INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY OF INDIA (HEALTH INSURANCE) REGULATIONS, 2016[1]

[Amended upto 19/11/2019] F. No. IRDAI/Reg/17/129/2016. - In exercise of the powers conferred under Section 114A of the Insurance Act, 1938 and Section 14 read with Section 26 of the IRDA Act, 1999 and in consultation with the Insurance Advisory Committee, the Authority hereby makes the following regulations, namely:-

CHAPTER I: GENERAL

1. Short title and commencement

a. These Regulations may be called Insurance Regulatory and Development Authority of India (Health Insurance) Regulations, 2016.

c. Unless otherwise provided by these Regulations, nothing in these Regulations shall deem to invalidate the Health insurance contracts entered into prior to these Regulations coming into force.

d. Unless otherwise mentioned herein, these Regulations are applicable to all registered Life Insurers, General Insurers and Health insurers, conducting health insurance business, as defined under the Act. These Regulations shall also be applicable to all TPAs wherever mentioned.

2. Definitions.(i) In these Regulations, unless the context otherwise requires,--

a. "Act" means the Insurance Act 1938.

b. "Health Services Agreement" means an agreement as defined in IRDAI (Third Party Administrators - Health Services) Regulations, 2016.

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

d. "AYUSH Treatment" refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

e. "Break in policy" means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

[1]Vide Notification No. IRDAI/Reg/17/129/2016 dated 12th July 2016 published in the Gazette of India, Extraordinary Part III – Section 4, vide No. 293 dated 12th July 2016 (w.e.f 18-07-2016)

f. "Cashless facility" means a facility extended by the insurer or TPA on behalf of the insurer to the insured, where the payments for the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.

g. "Product Filing Guidelines" mean the Guidelines specified by the Authority on the procedure to be followed by insurers before marketing or offering a product falling under Health Insurance Business.

h. “Health insurance business” means Health insurance business as defined under Section 2(6C) of the Act.

i. "Health Services by TPA" means the services specified in Regulation (3) of IRDAI (Third Party Administrators - Health Services) Regulations, 2016.

j. “Health plus Life Combi Products” mean products which offer the combination of a Life Insurance cover offered by a life insurer and a Health Insurance cover offered by General Insurer or Health Insurer.

k. “Network Provider” means network provider as defined in IRDAI (Third Party Administrators - Health Services) Regulations, 2016.

l. “Pilot product” means a close-ended product with a policy term of one year that may be offered for sale by General Insurers or Health Insurers for a period not exceeding five years from the date of launch of the product with a view to giving scope to innovation for covering risks that have not been offered hitherto or stand excluded in the extant products.

m. [2][***]

n. “Senior citizen” means any person who has completed sixty or more years of age as on the date of commencement or renewal of a health insurance policy.

o. “Specified” means specified by the Authority from time to time, by issue of Circulars, Guidelines or Instructions for the purpose of these regulations on matters listed in Schedule - III or any other matter which is required to be specified by the Authority under these Regulations.

[2]Omitted by Insurance Regulatory and Development Authority of India (Health Insurance) (Amendment) Regulations, 2019, dated 19th November, 2019 (w.e.f 21.11.2019). Prior to its omission, clause (m) read as under:

““Portability” means the right accorded to an individual health insurance policyholder (including family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another or from one plan to another plan of the same insurer.”

p. [3][***]

(ii). All words or expressions not defined in these Regulations but defined in the Insurance Act 1938 or Insurance Regulatory and Development Authority Act 1999 or Rules or Regulations made thereunder shall have the same meanings respectively assigned to them in those Acts, rules or regulations as amended from time to time.

3. Registration and Scope of Health Insurance Business

a. Health Insurance products may be offered only by entities with a valid registration granted to carry on Life Insurance or General Insurance or Health Insurance Business under the Insurance Regulatory and Development Authority (Registration of Indian Insurance Companies) Regulations 2000 as amended from time to time.

b. Life Insurers may offer long term Individual Health Insurance products i.e., for term of 5 years or more, but the premium for such products shall remain unchanged for at least a period of every block of three years, thereafter the premium may be reviewed and modified as necessary.

Provided that a life insurer may not offer indemnity based products either Individual or Group. All existing indemnity based products offered by life insurers shall be withdrawn as specified under these Regulations.

Provided also that no single premium health insurance product shall be offered under Unit Linked platform.

c. General Insurers and Health Insurers may offer individual health products with a minimum tenure of one year and a maximum tenure of three years, provided that the premium remains unchanged for the tenure.

d. Group Health Policies may be offered by any insurer for a term of one year except credit linked products where the term can be extended up to the loan period not exceeding five years.

Provided General Insurers and Health Insurers may also offer Credit Linked Group Personal Accident policies for a term extended upto the loan period not exceeding five years.

[3]Omitted by Insurance Regulatory and Development Authority of India (Health Insurance) (Amendment) Regulations, 2019, dated 19th November, 2019 (w.e.f 21.11.2019). Prior to its omission, clause (p) read as under:

""Third Party Administrators or TPA'' means any person who is registered under the IRDAI (Third Party Administrators – Health Services) Regulations,2016 notified by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services as defined in those Regulations."

Provided further, notwithstanding the provisions of Regulation 4 (b) of these Regulations, Life Insurers may offer Group Health Insurance Policies as specified in Regulation (3) (d).

e. Group Personal Accident Policies may be offered by General Insurers and Health insurers with term less than one year also to provide coverage to specific events. Other Insurance Products offering Travel Cover and Individual Personal Accident Cover may also be offered for a period less than one year.

f. Overseas or Domestic Travel Insurance policies may only be offered by General Insurers and Health Insurers , either as a standalone product or as an add-on cover to a health or personal accident policy.

Chapter II: Provisions relating to Health Insurance products

4. Product Filing Procedure for health insurance products

a. No insurance product of a Life Insurer, General Insurer and Health Insurer under Health Insurance Business and any revision or modification thereon shall be marketed or offered by any insurer unless it is filed with the Authority as per the Product Filing Guidelines and duly disposed of by the Authority as provided therein.

b. Health Insurance products of Life Insurers shall also be subject to the provisions specifically provided for health products in the following Regulations as modified from time to time:

1. IRDA (Linked Insurance Products) Regulations, 2013.

2. IRDA (Non-linked Insurance Products) Regulations, 2013.

5. Withdrawal of Health Insurance Product

i. Withdrawal of a health insurance product by Life Insurers, General Insurers and Health Insurers shall be subject to the Guidelines specified by the Authority.

ii. With regard to specific withdrawal of indemnity based health products offered by life insurers pursuant to the provisions of Regulation 3 (b) of these Regulations, the product shall be closed by giving a prospective date of closure not later than three months from the date of notification of these Regulations. For existing policyholders, the policy shall continue until the expiry of the respective policy term.

6. Review of Health Insurance Products

(i) All particulars of any health insurance product of Life Insurers, General Insurers and Health Insurers shall, after introduction, revision or modification be reviewed by the Appointed Actuary at least once a year. If the product is found to be financially unviable, or is deficient the Appointed Actuary may revise the product appropriately

and apply for revision under Product Filing Guidelines **subject to the provisions of Regulation 10 of these Regulations**.

7. Group Insurance

a. No Group Health Insurance Policy shall be issued by any Insurer where a Group is formed with the main purpose of availing itself of insurance. There shall be a clearly evident relationship as specified by the Authority from time to time between the members of the group and the group policyholder.

The Group shall have a size as determined by the Insurer which shall be applicable for all its group policies, subject to a minimum of 7, to be eligible for issuance of a Group Insurance Policy. Further, Insurer shall follow the Guidelines specified by the Authority on Group Insurance, from time to time.

8. Underwriting

a. All Life Insurers, General Insurers and Health Insurers shall evolve a Health Insurance Underwriting Policy which shall be approved by the Board of the Company. Every Insurer shall also put in place measures for periodical review of the underwriting policy in tune with the changes affecting the medical field and health insurance business.

b. The underwriting policy shall also cover the approach and aspects relating to offering health insurance coverage not only to standard lives but also to sub-standard lives. It shall have in place various objective underwriting parameters to differentiate the various classes of risks being accepted in accordance with the respective risk categorisation.

c. Any proposal for health insurance may be accepted as proposed or on modified terms or denied wholly based on the Board approved underwriting policy. A denial of a proposal shall be communicated to the prospect in writing, by recording the reasons for denial. Provided, the denial of the coverage shall be the last resort that an insurer may consider.

d. General Insurers and Health Insurers may devise mechanisms or incentives to reward policyholders for early entry, continued renewals (wherever applicable), favourable claims experience, preventive and wellness habits and disclose upfront such mechanism or

incentives in the prospectus and the policy document, by complying with the norms specified under Product Filing Procedure Guidelines. Provided that

what is proposed to be covered as part of wellness habits and preventive habits be clearly defined in each and every product. [4][***]

e. [5][The insured shall be informed in writing of any underwriting loading charged over and above the premium as filed and approved under the Product Filing Guidelines and specific consent of the policyholder for such loadings shall be obtained before issuance of a policy.]

9. <u>Proposal Form:</u>

a. Every Life Insurer, General Insurer and Health Insurer shall devise a proposal form to be submitted by a proposer seeking a health insurance policy. Such form should capture all the information necessary to underwrite a proposal in accordance with the stated Underwriting Policy of the Company.

form during the course of solicitation of an insurance policy or issuance of an insurance policy shall not be parted with to any third party, except with the statutory authorities in accordance with the existing statutory laws or in accordance to the instructions issued by the Authority or for the purpose of underwriting the policy of the same individual or claim settlement. No Insurer shall insert any clauses or conditions in the proposal forms, express or implied thereby obligating the prospect to part with the information pertaining to his/her proposal. Notwithstanding the above provisions, all Insurers shall comply with the applicable provisions of the Law, other applicable Regulations as well as Guidelines specified by the Authority while designing the proposal forms.

10. Principles of Pricing of Health Insurance Products offered by Life, General and Health Insurers:

a. Insurers shall ensure that the premium for a health insurance policy shall be based on,

i. Age: for individual policies and group policies.

ii. Other relevant risk factors as applicable

[4]Second proviso omitted by Insurance Regulatory and Development Authority of India (Health Insurance) (Amendment) Regulations, 2019, dated 19th November, 2019 (w.e.f 21.11.2019). Prior to its omission, second proviso read as under:
"Provided further that no discount shall be offered on any third party service or merchandise. However, discounts in premium or discounts and/or benefits on diagnostic or pharmaceuticals or consultation services of providers in the network are permitted."

[5]Inserted by Insurance Regulatory and Development Authority of India (Health Insurance) (Amendment) Regulations, 2019, dated 19th November, 2019 (w.e.f 21.11.2019).

b. For provision of cover under family floater, the impact of the multiple incidence of rates of all family members proposed to be covered shall be considered.

c. The premiums filed shall ordinarily be not changed for a period of three years after a product has been cleared in accordance to the product filing guidelines specified by the Authority. Thereafter the insurer may revise the premium rates depending on the experience subject to (d) (e) and (f) hereunder. However, such revised rates shall not be changed for a further period of at least one year from the date of launching the revision.

d. The policy premium rate shall be unchanged

i. for all group products for the term of the policy.

ii. for all individual and family floater products, other than travel insurance products offered by general insurers and health insurers, for at least: 1. a period of one year in case of one year renewable policies and 2. the period stipulated in 3(c) herein in case of the rest.

iii. In case of individual health products offered by life insurers, every block of three years as stipulated in Regulation (3) (b).

e. Subject to Regulation (3) (b), changes in rates will be applicable from the date of approval by the Authority and shall be applied only prospectively thereafter for new policies and from the date of renewal for the existing policies.

f. Notwithstanding the above provisions, all Insurers shall comply with the Guidelines specified by the Authority while pricing the products.

Chapter III: General Provisions relating to Health Insurance

11. Designing of Health Insurance Policies

a. Subject to Regulation 3 as applicable**,** Health insurance product may be designed to offer various covers;

i. For specific age or gender groups
ii. For different age groups
iii. For treatment in all hospitals throughout the country, provided the hospitals comply with the definition specified
iv. For treatment in specific hospitals only, provided the morbidity rates used are representative

v. For treatment in specific geographies only, provided the morbidity rates used are representative

Provided, such specifications are disclosed clearly upfront in the product prospectus, documents and during sale process. And provided that no insurer shall offer any benefit or service without any insurance element.

b. In order to facilitate offering of innovative covers by insurers, 'Pilot products' may be designed and filed for approval of the Authority in accordance with the Product Filing Guidelines specified by the Authority. Pilot products referred herein can be offered only by General Insurers and Health Insurers for policy tenure of one year. Every Pilot product may be offered upto a period not exceeding 5 years. After 5 years of launch of the pilot product, the product needs to get converted into a regular product or based on valid reasons may be withdrawn subject to the insured being given an option to migrate to another product subject to portability conditions. The Authority may specify guidelines for Pilot Products from time to time. Where a pilot product gets converted into a regular product, any exception made in these Regulations for pilot products shall no longer apply and the insurer shall ensure compliance with all the provisions of these Regulations.

c. Insurer shall not compel the insured to migrate to other health insurance products. In case of migration from a withdrawn product, the insurer shall offer the policyholder an alternative available product subject to portability conditions.

d. Insurers shall ensure adequate dissemination of product information on all their health insurance products on their websites. This information shall include a description of the product, copies of the prospectus as approved under the Product Filing Guidelines, proposal form, policy document wordings and premium rates inclusive and exclusive of Service Tax as applicable.

e. [6][To enable access to the basic health insurance covers, all insurers shall offer a standard health insurance product as per the guidelines as may be specified by the Authority from time to time.]

f. [7]**[**Any of the exclusions in all health insurance policies shall be subject to the guidelines as may be specified by the Authority from time to time.]

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[6]Inserted by Insurance Regulatory and Development Authority of India (Health Insurance) (Amendment) Regulations, 2019, dated 19th November, 2019 (w.e.f 21.11.2019).

[7]Inserted by Insurance Regulatory and Development Authority of India (Health Insurance) (Amendment) Regulations, 2019, dated 19th November, 2019 (w.e.f 21.11.2019).

12. Entry and Exit Age

i. Except as provided for in regulation 17(i), all health insurance policies shall ordinarily provide for an entry age of at least up to 65 years

ii. Except travel insurance products, personal accident products and Pilot Products referred to in Regulation 2(i) (l) herein, once a proposal is accepted and a policy is issued which is thereafter renewed periodically without any break, further renewal shall not be denied on grounds of the age of the insured.

13. Renewal of Health Policies issued by General Insurers and Health Insurers (not applicable for travel and personal accident policies)

i. A health insurance policy shall ordinarily be renewable except on grounds of fraud, moral hazard or misrepresentation or non-cooperation by the insured, provided the policy is not withdrawn.

ii. An insurer shall not deny the renewal of a health insurance policy on the ground that the insured had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy like critical illness policy.

iii. The insurer shall provide for a mechanism to condone a delay in renewal up to 30 days from the due date of renewal without deeming such condonation as a break in policy. However coverage need not be available for such period.

[8][Provided the renewal premium shall not be accepted more than 90 days in advance of the due date of the premium payment.]

iv. The promotion material and the policy document shall explicitly state the conditions under which a policy terminates, such as on the payment of the benefit in case of critical illness benefits policies.

14. Free Look Period

(i)All new individual health insurance policies issued by Life Insurers, General Insurers and Health Insurers, except those with tenure of less than a year shall have a free look period. The free look period shall be applicable at the inception of the policy and

[8]Inserted by Insurance Regulatory and Development Authority of India (Health Insurance) (Amendment) Regulations, 2019, dated 19th November, 2019 (w.e.f 21.11.2019).

(1)The insured will be allowed a period of at least 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable.

(2) If the insured has not made any claim during the free look period, the insured shall be entitled to—(a) A refund of the premium paid less any expenses incurred by the insurer on medical examination of the insured persons and the stamp duty charges or; (b) where the risk has already commenced and the option of return of the policy is exercised by the policyholder, a deduction towards the proportionate risk premium for period on cover or; (c)Where only a part of the insurance coverage has commenced,

such proportionate premium commensurate with the insurance coverage during such period; (d) In respect of unit linked policy, in addition to the above deductions, the insurer shall also be entitled to repurchase the unit at the price of the units as on the date of the return of the policy.

15. Manner of treating Cost of pre-insurance health check up by Life, General and Health Insurers:

i. The cost of any pre-insurance medical examination shall generally form part of the expenses allowed in arriving at the premium. However in case of products with term of one year and less, if such cost is to be incurred by the insured, not less than 50% of such cost shall be borne by the insurer once the proposal is accepted, except in travel insurance policies.

ii. Insurers shall maintain a list of medical examiners and institutions where such pre-insurance medical examination may be conducted whose reports will be accepted by them. Details of fee payable shall be made available to the prospective policyholder at the time of pre-insurance medical examination on demand.

16. Cumulative bonus

i. Cumulative bonuses offered under policies, shall be stated explicitly in the prospectus and the policy document.

ii. If a claim is made in any particular year, the cumulative bonus accrued may be reduced at the same rate at which it has accrued;

17. Migration of health insurance policy(not applicable for Travel and Personal Accident policies)

i. [9][General insurers and health insurers offering indemnity based health covers shall offer an option to the policyholders to migrate to a suitable alternative health insurance policy available at the time of modification or withdrawal of the policy. Further, indemnity based health covers offered to specific age groups, students, children under family floater policies, shall also offer an option to such lives to migrate to a suitable alternative health insurance policy available at the specific exit age. Every policy migrated shall be allowed suitable credits for all the previous policy years, provided the policy has been maintained without a break.]

ii. Pilot products offered by general insurers and health insurers, may be guided by Regulation 11(b).

iii. All health insurance policies issued by General and Health Insurers shall allow the portability of any policy in accordance with Schedule -1 of these Regulations.

iv. [10][Further to sub-regulation (i) to (iii), the norms on migration and portability of all policies issued by general insurers and health insurers shall be subject to the guidelines as may be specified by the Authority from time to time.]

18. AYUSH Coverage:

a. [11][All insurers may endeavour to provide coverage for one or more systems covered under "AYUSH treatment" provided, the treatment has been undergone in the hospitals or healthcare facilities subject to the guidelines as may be specified by the Authority from time to time.]

[9]Substituted by Insurance Regulatory and Development Authority of India (Health Insurance) (Amendment) Regulations, 2019, dated 19th November, 2019 (w.e.f 21.11.2019). Prior to its substitution, sub regulation(i) read as under:
"General Insurers and Health Insurers offering health covers specific to age groups such as maternity covers, children under family floater policies, students etc, shall offer an option to migrate to a suitable alternative available health insurance policy at the end of the specific exit age or at the time of withdrawal of the policy at the option exercised by the said lives by allowing suitable credits for all the previous policy years, provided the policy has been maintained without a break."

[10]Inserted by Insurance Regulatory and Development Authority of India (Health Insurance)(Amendment) 2019, dated 19th November, 2019 (w.e.f 21.11.2019).

[11]Substituted by Insurance Regulatory and Development Authority of India (Health Insurance) (Amendment) Regulations, 2019, dated 19th November, 2019 (w.e.f 21.11.2019). Prior to its substitution, sub regulation (a) read as under:
"General Insurers and Health Insurers may endeavour to provide coverage for one or more systems covered under 'AYUSH treatment' 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 or National Accreditation Board on Health."

19. Wellness and Preventive aspects:

[12][Insurers may endeavour promoting wellness amongst policyholders of health insurance as per the guidelines as may be specified by the Authority from time to time.]

20. Standard Definition of terms in health insurance policies(not applicable for Personal Accident and Travel policies)

i. Phrases and terms used in all health insurance policies issued by Life Insurers, General Insurers and Health Insurers shall carry the meaning attached to them as specified in 'Standard Definitions', if any, issued by the Authority from time to time, through Guidelines.

21. Standard Nomenclature and Procedures for Critical Illnesses(not applicable for Personal Accident and travel policies)

i. The nomenclature and procedures incorporated into policies offering 'critical illness cover' shall be as specified by the Authority from time to time through Guidelines.

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[12]Substituted by Insurance Regulatory and Development Authority of India (Health Insurance)(Amendment) Regulations, 2019, dated 19th November, 2019 (w.e.f 21.11.2019).Prior to its substitution, regulation 19 read as under: "While wellness and preventive elements as part of product design is encouraged, no policy of insurance shall promote or offer the products and services of third parties who are not Network Providers. Insurers shall neither offer any discounts to the policyholders, in any form, on the products of the third parties either as part of policy contract or

i. However, Insurers may endeavour promoting wellness amongst policyholders of health insurance by offering the following health specific services offered by Network Providers,

1. outpatient consultations or treatments or
2. Pharmaceuticals or
3. Health check-ups

including discounts on all the above at specific Network Providers.

ii. Insurers may also endeavour to put in place procedures for offering discounts on premiums on renewals based on the fitness and wellness criteria stipulated and disclosed.

Provided further the costs towards the above services are factored into the pricing of the underlying Health Insurance Product."

22. Optional Coverage for Certain Items(applicable to General Insurers and Health Insurers)

i. List of Generally Excluded Items that may be optionally covered by the Insurers may be specified by the Authority from time to time through Guidelines.

a) In respect of hospitalisation indemnity policies that exclude certain standard items, Insurers shall ensure that these are mentioned in the product filing when made under the Product Filing Guidelines.

b) Product wise specific list of excluded items shall be disclosed in the website of insurers and a reference shall be made in the prospectus and policy wordings of the respective products about such excluded items and the availability of the details on the website along with the address of website.

c) Insurers shall supply the policyholders on demand a copy of such excluded list of the concerned product if the same is not incorporated in the policy document.

d) Insurers may offer cover for these items and mention it clearly in the policy.

23. Special Provisions for Senior Citizens

i. The premium charged for health insurance products offered by Life Insurers, General Insurers and Health Insurers to senior citizens shall be fair, justified, transparent and duly disclosed upfront. [13][***]

ii. All Life Insurers, General Insurers and 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.

24. Multiple Policies

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

[13]The words "The insured shall be informed in writing of any underwriting loading charged as filed and approved under the Product Filing Guidelines over and above the premium and specific consent of the policyholder for such loadings shall be obtained before issuance of a policy.", omitted by Insurance Regulatory and Development Authority of India (Health Insurance) (Amendment) Regulations, 2019, dated 19th November, 2019 (w.e.f 21.11.2019).

ii. If two or more policies are taken by an insured during a period from one or more insurers to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any of his/her policies.

1. In all such cases the insurer who has issued the chosen policy shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
2. [14][Balance claim or claims disallowed under the earlier chosen policy/policies may be made from the other policy/policies even if the sum insured is not exhausted in the earlier chosen policy/policies. The insurer(s) in such cases shall independently settle the claim subject to the terms and conditions of other policy / policies so chosen.]
3. If the amount to be claimed exceeds the sum insured under a single policy after considering the deductibles or co-pay, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
4. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

25. Loadings on Renewals:

i. For Individual products, the loadings on renewal shall be in terms of increase or decrease in premiums offered for the entire portfolio and shall not be based on any individual policy claim experience.

ii. The discounts and loadings offered shall:

1. not be at the discretion of the insurer;
2. be based on an objective criteria;
3. be disclosed upfront in the prospectus and policy document along with the objective criteria, and shall be as approved under the Product Filing Guidelines

iii. No Insurer shall resort to fresh underwriting by calling for medical examination, fresh proposal form etc. at renewal stage where there is no change in Sum Insured offered. Provided that where there is an improvement in the risk profile, the Insurer may endeavour to recognise that for removal of loadings at the point of renewal.

[14]Substituted by Insurance Regulatory and Development Authority of India (Health Insurance) (Amendment) Regulations, 2019, dated 19th November, 2019 (w.e.f 21.11.2019). Prior to its substitution, clause 2 read as under:
"Claims under other policy/ies may be made after exhaustion of Sum Insured in the earlier chosen policy / policies."

Chapter IV: Administration of Health Insurance Policies

Every Life Insurer, General Insurer and Health Insurer shall ensure the following, as may be applicable:

26. Protection of Policyholders' Interest:

Every insured shall be provided with a **Customer Information Sheet** as specified by the Authority in the relevant Guidelines. The insurer shall establish necessary systems, procedures, offices and infrastructure to enable efficient issuance of pre-authorisations on a 24 hour basis and for prompt settlement of claims and grievances.

27. Settlement/Rejection of claim by insurer:

i. An insurer shall settle or reject a claim, as may be the case, within thirty days of the receipt of the last 'necessary' document.

ii. Except in cases where a fraud is suspected, ordinarily no document not listed in the policy terms and conditions shall be deemed 'necessary'. The insurer shall ensure that all the documents required for claims processing are called for at one time and that the documents are not called for in a piece-meal manner.

iii. The information that the insurer has captured in the proposal form at the time of accepting the proposal, the terms & conditions offered under the policy, the medical history as revealed by earlier claims, if any, and the prior claims experience shall all be maintained by the insurer as an electronic record and shall not be called for again from the policyholder/insured at the time of subsequent claim settlements.

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

v. Every Insurance Claim shall be disposed of in accordance to the Terms and Conditions of the policy contract and the extant Regulations governing the settlement of Claims. No Claim shall be closed in the books of the Insurers.

vi. [15][Further to sub-regulation (i) to (v), in matters relating to settlement of claims, the Authority may specify guidelines from time to time.]

[15]Inserted by Insurance Regulatory and Development Authority of India (Health Insurance) (Amendment) Regulations, 2019, dated 19th November, 2019 (w.e.f 21.11.2019).

28. Minimum Disclosures in Policy Document: In addition to the requirements stipulated in IRDA (Protection of Policyholders' Interest) Regulations, 2002 as amended from time to time the policy document shall contain:

i. List of disclosures required as per this regulation.

ii. Procedure for claims submission, time lines and possible course of action, if time lines for claim submission are not adhered to along with all the claims documents required for claim processing.

iii.

iv.

v. Sub-limits applicable on any of the covers offered in the health insurance product and the impact of such sub-limits on other covers provided in the product, if any, shall be clearly spelt out.

Penal interest provision shall invariably be incorporated in the policy document as per Regulation 9(6) of (Protection of Policyholders' Interests) Regulations, 2002 as modified from time to time.

The TPA(s) details, if any along with the complete address and contact numbers shall be attached to the policy document. It shall also be mentioned that the updated list of the TPAs will be available in the website of the Insurers.

29. Other Disclosures:

i. Every Insurer shall disclose product-wise or location or geography-wise particulars of the TPAs that are engaged for rendering health services in their respective website, and these details shall be updated whenever there is a change.

ii. Product-wise cashless services offered shall be clearly explained in the website of the respective Insurers.

iii. In case of Pilot Products referred under Regulation (2) (l) above, in addition to all the extant disclosure norms applicable to insurance advertisements, all the sales and publicity material pertaining to the 'Pilot products' shall disclose the following:

1. The product offered is a pilot product and that it is a close-ended one.
2. The product may be discontinued from the date of dd/mm/yyyy (to specify the maximum date on which the product be either withdrawn or converted into a regular product) or may be continued as a regular product.
3. In the event of the discontinuation of the Pilot product, the Insured would be provided the option of migration as per the extant applicable provisions.

4. The product shall carry a tag line of "PILOT PRODUCT" to demonstrate that the Health Insurance product promoted is a Pilot product.

iv. Insurer shall keep the insured informed of the list of Network Providers and display the same on their website. Such list shall be displayed geography wise and updated as and when there is any change in the Network providers.

30. Administration of Health Policies

a. Subject to the terms of a policy, General Insurers and Health insurers shall extend to all policy holders a cashless facility for treatment at specific establishments or the reimbursement of the costs of medical and health treatments or services availed at any medical establishment.

b. Cashless facility shall be offered only at establishments which have entered into an Agreement with the insurer to extend such services. Such establishments will be termed as Network Providers.

c. [16][Subject to the terms and conditions of the policy contract, reimbursement shall be allowed at any hospital or medical establishment. All such establishments must be licensed or registered as may be required by any Local, State or National Law as applicable.]

d. The administration of all health plus life-combi products shall be in accordance with the provisions of Schedule II of this Regulation.

e. Except in emergencies a cashless facility may require a Pre-Authorisation to be issued by the Insurer or an appointed TPA to the Network Provider where the treatment is to be undergone. The Authority may prescribe a Standard Pre-Authorisation form and standard reimbursement claims forms which shall be used for this purpose, as applicable.

f. To avail the benefit of cashless facility, insurers shall issue an Identification Card to the insured within 15 days from the date of issuance of a policy, either through a TPA or directly. Provided where there is no mention of the expiry date on the card, the Insurer may provide a permanent card which is valid as long as the policy is renewed with the company.

g. The identification card shall, at the minimum, carry details of the policyholder and the logo of the insurer. Insurers shall endeavour to issue Smart Cards with features such as

cards with Quick Response Code, Magnetic reader to enable the TPAs and Network Providers offer health services seamlessly.

[16]Substituted by Insurance Regulatory and Development Authority of India (Health Insurance) (Amendment) Regulations, 2019, dated 19th November, 2019 (w.e.f 21.11.2019). Prior to its substitution, clause (c) read as under:

"Reimbursement shall be allowed at any medical establishment. All such establishments must be licensed or registered as may be required by any Local, State or National Law as applicable."

h. 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 before the final settlement of the claim, then insurers shall provide the benefits of cashless facility to such policy holder as if such hospital continues to be on the Network Provider list.

i. An insurance company may enter into an arrangement with other insurance companies for sharing of Network Providers, transfer of claim and transactional data arising in areas beyond their service.

31. Health Services Agreements:

a. Insurance companies may offer policies providing cashless services to the policyholders provided:

i. The services are offered through network providers who have been enlisted to provide medical services under a direct written agreement with the insurer where there is a direct arrangement or by a tripartite agreement amongst health services provider, the TPA and the insurer where it is through a TPA. Where an insurer wishes to utilise the services of a TPA, it shall ensure that the written agreement is entered into for defined services with a TPA holding a valid Certificate of Registration issued in accordance with the IRDAI (Third Party Administrators – Health Services) Regulations, 2016 as may be amended from time to time.

b. The Agreements which shall be entered into between / amongst insurers, network providers or TPAs shall cover the following amongst others:

i. The tariff applicable with respect to various kinds of healthcare services being provided by the network provider.

ii. A clause empowering the insurer to cancel or modify the agreement in case of any fraud, misrepresentation, inadequacy of service or other non-compliance or default on the part of TPA or network provider.

iii. A standard clause as may be agreed upon providing for continuance of services by a network provider to the insurance company if the TPA is changed or the agreement with TPA is terminated.

iv. A clause providing for opting out of network provider from a given TPA or disempanelment of a network provider by a TPA subject to Guidelines specified by the Authority, if any, for reasons of inadequacy of service rendered by the TPA to the network provider.

v. A clause specifically fixing the onus on the Insurer to deny or repudiate a claim.

vi. A clause enabling insurer to inspect the premises of the Network Provider at any time without prior intimation.

c. Insurers and TPAs shall comply with standard clauses to be incorporated in all such agreements as specified by the Authority by way of guidelines.

d. The insurance company shall endeavour to enter into Agreements with adequate number of both public and private sector network providers across the geographical spread. The copy of the agreement shall be maintained by the Insurer for a period of not less than five years from the date of the expiry or termination of the agreement.

e. The Authority may specify, through Guidelines, certain standards, benchmarks and protocols for Network Providers from time to time. The Insurers and TPAs shall ensure that only those Providers who meet with such standards, benchmarks and protocols are enrolled into the network.

32. Payments to Network Providers and Settlement of Claims of Policyholders:

a. 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. Provided that, if a claimant opts for payment through a cheque or Demand Draft, the insurer shall not deny such request.

33. Engagement of Services of TPAs by Insurers in relation to Health Insurance Policies

a. Every Insurer shall provide detailed product wise guidelines to TPAs for handling of claims i.e. claim admissions and assessments. The guidelines shall articulate the payments / benefits allowed or disallowed under various products that are being serviced by the TPAs. While prescribing such guidelines the Insurers shall also prescribe the capacity requirements, internal control procedures to be put in place by the TPA under the agreement for rendering the services under such product.

b. *Detailed Claim Guidelines*: Every Insurer shall issue detailed product specific claim guidelines to TPAs

c. Insurers shall ensure that the TPAs are not carrying out the following activities as part of the agreement

i. Claim rejections/repudiations with respect to the health insurance policies;

ii. Payments to the policyholders, claimants or the network providers;

iii. Any services directly to the policyholder or insured or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the insurer and complies with the IRDAI (TPA-Health Services) Regulations, 2016.

d. **Settlement and Denial of Claims**:

i. Insurers and/or TPAs, as may be applicable, shall endeavour to collect documents for processing claims for disposal electronically. Claims that are being settled shall be done through e-payments by the insurers.

ii. Where claims are directly handled by the Insurers, the provisions of Regulation (21) (3) (c) (i) of IRDAI (TPA-Health Services) Regulations, 2016 shall be complied in the correspondence to the policyholder with respect to settlement of the claims

iii. The insurer shall be responsible for proper and prompt service to the policyholders at all times.

iv. Where a claim is denied or repudiated, the communication about the denial or the repudiation shall be made only by the Insurer by specifically stating the reasons for the denial or repudiation, while necessarily referring to the corresponding policy conditions. The insurer shall also furnish the grievance redressal procedures available with the Insurance Company and with the Insurance Ombudsman along with the detailed addresses of the respective offices.

e. More than one TPA may be engaged by an insurance company.

34. Change of TPAs by Insurers for servicing of Health Insurance Policies

a. Where there is a change in the TPA, insurers shall communicate to the policyholders 30 days before giving effect to the change.

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

c. The insurers shall take over all the data in respect of the policies serviced by the earlier TPA within thirty days from the cessation of the services of the TPA and make sure that the same is transferred seamlessly to the newly assigned TPA, if any. No inconvenience or hardship shall be caused to the policyholders

as a result of the change. In this regard, the following aspects shall receive special attention:

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

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

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

35. Data and related issues:

a. The TPA and the insurer shall establish a seamless flow of data transfer for all the claims. Towards this purpose the entities referred herein shall endeavour electronic flow of the data.

b. The respective claim settlement files shall be handed over to the insurer within 15 days thereof.

c. [17][Authority may require insurers, third party administrators and network providers to comply with data related matters and settlement of claims through electronic means as per the guidelines as may be specified by the Authority from time to time.]

36. Systems to be in place to mitigate Frauds: Insurers and TPAs should put in place systems and procedures to identify, monitor and mitigate frauds and also follow Guidelines, if any, specified by the Authority from time to time in this regard.

Chapter V: Submission of Returns to the Authority

37. Submission of Returns to the Authority

All insurance companies carrying on health insurance business shall furnish Returns to the Authority as may be specified by the Authority vide Guidelines.

[17]Substituted by Insurance Regulatory and Development Authority of India (Health Insurance) (Amendment) Regulations, 2019, dated 19th November, 2019 (w.e.f 21.11.2019). Prior to its substitution, clause (c) read as under:

"Authority may require Insurers, TPAs and Network Providers, to comply with data related matters as specified in the Guidelines that may be issued separately."

Chapter VI: Repeal and Savings and Removal of Difficulties

38. Repeal and Savings:

a. These Regulations supersede Insurance Regulatory and Development Authority (Health Insurance) Regulations 2013 and Insurance Regulatory and Development Authority (Health Insurance) (First Amendment) Regulations, 2014.

39. Removal of difficulties

In order to remove any difficulties in the application or interpretation of these regulations, the Chairperson of the Authority may issue clarifications, directions and guidelines in the form of circulars.

T.S.VIJAYAN,
Chairman

[ADVT.III/4/Exty/161/16]

Schedule-I

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

1. A policyholder desirous of porting his/her policy to another insurance company shall apply to such insurance company to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the premium renewal date of his/her existing policy.
2. Insurer may not be liable to offer portability if policyholder (a) fails to approach the new insurer at least 45 days before the premium renewal date, or (b) approaches the new Insurer more than 60 days prior to the premium renewal date.
3. Portability shall be opted for by the policyholder only as stated in (1) above and not during the currency of the policy.

4. In case insurer is willing to consider the proposal for portability even if the policyholder fails to approach insurer at least 45 days before the renewal date, it is free to do so.

5. Where the outcome of acceptance of portability is still awaited from the new insurer on the date of renewal

a. the existing policy shall be allowed to be extended, if requested for by the policyholder, for a short period of not less than one month by accepting a pro- rata premium for such short period and

b. existing insurer shall not cancel existing policy until such time a confirmed policy from new insurer is received or there is a specific written request of the insured

c. the new insurer, in all such cases, shall reckon the date of the commencement of risk to match with the date of expiry of the short period policy issued based on the request of the policyholder. If for any reason the

insured intends to continue the policy before the expiry of the policy or before the expiry of the short-period policy referred to under Clause (5) (a) above, with the existing insurer, it shall be allowed to continue by charging regular premium and without imposing any new condition.

6. In case the policyholder has opted as in Clause (5) (a), and there is a claim, the existing insurer may charge the balance premium for remaining part of the policy year provided the claims are accepted by the existing insurer. In such cases, policyholder shall be liable to pay the premium for the balance period and continue with the existing insurer for that policy year.

7. On receipt of intimation referred under Clause (1) above, 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 various health insurance products which could be offered.

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

9. On receipt of the Portability Form, the insurance company shall seek the necessary details of medical history and claim history of the concerned policyholder from the existing insurance company. This shall be done through the web portal of the IRDAI.

10. The existing insurer, on receiving such a request on portability shall furnish the requisite data for porting insurance policies in the prescribed format in the web portal of IRDAI within 7 working days of the receipt of the request.

11. In case the existing insurer fails to provide the requisite data in the data format to the new insurance company within the stipulated time frame, it shall be viewed as violation of directions issued by the IRDAI and the insurer shall be subject to penal provisions under the Insurance Act 1938.

12. On receipt of the data from the existing insurance company, the new insurance

company may underwrite the proposal and convey its decision to the policyholder in accordance with the Regulation 4 (6) of the IRDA (Protection of Policyholders' interest) Regulations, 2002.

13. If, on receipt of data within the above time frame, the insurance company does not communicate its decision to the requesting policyholder within 15 days in accordance with its underwriting policy as filed by the company with the Authority, the insurance company shall not have any right to reject such proposal and shall accept the proposal.
14. In order to accept a policy which is being ported in, the insurer shall not levy any additional [18][***] charges exclusively for the purpose of porting.
15. No commission shall be payable to any intermediary on the acceptance of a ported policy.
16. [19][Portability shall be allowed subject to the guidelines as may be specified by the Authority from time to time.]

[18]The words "loading or", omitted by Insurance Regulatory and Development Authority of India (Health Insurance) (Amendment) Regulations, 2019, dated 19th November, 2019 (w.e.f 21.11.2019).

[19]Substituted by Insurance Regulatory and Development Authority of India (Health Insurance) (Amendment) Regulations, 2019, dated 19th November, 2019 (w.e.f 21.11.2019). Prior to its substitution, clause 16 read as under:

"Portability shall be allowed in the following cases:

a. All individual health insurance policies issued by General Insurers and Health Insurers including family floater policies.

b. Individual members, including the family members covered under any group health insurance policy of a General Insurer or Health Insurer shall have the right to migrate from such a group policy to an individual health insurance policy or a family floater policy with the same insurer. Thereafter, he/she shall be accorded the right mentioned in 1 above."

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 members 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.

18. The portability shall be applicable to the sum insured under the previous policy and also to an enhanced sum insured, if requested for 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 2 lakhs 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 2.50 lakhs by charging the premium applicable for Rs 2.50 lakhs. If insurer B has no product for Rs 2.50 lakhs, insurer B would offer the nearest higher slab say Rs 3 lakhs to insured by charging premium applicable for Rs 3 lakhs SI. However, portability would be available only up to Rs 2.50 lakhs.

19. 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:

    a. all health insurance policies are portable;

    b. 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 delay in acceptance of the proposal by the other insurer.

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 in 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 follow…..Days/years ing disease(s)/treatment(s) is more than the previous policy terms. I additional waiting period hereby agree to observe t ent(s) he for the following disease(s)/treatm	Signature of the policyholder

Schedule-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 this schedule.

2. This schedule does not apply to Micro Insurance Products which are governed by IRDAI (Micro Insurance) Regulations, 2015.

3. All insurance companies that promote 'Health plus Life Combi products' shall adhere to the following:

a. **Scope of Combi Product Class:**

(i) 'Combi Products' may be promoted by all Life Insurance and General Insurers or Health Insurers.

(ii) 'Combi Product' shall be a combination of Life Insurance cover offered by life insurance companies and Health Insurance cover offered by General Insurance Companies or Health Insurance Companies.

(iii) Products offered as a combi-product shall have been individually cleared under the File and Use procedure applicable to Life Insurance Products and the Product Filing Guidelines applicable to Health Insurance Products respectively.

(iv) Riders and Add-on covers may be offered subject to File and Use procedure applicable to Life Insurance and the Product Filing Guidelines applicable to Health Insurance respectively.

(v) The premium components of both the risks are to be separately identified and disclosed to the policyholders at both pre-sale stage and post-sale stage and in all documents like policy document, prospectus and sales literature.

(vi) The product may be offered both as individual insurance policy and on group basis. However in respect of health insurance floater policies, the 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.

(vii) The integrated premium amount of the 'Combi Product' shall be basis for reckoning the threshold limit or applicability of extant Regulations, guidelines and circulars etc. issued by the Authority or any other statutory body.

(viii) Commission and Claim payouts in respect of 'Combi Products' shall be by respective insurers only.

(ix) 'Combi product' shall have a free look option as outlined in the extant Regulations. Free Look option is to be applied to the 'Combi Product' as a whole. Provided where an existing policyholder of any health insurance product has migrated to a Combi Product, such policyholder is entitled to all the rights of migration as per the applicable portability norms.

(x) The Health portion of the 'Combi Product' is entitled to be renewed at the option of the policyholder of the respective General Insurer or Health Insurer.

b. **Tie up between insurers:**

(i) It is mandatory that insurers offering a 'Combi Product' shall have in place a

Memorandum of Understanding covering the *modus operandi* of marketing, policy servicing and sharing of common expenses.

(ii) Insurers forming the tie-up shall obtain prior approval of the Authority by duly filing the copy of the agreement entered into in this regard.

(iii) A tie up is permitted between one life insurer and one General insurer or one Health Insurer only. Thus a life insurer is permitted to tie up with only one General insurer or health insurer and vice-versa.

(iv) Between these two Insurers any number of 'Combi Products' may be promoted. (v) Insurance companies shall carry out 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 'Combi Products'.

(vi) 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.

(vii) There shall be specific time frames / Turnaround Times (TAT) agreed upon between the insurance companies as part of the MOU for effective policy servicing, transmission of premiums received etc. at various stages of policy i.e., at pre-sale stage and post-sale stage.

(viii) Insurers shall ensure filing of the advertisements in accordance with IRDA (Insurance Advertisements and Disclosures) Regulations, 2000 within seven days from the date of issuing the advertisement with the Authority.

(ix) Proposed procedures for issuing Joint Sale Advertisements along with the common corporate agents shall be covered in the MoU.

(x) The modus operandi of proposed servicing at various stages of the policy viz., proposal stage, policy servicing, premium collection arrangements and claims service etc shall be detailed in the MoU.

(xi) The Information Technology systems put in place for supporting the sale and policy service of the 'Combi Products' shall also be part of the MoU.

(xii) Agreement on reimbursement of expenses in consideration of common services rendered by each of the insurance companies shall be covered in the MoU.

(xiii) Distribution Channel wise maximum commission allowed under the 'Combi Products' shall also be indicated.

(xiv) The manner in which premium is proposed to be collected subject to provisions of Section 64 VB of Insurance Act, 1938 shall be detailed,

(1) Provided the integrated premium collected under a Combi Product by one of the Insurers for transmission of relevant share of the premium to the other insurer shall be deemed to be in compliance of Section 64VB and the policyholder is entitled to the underlying benefits of both life insurance and health insurance components of the Combi Product from the date and time of acceptance of said premium by one of the Insurers.

(2) Provided further that the Date and Time of receipt of the premium by one of the Insurers shall be reckoned for entitlement of the underlying benefits of the policy.

(xv) The procedures put in place for expeditious transfer of the portion of premium that pertains to the other insurer of the product needs to be reflected in the MoU.

(1) Provided where time sensitive products such as Unit Linked Life Insurance Products are offered as part of Combi Products, the Life Insurers shall put in place effective procedures for complying with the extant Regulations.

(xvi) Operational procedures put in place for updating premium on policy data base on a real time basis shall also be mentioned.

(xvii) Options available to policyholders of 'Combi Products' to discontinue either portion of risk coverage while continuing with the other portion, subject to the extant law, regulations, guidelines etc shall be detailed.

(xviii) Copy of proposed common Sales Literature / Sales Illustrations, proposal form to be issued by both the insurers in respect of 'Combi Products', subject to the condition that these documents approved under File and Use procedure or Product Filing Guidelines are not modified shall also form part of the MoU.

(xix) Common Advertisements of 'Combi Products', subject to the condition that this shall be restricted to the features, terms and conditions of the 'Combi Product' shall also be agreed upon and made part of the MoU.

c. **Lead Insurer**:

(i) As two insurers are involved in offering the 'Combi Product' it may be mutually agreed that one of the insurance companies may act as a lead insurer in respect of each 'Combi Product' marketed with agreed terms, conditions and considerations.

(ii) The Lead Insurer for this purpose is the insurer mutually agreed by both the insurers to play a critical role in facilitating policy servicing as a contact point for rendering various services as required for combi products. The lead insurer may play a major role in facilitating underwriting and policy servicing.

(iii) The role of lead insurer shall not get diluted in the process of relying upon the existing operational infrastructure of the partner-insurance company for effective policy servicing of 'Combi Products'.

(iv) Either of the insurers shall not be absolved of their responsibility of proactive settlement of claims and other obligations in accordance with the terms and conditions of their respective policies.

4. Underwriting: Under the 'Combi Product', underwriting of respective portion of risk shall be carried out by respective insurance companies, that is; Life Insurance risk shall be underwritten by Life Insurer and the Health Insurance portion of risk shall be underwritten by General or Health.

5. File and Use/Product Filing Guidelines:

a. The life insurance product and the health insurance product to be offered as a combi product shall have prior approval under File and Use procedure or Product Filing Guidelines as may be the case.

b. Both the independent approved products shall be integrated as a single product and shall be filed with a common brand name.

c. The single product shall be offered without making any modifications to the approved products.

d. 'Combi Product' is to be filed at the stage of integrating for getting approval as per Product Filing Guidelines irrespective of the earlier approval for either of products.

e. 'Combi Product' filing shall follow the File and Use guidelines or Product Filing Guidelines in vogue and all such guidelines that would be issued from time to time.

f. The Combi Product shall be approved by the Authority subject to Product Filing Guidelines specified.

g. The application of 'Combi Product' under Product Filing Guidelines shall also specify the following:-

(i) Lead Insurer for the 'Combi Product' and demarcation of functions between insurers for carrying out activities

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

(iii) Where the servicing is to be necessarily attended to 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.

(iv) Results of feasibility study, if any, in giving limited access to the policy database for effecting over-the-counter policy service requests to the lead insurer.

(v) The results of the cost benefit analysis carried out by both the insurers and the possibility of offering any discounts on the premium in the combi product.

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

a. Based on the type of claim, that the other insurer also takes proactive measures for settlement of claims. In no case the Lead insurer shall guarantee the settlement of claim on behalf of the other insurer.

b. The risks accepted by one insurer under 'Combi Product' shall not affect the business of other insurance company.

c. As far as health portion of 'Combi Policies' are concerned, the extant regulations and guidelines shall apply.

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

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

7. <u>Distribution Channel</u>

a. The sale of 'Combi Product' may be solicited through all the Insurance Agents and Insurance Intermediaries who are eligible to solicit Insurance Business.

b. 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.

c. 'Combi Products' marketed by the Common Service Centres shall comply with IRDAI (Insurance Services by Common Service Centres) Regulations, 2015.

8. <u>Mandatory Minimum Disclosures</u>:

a. The mandatory minimum disclosures for a Combi Product shall be:

(i) The product is jointly offered by "abc insurance company" (specify General/ stand-

alone health insurer name) and "xyz insurance company" (specify life insurer name).

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

(iii) The liability to settle the claim vests with respective insurers, i.e., for health insurance benefits "abc insurance company" (specify General/ stand-alone health insurer name) and for life insurance benefits "xyz insurance company" (Specify life insurer name).

(iv) The legal/quasi legal disputes, if any, are dealt by the respective insurers for respective benefits.

(v) The policyholders of the 'Combi Product' under reference are eligible to continue with either part of the policy, discontinuing the other during the policy term.

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

(vii) Specific Disclosures on the available premium payment options on these 'Combi Products'.

(viii) Specific Disclosures about the available policy servicing facilities including claims servicing, for these 'Combi Products'.

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

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

(xi) 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.

b. Policy documents of 'Combi Products' shall contain the above referred points (iii) to, (xi) as minimum disclosures.

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c. Declaration from the prospect shall be obtained and attached to proposal form that he / she has understood the disclosures mentioned above.

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

10. In order to monitor the progress of the penetration of the product class, all insurance companies that are marketing 'Combi Products' shall submit the information that is specified by the Authority from time to time under the Guidelines.

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

SCHEDULE -III

See Regulation 2 (i) (o) of IRDAI (Health Insurance) Regulations, 2016

Matters in respect of which the Authority may specify by issue of Circulars, Guidelines or Instructions as referred in these regulations:

1. *Regulation (2) (g)*: Product Filing Guidelines to be followed by insurers before marketing or offering a product covering Health Insurance Business.
2. *Regulation (3) (b):* Withdrawal of existing Indemnity Based products offered by Life Insurers.
3. *Regulation (5):* Withdrawal of Health Insurance Products shall be subject to Guidelines specified by the Authority.
4. *Regulation (7) (a):* Guidelines on Group Insurance.
5. *Regulation (8) (d):* Norms on mechanisms or incentives to reward policyholders for early entry, continued renewals, favourable claims experience, preventive and wellness habits.
6. *Regulation (9) (d):* Guidelines on Proposal Forms
7. *Regulation (10) :* Guidelines on pricing

8. *Regulation (11) (c):* Guidelines on Pilot Products subject to Product Filing Guidelines 9. *Regulation (20):* Standard terms used in all health insurance policies.
10. *Regulation (21):* The nomenclature and procedures incorporated into policies offering 'critical illness cover'.
11. *Regulation (22) (i):* List of Generally Excluded Items that may be optionally covered by the Insurers.
12. *Regulation (26):* Customer Information Sheet
13. *Regulation (31) (b) (iv):* Guidelines on disempanelment of Network Provider.
14. *Regulation (31) (c):* Standard Clauses to be made part of Tripartite Agreement amongst Insurers, TPAs and Network Providers.
15. *Regulation (31) (e):* Standards, benchmarks and protocols for Network Providers. 16. *Regulation (35) (c)*: Data Related Issues to be complied with by TPAs, Insurers and Network Providers
17. *Regulation (36):* Systems and procedures to be put in place to identify monitor and mitigate frauds.
18. *Regulation (37):* Returns to be submitted to the Authority.
19. *Clause (10) Schedule – II*: Information on Life plus Health Combi Products