured can claim ?

Whether proportionate ?

Procedure for making second claim ? With xerxo copies duly certified by first tpa

ROOM RENT LIMIT - POLICIES

UIIC Policy period - 1-1-2022 to 31-12-2022 - Rs.5 Lakhs

Admitted on 01-02-2022 and discharged on 16-02-2022

Room rent limit – 1% and ICU 2% -

Claimed amount - Rs.5.80 lakhs, Non-Medical expenses - Rs.0.20 lakhs

Room used – Rs.10,000/-, Surgeon, Asst.Surgeons, Anesthetist and Doctor fees – Rs.1,50,000/-, Investigations – Rs.90,000/-, Implant – Rs.1 Lakh and Medicines and consumable including Non-Medical exp – Rs.80,000/-

calculation in next page

ROOM RENT LIMIT - POLICIES

Room Rent -Rs.5,000 (1%) * 16 days -	Rs.80,000/-
Surgeon, Anesthetist, etc. -	Rs.75,000/-
(Proportionately divided according to Room occupied vs.room eligibility)	
Investigations	Rs.45,000/-
Implant	Rs. 1 lakh
Medicines - Non-medicals	Rs.60,000
Total claim payable -	Rs.3,60,000/-

BONUS

UIIC Policy period - 1-1-2019 to 31-12-2019 - Rs.3 lakhs

Cumulative Bonus earned - 50% totalling to Rs.4.50 lakhs

Policy carry – 1% Room rent per day and 2% ICU per day

Admitted on 01-02-2019 and discharged on 16-02-2019

Claimed amount - Rs.4.80 lakhs

Non-Medical expenses - Rs.0.20 lakhs

What is room rent eligible ? - 1% of base si

What is the claim amount ? How to work out ?

If the admissible amount is above Rs.3 lakhs, then the Cumulative bonus is added and paid.

SUPER TOP UP

Year - 11th renewal - 01-01-2022 to 31-12-2022 - rs.5 lakhs

Super top up - 5th renewal - 01-01-22 - 31-12-22 -

Si rs.5 lakhs with threshold level - rs.3 lakhs

Claim in the month of June 2022 for rs.4.50 lakhs

Base policy claim paid - rs.2.90 lakhs after applying limits

1. **Balance not payable.**
2. **Rs.1.60 lakhs payable under super top**
3. **Rs.1.50 lakhs payable under super top**
4. **Nil claim under stup as base policy not exhausted.**

SUPER TOP UP

Year - 9th renewal - 01-01-2021 to 31-12-2021 - rs.5 lakhs

Super top up - 3rd renewal - 01-01-21 - 31-12-21 -

Si rs.5 lakhs with threshold level - rs.3 lakhs

treated for heart ailment in the year 2016.

Claim in the month of June 2021 for heart ailment rs.4.10 lakhs

Base policy claim paid - rs.2.60 lakhs after applying limits

1. Rs.1.50 lakhs payable under super top
2. Rs.1.10 lakhs payable under super top
3. Nil claim under super top.
4. Nil claim as it not exceeded base si.

QUESTION - 1

Mr.A had taken a health insurance policy for SI of Rs.5 lacs since 2018. during January 2024 he took a critical illness policy for SI of Rs.10 lakhs. He underwent heart surgery in the year 2021 and the claim was settled for Rs.3 lakhs.

During March 2024 he had heart attack and claimed an amount of Rs.9 lakhs spent for hospitalisation treatment and claimed the entire amount under both the policies.

What is the amount payable to Mr.A ?

QUESTION - 2

Mr.A had taken a family floater policy for SI of Rs.5 lakhs covering self, spouse and one child since Jan 2020. He has opted for maternity cover under the policy during its renewal in Jan 2023.

He claimed an amount of Rs.50,000/- for delivery of second child in the month of Jun 2023. he was admitted for chronic treatment in august 2023 and spent an amount of rs.4.65 lakhs and claimed the amount.

1. What is the amount payable under both the claims ?
2. What is the balance sum insured available /

QUESTION - 3

Mr.A has super top policy with sum insured of Rs.10 lakhs and threshold limit of Rs.5 lakhs.

He was hospitalised for 15 days and spent an amount of Rs.7 lakhs for the treatment ?

He claimed the entire amount of Rs.7 lakhs as the SI was 10 lakhs under super top up policy ?

What is the amount payable ?

QUESTION - 4

Mr.A had base policy of Rs.5 lakhs with a condition of 70% of sum insured for major illness and super top policy with SI of Rs.10 lakhs with threshold level of Rs.3 lakhs.

He was admitted in hospital for 10 days and spent an amount of Rs.7 lakhs for the treatment of major illness.

What is the amount payable under both the policies to Mr.A ?

Thank you