CHAPTER I
INTRODUCTION

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1.1 Introduction to the title

There is an exponential growth in health insurance industry and demand for health products is predominantly increasing day by day. The entry of new players in the insurance market igniting competition. The best way to sustain the competition and increase the customer domain is to study the products given by different companies, comparing the critical parameters of different policies to our policies and design a best policy which will cover major customer requirements.

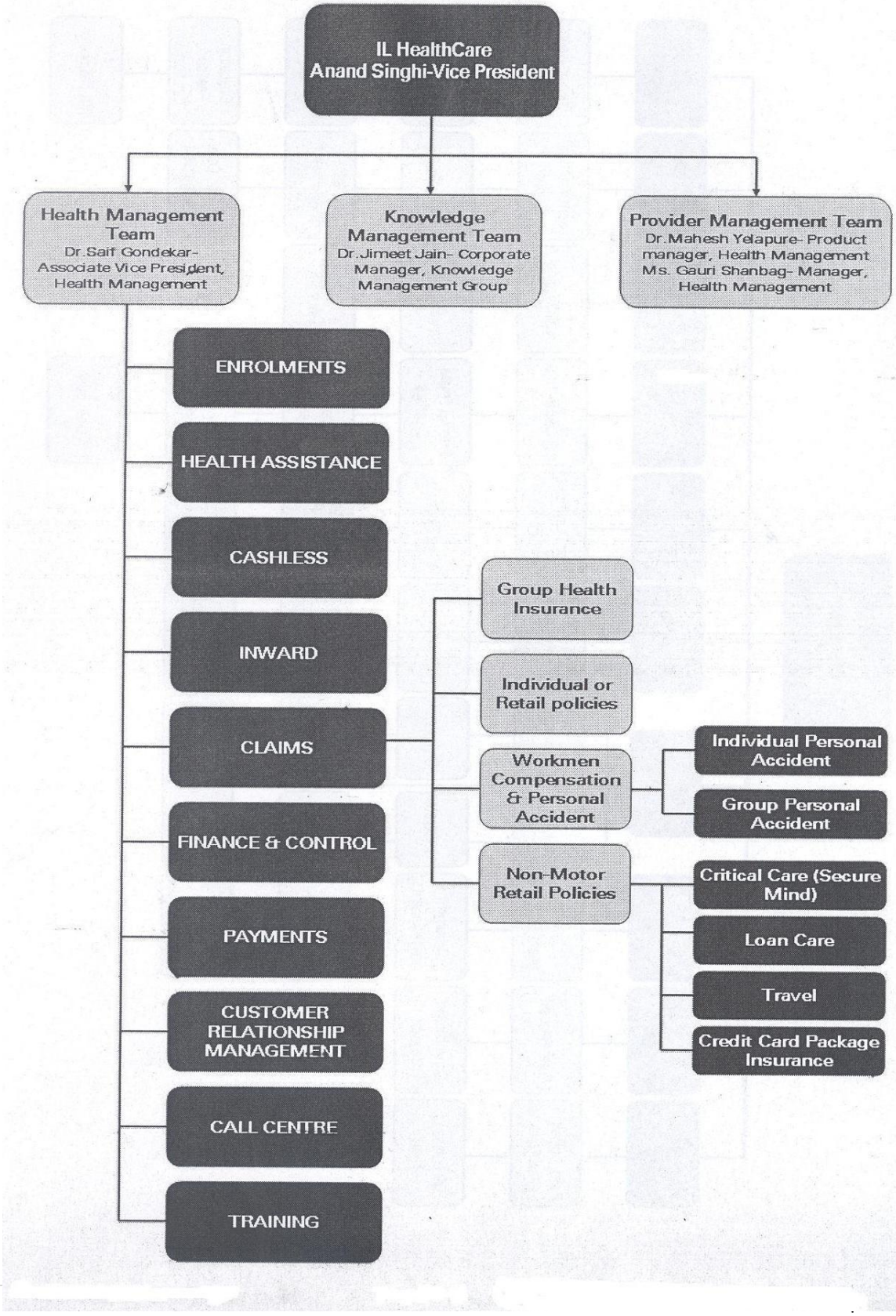
The goal of this project is to study the different health insurance products and find out the critical parameters and with the help of comparative studies deriving justifiable information in which areas our (icici Lombard General Insurance Co) products lagging behind. It also helps to draw the possible modifications that might improve the quality of the products, so that there will be an opportunity to attain the expectations of the customer. It will ultimately leads to customer loyalty and expansion of business.

1.2 Introduction to the company

ICICI Lombard GIC Ltd. is a 74:26 joint venture between ICICI Bank Limited, India's second largest bank with consolidated total assets of over USD 100 billion at March 31, 2010 and Fairfax Financial Holdings Limited, a Canada based USD 30 billion diversified financial services company engaged in general insurance, reinsurance, insurance claims management and investment management.

ICICI Lombard GIC Ltd. is the largest private sector general insurance company in India with a Gross Written Premium (GWP) of 36,948 million for the year ended March 31, 2010. The company issued over 44 Lakh policies and settled over 62 Lakh claims and has a claim disposal ratio of 96% (percentage of claims settled against claims reported) as on March 31, 2010. The company has 4,634 employees and 350 branches as on March 31, 2010.

IL HEALTHCARE MANAGEMENT FLOW



1.3 Profile and evolution of the healthcare industry

Insurance, in law and economics, is a form of risk management primarily used to hedge against the risk of a contingent loss. Insurance is defined as the equitable transfer of the risk of a loss, from one entity to another, in exchange for a premium.

History of insurance refers to the development of a modern laws and market in insurance against risks. In some sense insurance appears simultaneously with the appearance of human society. There are two types of economies in human societies: money economies (with markets, money, financial instruments and so on) and non-money or natural economies (without money, markets, financial instruments and so on). The second type is a more ancient form than the first. In such an economy and community, insurance prevails in the form of people helping each other. For example, if a house burns down, the members of the community help build a new one.

1.3.1 History of health insurance

Ancient world

Turning to insurance in the modern sense (i.e., insurance in a modern money economy, in which insurance is part of the financial sphere), early methods of transferring or distributing risk were practiced by Chinese and Babylonian traders as long ago as the 3rd and 2nd millennia BC, respectively. Chinese merchants travelling treacherous river rapids would redistribute their wares across many vessels to limit the loss due to any single vessel's capsizing. The Babylonians developed a system which was recorded in the famous Code of Hammurabi, c. 1750 BC, and practiced by early Mediterranean sailing merchants. If a merchant received a loan to fund his shipment, he would pay the lender an additional sum in exchange for the lender's guarantee to cancel the loan should the shipment be stolen.

Achaemenian monarchs were the first to insure their people and made it official by registering the insuring process in governmental notary offices. The insurance tradition was performed each year in Nowruz (beginning of the Iranian New Year); the heads of different ethnic groups as well as others willing to take part, presented gifts to the monarch. The most

important gift was presented during a special ceremony. When a gift was worth more than 10,000 Derrik (Achaemenian gold coin) the issue was registered in a special office. This was advantageous to those who presented such special gifts. For others, the presents were fairly assessed by the confidants of the court. Then the assessment was registered in special offices. The purpose of registering was that whenever the person who presented the gift registered by the court was in trouble, the monarch and the court would help him. Jahez, a historian and writer, writes in one of his books on ancient Iran: "Whenever the owner of the present is in trouble or wants to construct a building, set up a feast, have his children married, etc. the one in charge of this in the court would check the registration. If the registered amount exceeded 10,000 Derrik, he or she would receive an amount of twice as much."

A thousand years later, the inhabitants of Rhodes invented the concept of the 'general average'. Merchants whose goods were being shipped together would pay a proportionally divided premium which would be used to reimburse any merchant whose goods were jettisoned during storm or sink age.

The Greeks and Romans introduced the origins of health and life insurance c. 600 AD when they organized guilds called "benevolent societies" which cared for the families and paid funeral expenses of members upon death. Guilds in the Middle Ages served a similar purpose. The Talmud deals with several aspects of insuring goods. Before insurance was established in the late 17th century, "friendly societies" existed in England, in which people donated amounts of money to a general sum that could be used for emergencies.

Early modern

Separate insurance contracts (i.e., insurance policies not bundled with loans or other kinds of contracts) were invented in Genoa in the 14th century, as were insurance pools backed by pledges of landed estates. These new insurance contracts allowed insurance to be separated from investment, a separation of roles that first proved useful in marine insurance. Insurance became far more sophisticated in post-Renaissance Europe, and specialized varieties developed.

Toward the end of the seventeenth century, London's growing importance as a centre for trade increased demand for marine insurance. In the late 1680s, Mr. Edward Lloyd opened a coffee house that became a popular haunt of ship owners, merchants, and ships‘ captains, and thereby a reliable source of the latest shipping news. It became the meeting place for parties wishing to insure cargoes and ships, and those willing to underwrite such ventures. Today, Lloyd's of London remains the leading market (note that it is not an insurance company) for marine and other specialist types of insurance, but it works rather differently than the more familiar kinds of insurance.

Insurance can be traced to the Great Fire of London, which in 1666 devoured 13,200 houses. In the aftermath of this disaster, Nicholas Barbon opened an office to insure buildings. In 1680, he established England's first fire insurance company, "The Fire Office," to insure brick and frame homes.

The concept of health insurance was proposed in 1694 by Hugh the Elder Chamberlen from the Peter Chamberlen family. In the late 19th century, "accident insurance" began to be available, which operated much like modern disability insurance. This payment model continued until the start of the 20th century in some jurisdictions (like California), where all laws regulating health insurance actually referred to disability insurance.

The first insurance company in the United States underwrote fire insurance and was formed in Charles Town (modern-day Charleston), South Carolina, in 1732. Industrial revolution Benjamin Franklin helped to popularize and make standard the practice of insurance, particularly against fire in the form of perpetual insurance. In 1752, he founded the Philadelphia Contributionship for the Insurance of Houses from Loss by Fire. Franklin's company was the first to make contributions toward fire prevention. Not only did his company warn against certain fire hazards, it refused to insure certain buildings where the risk of fire was too great, such as all wooden houses.

1.3.2 Principles of insurance

Commercially insurable risks typically share seven common characteristics. from **Law of large numbers** :- It states that as the number of exposure units increases, the actual results are increasingly likely to become close to expected results. Large commercial property policies may insure exceptional properties for which there are no **homogeneous' exposure units**. Despite failing on this criterion, many exposures like these are generally considered to be insurable.

Definite Loss. The event that gives rise to the loss that is subject to insurance should, at least in principle, take place at a known time, in a known place, and from a known cause. The classic example is death of an insured on a life insurance policy. Fire, automobile accidents, and worker injuries may all easily meet this criterion. Other types of losses may only be definite in theory. Occupational disease, for instance, may involve prolonged exposure to injurious conditions where no specific time, place or cause is identifiable. Ideally, the time, place and cause of a loss should be clear enough that a reasonable person, with sufficient information, could objectively verify all three elements.

Accidental Loss. The event that constitutes the trigger of a claim should be fortuitous, or at least outside the control of the beneficiary of the insurance. The loss should be _pure,' in the sense that it results from an event for which there is only the opportunity for cost. Events that contain speculative elements, such as ordinary business risks, are generally not considered insurable.

Large Loss. The size of the loss must be meaningful from the perspective of the insured. Insurance premiums need to cover both the expected cost of losses, plus the cost of issuing and administering the policy, adjusting losses, and supplying the capital needed to reasonably assure that the insurer will be able to pay claims. For small losses these latter costs may be several times the size of the expected cost of losses. There is little point in paying such costs unless the protection offered has real value to a buyer.

Affordable Premium. If the likelihood of an insured event is so high, or the cost of the event so large, that the resulting premium is large relative to the amount of protection offered, it is not likely that anyone will buy insurance, even if on offer. Further, as the accounting profession formally recognizes in financial accounting standards, the premium cannot be so

large that there is not a reasonable chance of a significant loss to the insurer.

Calculable Loss. There are two elements that must be at least estimable, if not formally calculable: the probability of loss, and the attendant cost. Probability of loss is generally an empirical exercise, while cost has more to do with the ability of a reasonable person in possession of a copy of the insurance policy and a proof of loss associated with a claim presented under that policy to make a reasonably definite and objective evaluation of the amount of the loss recoverable as a result of the claim.

Limited risk of catastrophically large losses. The essential risk is often aggregation. If the same event can cause losses to numerous policyholders of the same insurer, the ability of that insurer to issue policies becomes constrained, not by factors surrounding the individual characteristics of a given policyholder, but by the factors surrounding the sum of all policyholders so exposed. Typically, insurers prefer to limit their exposure to a loss from a single event to some small portion of their capital base, on the order of 5 percent. Where the loss can be aggregated, or an individual policy could produce exceptionally large claims, the capital constraint will restrict an insurers appetite for additional policyholders. The classic example are earthquake insurance, wind insurance in hurricane zones. In extreme cases, the aggregation can affect the entire industry, since the combined capital of insurers and reinsurers can be small compared to the needs of potential policyholders in areas exposed to aggregation risk. In commercial fire insurance it is possible to find single properties whose total exposed value is well in excess of any individual insurer‘s capital constraint. Such properties are generally shared among several insurers, or are insured by a single insurer who syndicates the risk into the reinsurance market.

Indemnification The technical definition of "indemnity" means to make whole again. There are two types of insurance contracts; 1) an "indemnity" policy and 2) a "pay on behalf" or "on behalf of" policy. The difference is significant on paper, but rarely material in practice. An "indemnity" policy will never pay claims until the insured has paid out of pocket to some third party. Under the same situation, a "pay on behalf" policy, the insurance carrier would pay the claim and the insured would not be out of pocket for anything. Most modern liability insurance is written on the basis of "pay on behalf" language.

An entity seeking to transfer risk (an individual, corporation, or association of any type, etc.) becomes the 'insured' party once risk is assumed by an 'insurer', the insuring party, by means of a contract, called an insurance 'policy'. Generally, an insurance contract includes, at a minimum, the following elements: the parties (the insurer, the insured, the beneficiaries), the premium, the period of coverage, the particular loss event covered, the amount of coverage (i.e., the amount to be paid to the insured or beneficiary in the event of a loss), and exclusions (events not covered). An insured is thus said to be "indemnified" against the loss events covered in the policy.When insured parties experience a loss for a specified peril, the coverage entitles the policyholder to make a 'claim' against the insurer for the covered amount of loss as specified by the policy. The fee paid by the insured to the insurer for assuming the risk is called the 'premium'. Insurance premiums from many insureds are used to fund accounts reserved for later payment of claims—in theory for a relatively few claimants—and for overhead costs. So long as an insurer maintains adequate funds set aside for anticipated losses (i.e., reserves), the remaining margin is an insurer's profit.

Insurer's business model

Profit = earned premium + investment income - incurred loss - underwriting expenses.

Insurers make money in two ways:

(1) through underwriting, the process by which insurers select the risks to insure and decide how much in premiums to charge for accepting those risks and (2) by investing the premiums they collect from insureds.

The most complicated aspect of the insurance business is the underwriting of policies.. Actuarial science uses statistics and probability to analyze the risks associated with the range of perils covered, and these scientific principles are used to determine an insurer's overall exposure. Upon termination of a given policy, the amount of premium collected and the investment gains thereon minus the amount paid out in claims is the insurer's underwriting profit on that policy. Of course, from the insurer's perspective, some policies are winners (i.e., the insurer pays out less in claims and expenses than it receives in premiums and investment income) and some are losers (i.e., the insurer pays out more in claims and expenses than it receives in premiums and investment income).

An insurer's underwriting performance is measured in its combined ratio. The loss ratio (incurred losses and loss-adjustment expenses divided by net earned premium) is added to

the expense ratio (underwriting expenses divided by net premium written) to determine the company's combined ratio. The combined ratio is a reflection of the company's overall underwriting profitability. A combined ratio of less than 100 percent indicates underwriting profitability, while anything over 100 indicates an underwriting loss.

Insurance companies also earn investment profits on **—float||**. —Float|| or available reserve is the amount of money, at hand at any given moment, that an insurer has collected in insurance premiums but has not been paid out in claims. Insurers start investing insurance premiums as soon as they are collected and continue to earn interest on them until claims are paid out.

Naturally, the —float|| method is difficult to carry out in an economically depressed period. Bear markets do cause insurers to shift away from investments and to toughen up their underwriting standards. So a poor economy generally means high insurance premiums. This tendency to swing between profitable and unprofitable periods over time is commonly known as the "underwriting" or insurance cycle.

Finally, **claims and loss handling** is the materialized utility of insurance. In managing the claims-handling function, insurers seek to balance the elements of customer satisfaction, administrative handling expenses, and claims overpayment leakages. As part of this balancing act, fraudulent insurance practices are a major business risk that must be managed and overcome.

1.3.3 Types of insurance

- Health
- Disability
- Casualty
- Life
- Property

- Liability
- Credit
- Other types

Casualty

Casualty insurance insures against accidents, not necessarily tied to any specific property. Crime insurance is a form of casualty insurance that covers the policyholder against losses arising from the criminal acts of third parties. For example, a company can obtain crime insurance to cover losses arising from theft or embezzlement.

Political risk insurance is a form of casualty insurance that can be taken out by businesses with operations in countries in which there is a risk that revolution or other political conditions will result in a loss.

Life

Life insurance provides a monetary benefit to a decedent's family or other designated beneficiary, and may specifically provide for income to an insured person's family, burial, funeral and other final expenses. Life insurance policies often allow the option of having the proceeds paid to the beneficiary either in a lump sum cash payment or an annuity.

Annuities and pensions that pay a benefit for life are sometimes regarded as insurance against the possibility that a retiree will outlive his or her financial resources.

Some policies, such as annuities and endowment policies, are financial instruments to accumulate or liquidate wealth when it is needed.

Property insurance provides protection against risks to property, such as fire, theft or weather damage. This includes specialized forms of insurance such as fire insurance, flood insurance, earthquake insurance, home insurance, inland marine insurance or boiler insurance.

- Automobile insurance,
- Aviation insurance
- Builder's risk insurance

- Crop insurance
- Earthquake insurance
- Flood insurance
- Marine insurance
- Terrorism insurance
- Liability insurance
- Professional liability insurance,.
- Credit insurance
- Mortgage insurance.
- Expatriate insurance
- Financial loss insurance

Insurance company

Insurance companies may be classified into two groups:

- Life insurance companies, which sell life insurance, annuities and pensions products.

- Non-life, General, or Property/Casualty insurance companies, which sell other types of insurance.

General insurance companies can be further divided into these sub categories.

- Standard Lines

- Excess Lines

1.4 Importance of the Study

The concept of health insurance was proposed in 1694 by Hugh the Elder Chamberlen from the Peter Chamberlen family. In the late 19th century, "accident insurance" began to be available, which operated much like modern disability insurance. This payment model continued until the start of the 20th century in some jurisdictions (like California), where all

laws regulating health insurance actually referred to disability insurance. Accident insurance was first offered in the United States by the Franklin Health Assurance Company of Massachusetts. This firm, founded in 1850, offered insurance against injuries arising from railroad and steamboat accidents. Sixty organizations were offering accident insurance in the US by 1866, but the industry consolidated rapidly soon thereafter. While there were earlier experiments, the origins of sickness coverage in the US effectively date from 1890. The first employer-sponsored group disability policy was issued in 1911.

Before the development of medical expense insurance, patients were expected to pay all other health care costs out of their own pockets, under what is known as the fee-for-service business model. During the middle to late 20th century, traditional disability insurance evolved into modern health insurance programs. Today, most comprehensive private health insurance programs cover the cost of routine, preventive, and emergency health care procedures, and also most prescription drugs, but this was not always the case.

Hospital and medical expense policies were introduced during the first half of the 20th century. During the 1920s, individual hospitals began offering services to individuals on a pre-paid basis, eventually leading to the development of Blue Cross organizations. The predecessors of today's Health Maintenance Organizations (HMOs) originated beginning in 1929, through the 1930s and on during World War II.

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Health insurance policy is a contract between an insurance company and an individual. The contract can be renewable annually or monthly. The type and amount of health care costs that

will be covered by the health plan are specified in advance, in the member contract or Evidence of Coverage booklet. The individual policy-holder's payment obligations may take several forms.

Health plan vs. health insurance

Historically, HMOs tended to use the term "health plan", while commercial insurance companies used the term "health insurance". A health plan can also refer to a subscription-based medical care arrangement offered through health maintenance organization, HMO, PPO, or POS plan. These plans are similar to pre-paid dental, pre-paid legal, and pre-paid vision plans. Pre-paid health plans typically pay for a fixed number of services (for instance, $300 in preventive care, a certain number of days of hospice care or care in a skilled nursing facility, a fixed number of home health visits, a fixed number of spinal manipulation charges, etc.) The services offered are usually at the discretion of a utilization review nurse who is often contracted through the managed care entity providing the subscription health plan. This determination may be made either prior to or after hospital admission (concurrent utilization review).

Comprehensive vs. scheduled

Comprehensive health insurance pays a percentage (may be 100, 90, 80, 70, 60, 50, percent) of the cost of hospital and physician charges after a deductible (usually applies to hospital charges) or a co-pay (usually applies to physician charges, but may apply to some hospital services) is met by the insured. These plans are generally expensive because of the high potential benefit payout — $1,000,000 to 5,000,000 is common — and because of the vast array of covered benefits. Scheduled health insurance plans are not meant to replace a traditional comprehensive health insurance plans and are more of a basic policy providing access to day-to-day health care such as going to the doctor or getting a prescription drug. In recent years, these plans have taken the name mini-med plans or association plans. These plans may provide benefits for hospitalization and surgical, but these benefits will be limited. Scheduled plans are not meant to be effective for catastrophic events. These plans cost much less then comprehensive health insurance. They generally pay limited benefits amounts directly to the service provider, and payments are based upon the plan's "schedule of benefits". Annual benefits maximums for a typical scheduled health insurance plan may range from $1,000 to $25,000.

1.5 Inherent problems with insurance

Insurance systems must typically deal with two inherent challenges: adverse selection, which affects any voluntary system, and ex-post moral hazard, which affects any insurance system in which a third party bears major responsibility for payment, whether that is an employer or the government. Some national systems with compulsory insurance utilize systems such as risk equalization and community rating to overcome these inherent problems.

Adverse selection

Insurance companies use the term "adverse selection" to describe the tendency for only those who will benefit from insurance to buy it. Specifically when talking about health insurance, unhealthy people are more likely to purchase health insurance because they anticipate large medical bills. On the other side, people who consider themselves to be reasonably healthy may decide that medical insurance is an unnecessary expense.

The fundamental concept of insurance is that it balances costs across a large, random sample of individuals .For instance, an insurance company has a pool of 1000 randomly selected subscribers, each paying $100 per month. One person becomes very ill while the others stay healthy, allowing the insurance company to use the money paid by the healthy people to pay for the treatment costs of the sick person. However, when the pool is self-selecting rather than random, as is the case with individuals seeking to purchase health insurance directly, adverse selection is a greater concern. A disproportionate share of health care spending is attributable to individuals with high health care costs. In the US the 1% of the population with the highest spending accounted for 27% of aggregate health care spending in 1996. The highest-spending 5% of the population accounted for more than half of all spending. These patterns were stable through the 1970s and 1980s, and some data suggest that they may have been typical of the mid-to-early 20th century as well. A few individuals have extremely high medical expenses, in extreme cases totaling a half million dollars or more. Adverse selection could leave an insurance company with primarily sick subscribers and no way to balance out the cost of their medical expenses with a large number of healthy subscribers.

Because of adverse selection, insurance companies employ medical underwriting, using a patient's medical history to screen out those whose pre-existing medical conditions pose too

great a risk for the risk pool. Before buying health insurance, a person typically fills out a comprehensive medical history form that asks whether the person smokes, how much the person weighs, whether the person has been treated for any of a long list of diseases and so on. In general, those who present large financial burdens are denied coverage or charged high premiums to compensate. One large US industry survey found that roughly 13 percent of applicants for comprehensive, individually purchased health insurance who went through the medical underwriting in 2004 were denied coverage. Declination rates increased significantly with age, rising from 5 percent for individuals 18 and under to just under a third for individuals aged 60 to 64. Among those who were offered coverage, the study found that 76% received offers at standard premium rates, and 22% were offered higher rates. On the other side, applicants can get discounts if they do not smoke and are healthy.

Moral hazard

Moral hazard occurs when an insurer and a consumer enter into a contract under symmetric information, but one party takes action, not taken into account in the contract, which changes the value of the insurance. A common example of moral hazard is third-party payment—when the parties involved in making a decision are not responsible for bearing costs arising from the decision. An example is where doctors and insured patients agree to extra tests which may or may not be necessary. Doctors benefit by avoiding possible malpractice suits, and patients benefit by gaining increased certainty of their medical condition. The cost of these extra tests is borne by the insurance company, which may have had little say in the decision. Co-payments, deductibles, and less generous insurance for services with more elastic demand attempt to combat moral hazard, as they hold the consumer responsible.

Other factors affecting insurance prices

Increased utilization created by increased consumer demand, new treatments, and more intensive diagnostic testing, is the most significant driver. People in developed countries are living longer. The population of those countries is aging, and a larger group of senior citizens requires more intensive medical care than a young healthier population. Advances in medicine and medical technology can also increase the cost of medical treatment. Lifestyle-

related factors can increase utilization and therefore insurance prices, such as: increases in obesity caused by insufficient exercise and unhealthy food choices; excessive alcohol use, smoking, and use of street drugs.

1.6 Limitations

1) The study was limited to retail health insurance policies and critical illness policies provided by different general insurance companies in india.

2) The study do not cover market shares of the policies as the study was more interested towards the parameters covered in the policy.

3) The study was conducted for the sake of knowledge and not to criticize any general insurance company or any specific policy.

4) The study only identifies whether the parameter is covered or not but do not have any scope why that parameter is covered or not covered.

CHAPTER-II

REVIEW OF LITERATURE

CHAPTER-II REVIEW OF LITERATURE

2.1 Why consider health insurance:

- Attracting additional money for health
- Additional resources may be available through insurance because firstly, consumers are more enthusiastic about paying for health insurance than paying general taxation as the benefits are specific and visible and secondly, consumers are more able and prefer, to pay regular, affordable premiums rather than paying fees for treatment when they are ill.
- Getting better value for money (or increasing efficiency).
- Improving the quality and targeting of healthcare (increasing effectiveness)
- A greater explicitness and visibility of spending on health services occurs as a result of insurance.
- The third party institution can specify in contracts the kinds of healthcare that are to be provided and can therefore concentrate on providing cost effectiveness
- Consumers, and their representatives, will demand better quality care because they can see a definite link between their payments and services

Market Overview

World health organization defines health as complete physical, mental and social well being and not merely the absence of disease and injury. As per WHO, a country‘s Health Systems comprise of all the organizations, institutions and resources that are devoted to produce health actions.

2.2 Historical Perspective

The history of life insurance in India dates back to 1818 when it was conceived as a means to provide for English Widows. Interestingly in those days a higher premium was charged for Indian lives than the non-Indian lives as Indian lives were considered more riskier for coverage.

The Bombay Mutual Life Insurance Society started its business in 1870. It was the first company to charge same premium for both Indian and non-Indian lives. The Oriental Assurance Company was established in 1880. The General insurance business in India, on the other hand, can trace its roots to the Triton (Tital) Insurance Company Limited, the first general insurance company established in the year 1850 in Calcutta by the British. Till the end of nineteenth century insurance business was almost entirely in the hands of overseas companies.

Insurance regulation formally began in India with the passing of the Life Insurance Companies Act of 1912 and the provident fund Act of 1912. Several frauds during 20's and 30's sullied insurance business in India. By 1938 there were 176 insurance companies. The first comprehensive legislation was introduced with the Insurance Act of 1938 that provided strict State Control over insurance business. The insurance business grew at a faster pace after independence. Indian companies strengthened their hold on this business but despite the growth that was witnessed, insurance remained an urban phenomenon.

The Government of India in 1956, brought together over 240 private life insurers and provident societies under one nationalized monopoly corporation and Life Insurance Corporation (LIC) was born. Nationalization was justified on the grounds that it would create much needed funds for rapid industrialization. This was in conformity with the Government's chosen path of State lead planning and development.

The (non-life) insurance business continued to thrive with the private sector till 1972. Their operations were restricted to organized trade and industry in large cities. The general insurance industry was nationalized in 1972. With this, nearly 107 insurers were amalgamated and grouped into four companies- National Insurance Company, New India Assurance Company, Oriental Insurance Company and United India Insurance Company. These were subsidiaries of the General Insurance Company (GIC).

Indian federal government considers insurance as one of major sources of funds for infrastructure development. The government has identified the following as major thrust areas:

* Timely and reliable statistical data and information about policies and markets to instill a degree of credibility;
* A code of good practices based on international best practices to raise the standard of Indian insurance sector;
* Strengthening of supervision and regulation;
* Market participation in decision-making;
* High solvency standard' and Developing alternative channels.

The entire general insurance business in India was nationalized by General Insurance Business (Nationalization) Act, 1972 (GIBNA). The Government of India (GOI), through Nationalization took over the shares of 55 Indian insurance companies and the undertakings of 52 insurers carrying on general insurance business.

General Insurance Corporation of India (GIC) was formed in pursuance of Section 9(1) of GIBNA. It was incorporated on 22 November 1972 under the Companies Act, 1956 as a private company limited by shares. GIC was formed for the purpose of superintending, controlling and carrying on the business of general insurance.

As soon as GIC was formed, GOI transferred all the shares it held of the general insurance companies to GIC. Simultaneously, the nationalized undertakings were transferred to Indian insurance companies. After a process of mergers among Indian insurance companies, four companies were left as fully owned subsidiary companies of GIC (1) National Insurance Company Limited, (2) The New India Assurance Company Limited, (3) The Oriental Insurance Company Limited, and (4) United India Insurance Company Limited
The next landmark happened on 19th April 2000, when the Insurance Regulatory and Development Authority Act, 1999 (IRDAA) came into force. This act also introduced amendment to GIBNA and the Insurance Act, 1938. An amendment to GIBNA removed the exclusive privilege of GIC and its subsidiaries carrying on general insurance in India.

In November 2000, GIC is refortified as the Indian Reinsurer and through administrative instruction, its supervisory role over subsidiaries was ended. Currently insurance companies- both private and public-- have to cede 20 percent of its reinsurance with GIC. GIC is planning to increase re-insurance premium by 20 percent which works out at Rs 3000 cr. GIC is actively considering entry into overseas markets including West Asia, South-east Asia and SAARC region.

With the General Insurance Business (Nationalization) Amendment Act 2002 (40 of 2002) coming into force from March 21, 2002 GIC ceased to be a holding company of its subsidiaries. Their ownership were vested with Government of India

Insurance Sector Reforms

In 1993, Malhotra Committee- headed by former Finance Secretary and RBI Governor R.N. Malhotra- was formed to evaluate the Indian insurance industry and recommend its future direction. The Malhotra committee was set up with the objective of complementing the reforms initiated in the financial sector. The reforms were aimed at creating a more efficient and competitive financial system suitable for the requirements of the economy keeping in mind the structural changes currently underway and recognizing that insurance is an important part of the overall financial system where it was necessary to address the need for similar reforms. In 1994, the committee submitted the report and some of the key recommendations included:

i) Structure
ii) Competition
iii) Regulatory Body
iv) Investments
v) Customer Service

The committee felt the need to provide greater autonomy to insurance companies in order to improve their performance and enable them to act as independent companies with

economic motives. For this purpose, it had proposed setting up an independent regulatory body- The Insurance Regulatory and Development Authority.

2.3 Duties, Powers and Functions of IRDA

Section 14 of IRDA Act, 1999 lays down the duties, powers and functions of IRDA..(1) Subject to the provisions of this Act and any other law for the time being in force, the Authority shall have the duty to regulate, promote and ensure orderly growth of the insurance business and re-insurance business. (2) Without prejudice to the generality of the provisions contained in sub-section (1), the powers and functions of the Authority shall include, -

(a) Issue to the applicant a certificate of registration, renew, modify, withdraw, suspend or cancel such registration;
(b) protection of the interests of the policy holders in matters concerning assigning of policy, nomination by policy holders, insurable interest, settlement of insurance claim, surrender value of policy and other terms and conditions of contracts of insurance;
(c) Specifying requisite qualifications, code of conduct and practical training for intermediary or insurance intermediaries and agents;
(d) Specifying the code of conduct for surveyors and loss assessors;
(e) Promoting efficiency in the conduct of insurance business;
(f) Promoting and regulating professional organizations connected with the insurance and re-insurance business;
(g) Levying fees and other charges for carrying out the purposes of this Act;
(h) Calling for information from, undertaking inspection of, conducting enquiries and investigations including audit of the insurers, intermediaries, insurance intermediaries and other organizations connected with the insurance business;
(i) Control and regulation of the rates, advantages, terms and conditions that may be offered by insurers in respect of general insurance business not so controlled and regulated by the Tariff Advisory Committee under section 64U of the Insurance Act, 1938 (4 of 1938);
(j) Specifying the form and manner in which books of account shall be maintained and statement of accounts shall be rendered by insurers and other insurance intermediaries;

(k) Regulating investment of funds by insurance companies;
(l) Regulating maintenance of margin of solvency;
(m) Adjudication of disputes between insurers and intermediaries or insurance intermediaries;
(n) Supervising the functioning of the Tariff Advisory Committee;
(o) Specifying the percentage of premium income of the insurer to finance schemes for promoting and regulating professional organizations referred to in clause (f);
(p) Specifying the percentage of life insurance business and general insurance business to be undertaken by the insurer in the rural or social sector; and
(q) Exercising such other powers as may be prescribed

Reforms in the Insurance sector were initiated with the passage of the IRDA Bill in Parliament in December 1999. The IRDA since its incorporation as a statutory body in April 2000 has fastidiously stuck to its schedule of framing regulations and registering the private sector insurance companies. Since being set up as an independent statutory body the IRDA has put in a framework of globally compatible regulations. The other decision taken simultaneously to provide the supporting systems to the insurance sector and in particular the life insurance companies was the launch of the IRDA online service for issue and renewal of licenses to agents. The approval of institutions for imparting training to agents has also ensured that the insurance companies would have a trained workforce of insurance agents in place to sell their products.

2.4 Why Health Care Insurance

Few reasons why health insurance is a must:-
Indians at greater risk

- **Reason 1: Lifestyles have changed**. Indians today suffer from high levels of stress. Long hours at work, little exercise, disregard for a healthy balanced diet and a consequent dependence on junk food have weakened the immune systems resulting in an an increased risk of contracting illnesses.

- **Reason 2: Rare non-communicable diseases are now common**. Obesity, high blood pressure, strokes, and heart attacks, which were earlier considered rare, now affect an increasing number of urban Indians.

• 18% of the urban population suffers from hypertension, which leads to renal failure, stroke and cardio-vascular diseases
• 30% of the population suffers heart attacks before age 40
• 66% of deaths today are due to cardio-vascular diseases
• Almost 3.5 million Indians suffer from diabetes
• Cardio-vascular diseases (CVDs) like heart disease and stroke are the main causes of death and disability

The Cost Factor

- **Reason 3: Medical care is unbelievably expensive**: Medical breakthroughs have resulted in cures for dreaded diseases. These cures, however, are available only to a select few. High operating expenses—therapy for breast cancer costs as much as Rs. 2 lakh for 3 days—have restricted treatment to the richest. In fact, even among the affluent groups, 20% need to sell their valuable assets so they can accumulate the required amount to meet healthcare costs.

- **Reason 4: Indirect costs add to the financial burden**: Indirect sources of expense—travel, boarding and lodging, and even temporary loss income account for as much as 35% of the overall cost of treatment.

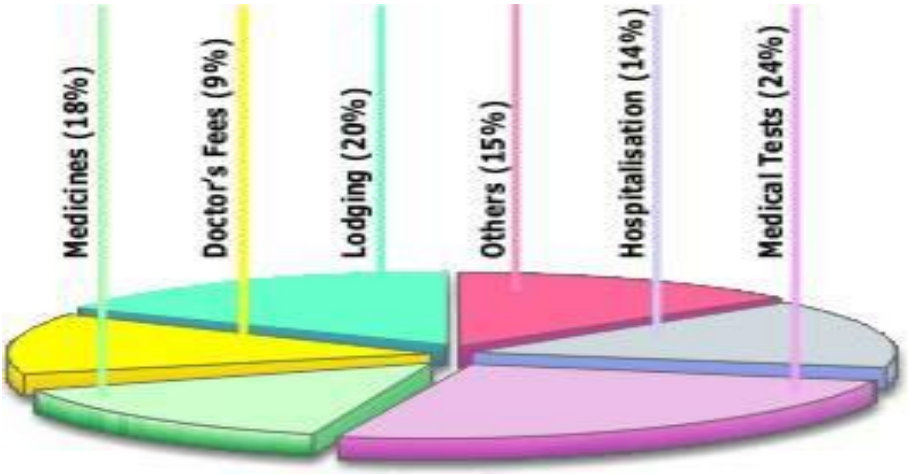


Figure-2: Medical expenditure distribution chart

- **Reason 5: Incomplete financial planning**: Illnesses strike without warning—and seriously impact our finances and eat into our savings in the absence of a good health insurance or medical insurance plan. Over two thirds of all Indians sell assets or dip into existing savings to meet healthcare costs.

Types Of Health Care Insurance Available:

- Medical Insurance
- Critical Illness Insurance

Medical Insurance

Medical insurance in India is gaining such a high trend that policies are out even for infants. It is the buffer against medical emergencies. This cover is a hospitalization cover and

reimburse the medical expenses incurred in respect of covered disease /surgery while the insured was admitted in the hospital as an in patient.

Different types of Medical Insurance are available here:

- Individual Medical Insurance
- Group Medical Insurance
- Overseas Medical Insurance

Critical Illness Insurance

Critical Illness Insurance provides for payment of amount equal to sum assured, if illness strikes, irrespective of expenses incurred on treatment. Most insurance companies are providing this insurance as an addition to the life insurance; additional premium payable for critical illness. It is introduced as a value addition to meet the demands and also as marketing strategy. The insurance covers surgery cost, critical illness cover and post-hospitalization. The insurance is different in paying only for prolonged hospitalizations. One of the unique features of this insurance is that a lump sum allowance is paid irrespective of the actual medical expenses.

Calculation of Critical Illness Insurance Amount/Premium:

The amount of premium depends on the insurance of the insurance company. Sometimes life insurance companies charge extra premium for the insurance, which is an add on to the LIP. Premium is generally paid on a yearly basis.

CHAPTER-III

RESEARCH METHODOLOGY

CHAPTER-III RESEARCH METHODOLOGY

3.1 Research Question:

"Which one is the best health insurance product available in the market that suits best to the requirements?"

Supplementary question: *"On what basis a health insurance product should be evaluated?"*

3.2 Research Design: Comparative Research(Descriptive comparison)

The design of comparative research is simple. The objects are specimens or cases which are similar in some respects (otherwise, it would not be meaningful to compare them) but they differ in some respects. These differences become the focus of examination. The goal is to find out why the cases are different: to reveal the general underlying structure which generates or allows such a variation.

Comparison is one of the most efficient methods for explicating or utilizing tacit knowledge or tacit attitudes. This can be done, for example, by showing in parallel two slides of two slightly different objects or situations and by asking people to explain verbally their differences.

The method is also versatile: you can use it in detail work as a complement to other methods, or the entire structure of a research project can consist of the comparison of just a few cases.

In comparative study, you are examining two (or more) cases, specimens or events, often in the form of a table such as can be seen on the right where a column is reserved for each case, here called "Case 1" and "Case 2". On the basis of the target of The study you have to decide which are the interesting aspects, properties or attributes that you will have to note and record for each of the cases. In the table on the right, these aspects are called A, B and C. During the process of analysis, you then can add new aspects or drop out fruitless ones. Those aspects that are similar in both the cases need not be recorded, because here you are not making two case studies but only a comparison of the cases.

The final goal of research is usually to reveal the systematic structure, invariance, that is true not only for the cases that were studied, but for the entire group (population) where the cases came from. In other words, the goal is to generalize the findings. Of course, it would be foolhardy to assert anything about a larger group, if The study consisted of just two cases. The plausibility of The generalization will increase, if you have instead of "Case 1", several cases from the same group, let us call it "Group 1", and similarly several cases from "Group 2". If all or the majority of these pairs show the same invariance, its credibility will quickly rise. There are statistical methods to calculate the credibility, or statistical significance of the findings. The question whether the found invariance then is true even outside the population, is something that the researcher normally leaves to be speculated by the readers of his report. In the case that you wish to compare more than two groups, or the number of cases is large, the study begins to approach classification, a method that is discussed on another page. In comparative like in most other studies there are two different styles, both of which will be discussed below: Descriptive Comparison aims at describing and perhaps also explaining the invariance's of the objects. It does not aim at generating changes in the objects, on the contrary, it usually tries to avoid them. A special style of research is needed when the aim is not just to detect and explain but also to improve the present state of the object, or to help improving or developing similar objects in the future. This is the technique of Normative Comparison.

3.3 Need of the study:

- To know different health insurance products available in the market at present.
- To know what are the major critical parameter to evaluate a health product.
- To know in which parameters our (icici lombard general insurance co) products are lagging behind.
- To modify or design a new kind of policies as per the requirements of customers

3.4 Step vise implementation of the study:

- Identifying the various products of the existing and new players in the market based on the market shares.
- Categorizing various products into –
  Individual products,
  Group products,
  Family products,
  Critical Illness products,
- Developing critical parameters for evaluation of various policies under each of the above products.
- Comparing the various terms and conditions, coverage‘s and exclusions of each product.
- Drawing up of suitable conclusions and inferences.

3.5 Objectives:

- To identify the major players in health nsurance market.
- To categorize the various health products provided by those players.
- To identify and develop the various parameters for evaluation of the products.
- To analyze the various products based on the parameters devised.
- To study the policies with reference to the terms and conditions, coverage‘s and exclusions.

3.5 Methodology:

Population size = More than 100

Sample size = 28

Sampling technique = Purposive sampling

Data type = Secondary Data

Data collection methods = Telephonic conversations, websites etc

Test of hypothesis Sign test. Tools and techniques applicable: The following may be the tools and techniques used to analyze the data gathered

1) Histograms.

2) Check sheets. Etc

3) Ranking method.

Many statistical tests require that your data follow a normal distribution. Sometimes this is not the case. In some instances it is possible to transform the data to make them follow a normal distribution; in others this is not possible or the sample size might be so small that it is difficult to ascertain whether or not the data a normally distributed. In such cases it is necessary to use a statistical test that does not require the data to follow a particular distribution. Such a test is called a non-parametric or distribution free test. The sign test is an example of one of these. The sign test is used to test the null hypothesis that the median of a distribution is equal to some value. It can be used a) in place of a one-sample t-test b) in place of a paired t-test or c) for ordered categorial data where a numerical scale is inappropriate but where it is possible to rank the observations. (Note that the Wilcoxon Signed Rank Sum Test is also appropriate in these situations and is a more powerful test than the sign test.)

3.7 Major players in health insurance Public sector players

1. The New India Assurance Company Ltd.

2. The National Insurance Company Ltd.

3. The Oriental Insurance Company Ltd.

4. The United India Insurance Company Ltd.

PRIVATE SECTOR COMPANIES

1. Bajaj Allianz General Insurance Co. Ltd.
2.ICICI Lombard General Insurance Co. Ltd.
3.IFFCO Tokio General Insurance Co. Ltd.
4. Reliance General Insurance Co. Ltd.
5. Royal Sundaram Alliance Insurance Co. Ltd
6. Tata AIG General Insurance Co. Ltd.
7. Cholamandalam MS General Insurance Co. LtD
8. Star Health and Allied Insurance Company Limited
9. Apollo DKV Insurance Company Limited
10. Future Generali India Insurance Company Limited
11. Universal Sompo General Insurance Co. Ltd.
12. Shriram General Insurance Company Limited,

3.8 CATEGORIES OF HEALTH INSURANCE PRODUCTS

Individual Mediclaim Policy

This is the plain vanilla mediclaim or health insurance policy for an individual protecting this person from the expenses incurred due to disease or injury.

Floater Policy

A floater health insurance policy covers The entire family under one policy with one sum insured and one premium. It covers all the expenses as covered under mediclaim only the cover is now extended to the family instead of one person. This cover can be used by any member of the family any number of times. The advantage of this policy is that saves money by spreading the cover across family members.

Group Insurance

A firm or an association may buy a policy to insure members of a group. For example a Company may take a policy to cover a large group of its employees. Insurance coverage for a group of individuals engaged in some common activity. Ex.Employees of an organization, members of an association of professionals, farmers registered as a society for rural activities etc. Insurers issue group policies in accident insurance, medical insurance, professional indemnity insurance, etc.

Group Mediclaim Insurance Mediclaim Insurance Policy issued in favour of an enterprise or an organization or any employer, to cover their employees and dependants. These policies are also issued to associations, clubs etc. for the benefit of their members. The essential requisites for a group policy are: Some common relationship among the persons to be insured and a central point for administration of the policy scheme.

Group Personal Accident Insurance

Personal Accident Insurance Policy issued in favor of an enterprise or an organization or any employer, to cover their employees (and dependants also sometimes). These policies are also issued to associations, clubs etc. for the benefit of their members. The essential requisites for

a group policy are: Some common relationship among the persons to be insured and a central point for administration of the policy scheme.

Rural insurance

Investing in rural markets is seen as a keen social responsibility. The protection provided to the rural class is specified and customized according to their needs. Through a multiple channel system , not only agricultural protection but also health, motor and other covers is provided.

Critical Illness Policy

Insurance companies define certain specified illness or diseases as ―critical‖. If you have a critical illness policy, then the insurance company will pay you a lump sum payment if you are diagnosed with a critical illness as defined by the insurance company. Some of the diseases/conditions which are usually deemed critical are Cancer ,Heart Attack, Kidney Failure, Major Organ Transplant, Stroke,Paralysis and Heart Valve Replacement Surgery. Unlike other general insurance policies, these policies come with multiple options in terms of sum assured and term of the policy. For example ICICI Lombard provides critical cover for 5 years for a Rs. 12,00,000 coverage. These policies are also available with disability coverage to ensure that you are also covered for loss of income during that critical period.

Overseas Mediclaim Policy

An Overseas Mediclaim Insurance policy provides cover for medical expenses incurred abroad for treatment of illness and diseases contracted or injury sustained during the insured period of overseas travel. Anyone who is traveling abroad for business or pleasure or for educational purposes should have this policy.

3.9 Parameters For Analyzing The Various Health Products

POLICY

A policy is a stamped document which is evidence of the contract of insurance between the insurer and the insured. The policy encapsulates the benefits and features of the policy.

ELIGIBILITY

The insurance is available to persons between age of 5 and 80 years. Children between the age of 3 months and 5 years can be covered provided one or both parents are covered concurrently.

INPATIENT TREATMENT

It indicated that the individual has been admitted to the Hospital for care, treatment and or observation.

PRE-EXISTING DISEASES

A pre - existing disease is any ailment or disease that a person is already suffering from at the time of purchasing health insurance. A pre-existing condition is defined as any injury, illness, sickness, disease, or other physical, medical, mental or nervous condition, disorder or ailment that existed at the time of application or during the past duration(specified by each insurance plan) prior to the effective date of the insurance, including any subsequent, chronic or recurring complications or consequences related to thereto or arising there-from Out-patient insurance covers consultations and treatments provided by a specialist or medical practitioner when an overnight stay in hospital is not necessary.

The premium for out-patient cover will be roughly the same cost as the premium for in-patient cover. In general out-patient claims are frequent but the amount of the claim relatively small. Not all expats consider the cost of outpatient cover worth the additional cost and are prepared to stand these smaller but possibly frequent expenses. However where families are concerned it is advisable to include the out-patient cover.

Not all treatments are covered automatically in an international health insurance plan. When you take out an insurance plan the insurance company will ask you about the medical history. Based on the information you provide they will make a decision regarding the coverage of the pre-existing conditions and will underwrite' the application.

The insurance company can take a number of options when deciding to underwrite the application.

The most typical option is for the insurance company to exclude the pre-existing condition' from the cover. This means they will not cover the cost of treatment for the condition or any related conditions.

A second option is that the international health insurance company may place a loading on the plan. The annual premium will rise but the insurance company will agree to cover the costs of treatment for the pre-existing condition'. This practice is less common; however our consultants are happy to source an overseas health insurance company that will allow you to cover a pre-existing condition' in this manner.

Alternatively the expatriate insurance company may place a moratorium on the pre-existing condition', this is usually two years. If you have had no recurrences or treatment during this two year period the company may agree to reconsider including the condition in the cover.

When applying for a group policy it may be possible to arrange a plan that covers all members of the group for all pre-existing conditions'. This option is generally only available to large groups but can be arranged if this is important to The group.

OUTPATIENT TREATMENT

A patient who is not an inpatient (not hospitalized) but instead is cared for elsewhere -- as in a doctor's office, clinic, or day surgery center is called an outpatient.

Out-patient insurance covers consultations and treatments provided by a specialist or medical practitioner when an overnight stay in hospital is not necessary.

The premium for out-patient cover will be roughly the same cost as the premium for in-patient cover. In general out-patient claims are frequent but the amount of the claim relatively small. Not all expats consider the cost of outpatient cover worth the additional cost and are prepared to stand these smaller but possibly frequent expenses. However where families are concerned it is advisable to include the out-patient cover.

PRE-HOSPITALIZATION EXPENSES

It covers all the expenses for treatment taken 30 days prior to hospitalization.

POST-HOSPITALIZATION EXPENSES

It covers the expenses for the treatment taken for 60 days after hospitalsation.

Pre & Post Hospital Expenses:

- Medicines: Mandatory to provide doctor‘s prescription advising medicines and the relevant chemist bill.
- Doctor‘s Consultation Charges: Mandatory to provide the Doctor‘s prescription and the doctor‘s bill and receipt.
- Diagnostic Tests: Mandatory to provide the Doctor‘s prescription advising tests, the actual test reports and the bill and receipt from the diagnostic centre.

COVERAGE

The scope of protection provided under a contract of insurance; any of several risks covered by a policy. n general, the Policy covers reimbursement of Hospital / Nursing Home expenses incurred by the insured as an inpatient for treatment of any disease or Bodily injury through an accident. The expense incurred in the policy period, covered up to a maximum of the sum insured in aggregate are:

Room, Boarding Expenses as provided by the Hospital / Nursing Home, Nursing Expenses, Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists fees.

Anesthesia, Blood, Oxygen, O.T.Charges, Surgical appliances, Medicine and Drugs, Diagnostic Materials and X-Ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs & Cost of Organs and Similar Expenses.

DAY-CARE COVERAGE

When treatment such as Dialysis, Chemotherapy, Radiotherapy etc is taken in the Hospital/Nursing Home and the insured person-patient is discharged on the same day, the treatment will be considered to be taken under Hospitalization Benefit Scheme.

Outpatient surgery allows a person to return home on the same day that a surgical procedure is performed. Outpatient surgery is also referred to as ambulatory surgery or same-day surgery or day- care surgery.

DOMICILIARY COVERAGE

Domiciliary Hospitalization is the treatment of the patient is carried out at home. This needs to be as per the doctor's recommendation. Most health insurance companies do cover domiciliary hospitalization subject to a certain limit depending on the sum insured. The policy provides for domiciliary hospitalization expenses when medical treatment is taken for a period exceeding 3 days for an illness/disease/injury (not specifically excluded) which normally would require treatment as an in-patient in a hospital/nursing home but is actually taken whilst confined at home in India under the following circumstances:

Either the condition of the patient is such that he/she cannot be removed to the hospital/nursing home OR the patient cannot be removed to the hospital/nursing home for lack of the accommodation therein.

This hospitalization will however not cover pre and post hospitalization and treatment for asthma , bronchitis, chronic nephritis and nephritic syndrome, diarrhea and all type of dysenteries including gastroenteritis, diabetes mellitus and insipidus , epilepsy, hypertension , influenza, cough and cold, pyrexia of unknown origin, all psychiatric or psychosomatic disorders, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis.

MATERNITY COVER

It covers maternity benefit i.e. expenses incurred in delivery. It is generally excluded in an individual policy but is provided as an add-on cover in group policies, provided the extension is taken for all the members covered in the group.

Normally maternity cover would include costs related to:

- Pre and Post-natal treatments & examinations
- Medically prescribed Caesarian
- Normal delivery
- Delivery with complications
- Delivery following fertility treatment
- Hospital or Home delivery costs

More comprehensive maternity plans will also cover:

- Care of newborn children
- Fertility treatments
- Congenital birth defects

Dental Cover

Insufficient dental cover can prove to be very expensive as the cost of dental treatment in most countries is very high. Some employers do offer a dental cover plan to their employees, but this is usually at a very low level and not appropriate for most expats.

Insurance Companies normally have a waiting period before they will accept any claims for treatments. This period can vary between individual insurance companies and it is important to check the specific conditions when considering dental coverage.
Almost all Insurance Companies accept pre-existing dental problems.

The majority of individuals are likely to have undergone treatments such as simple fillings, tooth cleaning and root treatment. It is therefore extremely rare for the individual not to have any pre-existing conditions. This is why the insurance company will cover the pre-existing conditions after a period of time.

Insurance companies normally offer two levels of dental cover to enable the client to select the most suitable plan.

- Routine Dental Treatment
- Major Dental Treatment

CRITICAL ILLNESS

A Critical illness plan protects against the hardships associated with suffering a serious illness.

This lump sum is normally used to help cover the costs of any ongoing medical treatment, lifestyle adjustments (home renovations, medical support equipment) that may be needed because of the illness, or to lessen the financial impact due to lost income because of the diagnosis.

The purpose of of a critical illness plan is put aside a small regular amount now, as an insurance against all this happening. It covers –

- Cancer
- Coronary Artery bypass surgery
- First Heart attack Failure
- Multiple sclerosis
- Major organ transplant S
- troke Arota graft surgery
- Paralysis
- Primary Pulmonary Arterial Hypertension.

The premiums of a Critical Illness plan are calculated using a number of factors including the policyholder's state of health at the start of the plan, their age, total sum insured, and whether they smoke or not. It is important to note that a Critical Illness plan will not offer coverage for any pre-existing conditions that are present prior to the plan's commencement.

Normally, regardless of a policyholder's general state of health, a critical illness policy can be renewed every year until the normal age of retirement as long as the policyholder has paid their premiums. In many cases when renewing the plan, a policyholder can apply to increase the level of cover, giving an extra level of control over the plan. Many critical illness plans will give the option of adding Total and Permanent Disablement cover to protect in the event of a serious injury.

Major illnesses can cause significant financial hardship in a family especially if the major income provider is the one diagnosed. Critical illness plans can help protect against the high costs of recovery and the loss of income associated with the illness.

HEALTH CHECK-UP

Cost of health check up reimbursable at the end of 4 continuously claim free underwriting years limited to 1% of Average sum insured of 4 claim free years

CONTACT LENS, HEARING AID The cost of supporting items like braces, contact lens, spectacles, etc will not be paid/reimbursed under the mediclaim policy except in policies with suitable extensions as these are considered as the costs of mantainence.

FLOATER A floater is a unique plan wherein the value of sum insured opted can be used by all the members of the family or by a single-family member. Basically, the sum insured amount floats over all the members covered. For example: if the policy is bought for 3 lacs, then either all three members of the family can use Rs 1 lac each or one member can use the entire cover of 3 lacs.

EMERGENCY AMBULANCE OVER In the event of an emergency, cover is provided for expenses incurred on ambulance services to the nearest hospital where Emergency Health facilities are available.

OTHER THAN ALLOPATHIC COVER The systems of Ayurveda, Homeopathy and Unani are generally covered by Health Insurance, subject, however to the terms and

conditions of the policy. Some policies may exclude certain systems of medicine or may specify coverage for certain systems of medicine

RIDER Insurance policies are usually written in a standard form, most of which is dictated by state insurance law. If you need additional coverage or if there are changes to the standard document, these changes can be made by way of a rider. The information to be conveyed in the rider is typed up on a separate piece of paper, which is attached to the standard policy. An endorsement can accomplish the same goal; the only difference is that an endorsement is actually incorporated into the body of the existing policy. Some common health insurance riders are as follows.

- Multiple indemnity
- Waiver of premium
- Exclusion
- Additional coverage
- Accelerated Death Benefit
- Free look period
- Guaranteed renewable
- Inflation protection
- Level premiums
- Longer waiting periods

PREMIUM

Premium is the amount paid by the insured(the buyer) to the insurer for the policy. Simply put, it is the cost of the insurance policy.

TAX EXEMPTIONS

There is a tax benefit available under Section 80D of the income tax act 1961. Every tax payer can avail an annual deduction of Rs. 15,000 from taxable income for payment of Health Insurance premium for self and dependants. For senior citizens, this deduction is Rs. 20,000. Please note that you will have to show the proof for payment of premium. (Section 80D benefit is different from the Rs 1,00,000 exemption under Section 80 C)

ACCIDENT COVER

Personal Accident is an insurance cover wherein, in the event of the person sustaining bodily injuries resulting solely and directly from an accident caused by EXTERNAL, VIOLENT & VISIBLE means , resulting into death or disablement. An accident may include events like: •Rail / Road / Air Accident. • Injury due to any collision/fall. • Injury due to Bursting of gas cylinder. • Snake-bite, Frost bite/Dog bite. • Burn Injury, Drowning, Poisoning etc.

DISABLEMENT COVER

(i) When an insured person sustains accidental injuries resulting in loss of limb and is certified by a medical specialist that the injury is of a permanent total or permanent partial nature, then only the insured shall deemed to be **permanently totally/partially disabled.**

(ii) **Temporary total disablement** arises when a person is not in a position to perform the duties that he performing immediately prior to the accident, which has to be certified by a medical professional. In the event of an accidental injury resulting in temporary total disablement (to be confirmed by the attending physician)the insured shall be entitled to a compensation @ 1% of sum insured per week subject to a maximum of 104 weeks. Such weekly compensation shall in no case exceed Rs.5,000/- per week.

EXCLUSIONS

Exclusions are diseases and conditions for which medical expenses are not covered by the health insurance policy.

The most important exclusions however are pre-existing chronic conditions which the client has suffered or had treatment for prior to taking out the policy. The company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of: :

- All diseases/ injuries which are pre existing when the cover incepts for the first time.

- Any disease other than those stated in Point No. 3 below contracted by the insured person during the first 30 days from the commencement date of the policy. This exclusion shall not however apply if in the opinion of the Panel of Medical Practitioners constituted by the Company for this purpose, the insured person could not have known of the existence of the disease or any symptoms or complaints thereof at the time of making the proposal for insurance to the Insurance company. This condition shall not however apply in case of the insured person having been covered under this scheme or group insurance with any of the India Insurance companies for a continuous period of preceding 12 months without any break.

- During the first year of the operation of Insurance cover, the expenses on treatment of disease such as Cataract, Benign Prostate Hypertrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Congenital internal disease/defect, Fistula in anus, piles, Sinusitis and related disorders are not payable. If these diseases (other than congenital internal diseases/defect) are pre existing at the time of proposal they will not be covered even during subsequent period of renewal. If insured is aware of the existence of congenital internal diseases/defect before inception of policy it will be treated as pre-existing.

- Injury or disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign enemy, war like operations (whether war be declared or not).

- Circumcision unless for treatment of a disease not excluded hereunder or as may be necessitated due to an accident, vaccination or inoculation or change of life or cosmetic or aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.

- Cost of spectacles and contact lenses, hearing aids.

- Any dental treatment or surgery which is a corrective, cosmetic or aesthetic procedure, including wear and tear, unless arising from disease or injury and which requires hospitalization for treatment.

- Convalescence, general debility, "Run-down" condition or rest cure, congenital external disease or defects or anomalies, sterility, venereal disease, intentional self-injury and use of intoxicating drugs/ alcohol.

- All expenses arising out of condition directly or indirectly caused to or associated with human T cell lymphotropic virus type III (HTLB III) or lymphadinopathy associated virus (LAV) or the mutant's derivative or variations deficiency syndrome or any syndrome or condition of a similar kind commonly referred to as "AIDS".

- Charges incurred at hospital or nursing home primarily for diagnostic, X-Ray or laboratory examinations not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any ailment, sickness or injury for which confinement is required at a hospital/ nursing home.

- Expenses on vitamins or tonics unless forming part of treatment for injury or disease as certified by the attending physician.

- Injury or disease directly or indirectly caused by or contributed to by nuclear weapons or materials

- Treatment arising from or traceable to pregnancy, childbirth, miscarriage, abortion or complications of any of this, including caesarian section.

- Naturopathy treatment.

DEATH BENEFITS

A payment made to the nominee or the legal heir of the insured under a Personal Accident Insurance Policy in the event insured‘s death.

BENEFITS

An amount payable to the insured or his legal heir as a percent of the sum insured in case of accidental death to provide for education of the insured‘s children , etc.

3.10 TERMS ENCOUNTERED IN A HEALTH INSURANCE POLICY

Assignment

Assignment means that in the event of fatal accident of the insured person, the compensation is made to the assignee on the basis of his full and final discharge. In case the assignment is not made under Personal Accident Policy, the insurance company insist for SUCESSION CERTIFICATE from the Court for settlement of claim compensation, which is a time consuming, lengthy & cumbersome procedure

Claim

The process of applying to the insurer for reimbursement of the expenses incurred for treatment is called ―filing a claim‖. Usually, this process is handled by a service provider to the health insurance company. This service provider is called a ―Third Party Administrator

Coverage Amount

Coverage amount is the maximum amount payable in the event of a claim. It is also known as ―sum insured‖ and ―sum assured‖. The premium of the health insurance policy is dependent on the coverage amount chosen .

Coverage limits:

Some health plans only pay for health care up to a certain dollar amount. The policy-holder may be expected to pay any charges in excess of the health plan's maximum payment for a specific service. In addition, some plans have annual or lifetime coverage maximums. In

these cases, the health plan will stop payment when they reach the benefit maximum and the policy-holder must pay all remaining costs.

Co-Insurance:

After paying the deductible, percentage or amount of covered expenses that the insured pays. For example, an insurance policy brochure may mention that the policy will pay 80% of the first $5,000 and 100% hereafter of the usual and customary charges; In some health insurance plans, it is also called "co-payment".

Cumulative Bonus

Each claim free year ensures a benefit known as ―cumulative‖bonus. The health insurance company adds more benefits for the same premium paid if the insured does not make any claim on his policy.

If the insured person does not prefer any claim in the expiring policy, he is entitled to 5% cumulative bonus for every such claim free year subject to maximum of 50% cumulative bonus that means the sum insured under the renewed policy will be increased by 5% every year without charging any additional premium. In the event of a claim, the increased percentage will be reduced by 10% subject to minimum of the basic sum insured selected.

Deductible

The proportion of loss that the insured bears in respect of any claim. This will be in two forms, namely, Amount of excess, which will be mentioned either as a fixed amount or a percentage of the sum insured or the claim amount. Time excess by which the insured will not be entitled to the claim relatable to a specific period (usually number of days) stated in the policy

Endorsement

Memorandum issued in connection with effecting some additions, alterations or deletions in the terms of coverage granted under the standard form of policies, either at the time of issue of the standard policy at the time of commencement of insurance or any time during its

currency based on mutual agreements between insured and insurer. This will be signed by the authorized signatory of the insurer and once issued, the policy and the endorsement together will constitute the evidence of the contract.

Floater Policy

A floater policy is issued with a single sum insured covering number of individuals. Simply put, it is a one premium and one policy for all members of the family. The cover can be used any member of the family any number of times. For example, there are four members in The family- you, The spouse and The two children. You purchase a family floater policy with a sum insured of Rs 500,000. This means that if you fall sick and utilize Rs 200,000 in treatment- the balance Rs. 300,000 can be utilized by any member of the family including The self. The total expenses across the family would however be capped at Rs. 500,000.

Good Faith – Uberrima Fides

Good Faith is a minimum standard to get into a contractual arrangement. It requires both the buyer and seller in a transaction to act honestly toward each other and to not mislead or refrain from providing critical information to the other party. In the context of health insurance in India, it requires you to disclose all relevant personal information like previous disease history to the insurer before buying insurance.

Group Discount

Discount allowed in the premium arrived as per manual or prospectus rates depending upon the number of persons covered under a Group Personal Accident or Group Mediclaim Insurance Policy. Group Discounts are also allowed in the Industrial All Risks Policy, Householder's Comprehensive Insurance Policy, Shop Keeper's Package Policy also, where the discount depends upon the number of sections of coverage availed. **Hospitalization** Admission of a patient in a hospital or a nursing home and treatment to him for injury, illness, sickness or disease.

Policy

A policy is a stamped document which is evidence of the contract of insurance between the insurer and the insured. The policy encapsulates the benefits and features of the policy.

Proposal

Proposal forms are used to give the insurance company full particulars of the risk against which insurance protection is desired. This proposal form is the basis of the health insurance policy. Any misrepresentation or non disclosure of facts would make the insurance null and void.

Proposer

Proposer is the insured who seeks protection against loss he may suffer due to happening of a contingency..

Renewal

Health insurance policies are usually annual contracts. At the end of the policy period, the policy has to be renewed by the insurers. But renewing a contract of insurance is at the discretion of the insurer. There should be continuous renewal of the policies. If there is a break in insurance, the insured would lose the benefits of insurance in the event of any contingency.

Reimbursement

Under a Health Insurance policy, the cost of various hospital charges (such as bed charges, medicines, lab tests, surgeon's fees etc) are paid back to the insured who makes the claim. In other words, the insured pays the (hospital) expenses incurred, but thereafter gets reimbursed by the insurance company.

SUM INSURED

Sum insured is based on various factors namely :

(1) Income from gainful employment,

(2) Type of occupation,

(3) Age as on date of proposal,

(4) Period of insurance

(5) Conditions prevailing at the place from where the proposal is made etc.

(6) As regards the non-earning spouse of the insured the sum insured in respect of such spouse shall not exceed 50% of the eligibility of the insured, subject to a limit of Rs.One Lakh under benefits available under Table III of the policy.

(7) Dependant children can be offered a sum insured not exceeding Rs.50000/- to cover death and disablement only. NO TEMPORARY DISABLEMENT COVER SHALL BE OFFERED.

Waiting Period:

This refers to a pre-specified time period during which you will not be covered by The insurance (for a particular healthcare issue). he duration of waiting periods can be found in the policy conditions section of the insurance plan. Insurance companies enforce these periods in order to prevent policy holders making claims soon after the policy is in place.

3.11 PROJECT DATA:

Policy wordings of different types of policies.

3.11.1. Individual and Family Health Insurance Policies

The different health products considered under this category are :

1	apollo dkv – premia plan
2	apollo dkv –family premia plan
3	bharati-axa smart health
4	icici lombard-health advantage plus

5	max-bupa heart beat family
6	max-bupa individual
7	oriental family floater
8	reliance-health wise policy
9	iffco-tokio individual medishield
10	iffco-tokio swasthya kavach family
11	apollo dkv – easy health individual plan

12	new india mediclaim
13	united india family medicare
14	icici lombard-family floater
15	royal sundaram-health shield
16	tata-aig wellsurance
17	star-unique individual
18	star-family health optima
19	reliance-mediclaim policy
20	bajaj allianz-individual health guard
21	bajaj allianz-family health guard

The various parameters used for evaluating these policies are:

1. Eligibility

2. In patient treatment

3. Pre Existing diseases

4. Out patient treatment

5. Pre hospitalization

6. Post hospitalization

7. Day care procedures

8. Domiciliary coverage

9. Maternity cover

10. Dental treatment cover

11. Critical illness

12. Health check up

13. Contact lens, Hearing Aid etc

14. Floater

15. Attendant charges

16. Other than allopathic cover

17. Emergency Ambulance cover

18. Organ transplantation coverage

19. Investment option

20. Cosmetic treatment cover

21. Premium (aged up to 35 years for Rs 3 lac SI, option of RIDER on critical illness without service tax in INR)

APOLLO DKV – EASY HEALTH STANDARD PLAN

Easy Health Plan protects against the spiraling medical costs and will also guide you on the path of wellness, providing with **double protection of prevention and cover**. It is a broad cover for medical treatment and illness and accidents requiring `in-patient¿ hospitalization and also features an Optional Critical Illness Cover.

The Easy Health Individual Insurance Plan is available in **3 variants: Standard, Exclusive and Premium.** The cover amount ranges from Rs. 1,00,000 to Rs. 10,00,000 according to product variant.

The plan provides for in-patient hospitalization expenses and is designed to cover diagnostic procedures, boarding and lodging, the intensive care unit, operation theatre, anesthesia, blood, oxygen, surgical appliances, cost of prosthetic and other devices or equipment if implanted internally during a surgical procedure, medicines, drugs and consumables, nursing and medical practitioner charges as per the policy schedule.

Health Insurance at Rs. 3 per day Just pay Rs. 3 per day (for any individual below 35 years of age) and get an annual insurance cover of Rs. 1,00,000 (for our standard variant).

Points to Remember

1. Easy Health Insurance Plan will offer cover to persons from the age of 5 years onwards. A child dependent can be covered from the 91st day if both parents are covered under this

policy. The maximum entry age is 60 years. There is no maximum cover ceasing age in this policy.

2. The cover will be valid for a period of 1 year

3. An individual and/or his family members namely spouse, dependent children and dependent parents are eligible for buying this cover.

4. The cover will be on an Individual Sum Insured basis

- Wide options of Sum Insured- Rs. 1.00 Lac, 2.00 Lac, 3.00 Lac, 4.00 Lac and 5.00 Lac

- In-patient Treatment, Pre and Post Hospitalization, Domiciliary Treatment, Day Care expenses are covered.

- Daily Cash allowance of Rs 500 per day (maximum limit being Rs. 3000) for choosing shared accommodation
- Expenses for Organ Donor of a transplant are covered
- Emergency Ambulance expenses up to Rs. 2000
- Daily cash for accompanying an insured child is not covered
- Health Check-up expenses up to 1% of Sum Insured every 4th Year

STAR HEALTH – MEDICLASSIC

The Medi Classic insurance policy aims to provide reimbursement of hospitalization expenses incurred as a result of illness/disease/sickness and / or accidental injuries.

THE BENEFITS

- Hospitalization cover - In-patient hospitalization expenses for a minimum of 24hours.Includes room rent & boarding @ 2% of sum insured subject to a maximum of Rs.4000/- per day.
- Nursing expenses

- Surgeon's fees. Consultant’s fees. Anesthetist’s fees.
- Cost of blood, oxygen, diagnostic expenses, cost of pacemakers.
- Cost of medicines and drugs.
- Emergency ambulance charges for transporting the insured patient to the hospital @ Rs.750/- per hospitalization and Rs.1500/- per policy period.
- Pre-hospitalization medical expenses upto 30 days prior to date of admission into the hospital.
- A lump sum calculated at 7% of the hospitalization expenses payable towards post-hospitalization, subject to a maximum of Rs.5000/- per occurrence as per the policy.
- Non-allopathic treatments up to Rs. 25,000/- per occurrence, subject to a maximum of 25% of Sum insured per policy period.
- No claim discount ranging from 5% to 25% for every Claim - free year(except Family Package).
-

OPTIONAL BENEFITS ON PAYMENT OF ADDITIONAL PREMIUM

- Hospital Cash- Provides for payment of Rs.500/- for each completed day of hospitalization. Premium ranging from Rs.200 to 350 per person, depending upon the age.

- Patient Care- Available for persons above 65 years. it pays for the attendant charnges after discharge from the hospital@Rs.400/- per day to a maximum 5 days per hospitalization. Premium Rs.300/- per person.

- New Born Baby cover - Available with Family package plan and provides for The New - Born from birth up to the expiry of the policy period. The sum insured is restricted to 10% of the sum insured in respect of the mother. Premium 10% of policy premium.

How much to pay (for individuals)

Service Tax at 12.36% will be extra

Exclusions:

- Expenses incurred for treatment of any illness/disease/condition, which is pre - existing at the time of commencement of insurance.

- Any expenses incurred for treatment of illness/disease/sickness contracted by the insured person during the first 30 days from the commencement of the policy.

- First Year Exclusions- Hernia, Piles, Hydrocele, Congenital internal disease/defect, Sinusitis,Gall Stone/Renal Stone removal/treatment, and Benign Prostrate Hypertrophy.

- Two Years Exclusions- Hysterectomy, Cataract,Joint/Knee replacement surgery (other than caused by an accident). Prolapsed intervertibral Disc. Varicose veins/ulcers.

- Naturopathy treatment. Expenses, which are purely diagnostic in nature with no positive existence of any disease.

- Expenses that are mainly cosmetic in nature.

ROYAL SUNDARAM – HEALTH SHIELD

Health Shield is a comprehensive Health Insurance package specially designed to offer complete protection to the insured and his family. You can cover The spouse, children (above 90 days) and dependent parents (up to 60 years) from all Health worries. However, renewal is accepted only up to 70 years.

Age of the Primary insured person on first enrolment should be less than 60 years. With Health Shield, an access to value added services like cashless treatment (subject to conditions

and authorizations) at a list of hospitals provided by us, a 24 hour helpline and ambulance referral facility at no additional cost is provided.
Health Shield Coverage

Hospitalization cover: All inpatient hospitalization expenses in case of any accidents/illnesses covered by the policy for hospitalization for more than 24 hours.

Pre and post-hospitalization expenses: Covers all relevant medical expenses incurred 30 days prior to and 60 days after hospitalization.

Day care treatment expenses are covered in certain areas.

In the event of any claim becoming admissible under the Policy, the Company will pay to the Proposer, the Reasonable and Customary expenses, subject to the various limits mentioned hereunder, but not exceeding the Sum Insured and the Cumulative Bonus, if any, mentioned in the Schedule for all claims admitted during the Period of Insurance.

The Claim amount payable towards the treatment of following disease, illness, medical condition or injury is subject to a limit of:

Pre-existing conditions waiver: Normally all pre-existing illness at the time of taking the policy are excluded. However, if you continue to be with Health Shield for 5 years consecutively, pre-existing diseases will not be excluded from the sixth year.

Cumulative Bonus: Sum Insured under this policy increases by 5% for every claim free year, up to a maximum of 50%.

Hospital Cash Allowance: A lump sum of 2% of the Sum Insured per claim, in case of continuous hospitalization for a period of more than 15 days.

Ambulance charges in an emergency, subject to a limit of Rs.1000/- per claim.

Reimbursement of expenses, subject to a maximum of Rs.750/- per Insured Person, towards Master Health Check up for the Insured Person, after each 5 consecutive claim free for the Insured (excluding Cumulative Bonus) for each of those 5 years is equal to or more than 1,00,000/- per person.

Room, Boarding Expenses as charged by the Hospital/Nursing Home, subject to a limit of 1.5% of the Sum Insured per day and for Intensive Care Unit 3% of the Sum Insured per day.

Surgeon, Anesthetist, Medical Practitioner, Consultants and Specialist Fees are subject to a limit of 40% of the Sum Insured.

Family Discount: A discount of 10% is allowed on the premium payable by you if 3 or more persons opt for Health Shield Standard at the same time.

Exclusion waivers: If you are holding an existing Health Insurance Policy and are below the age of 40 years, first year exclusions and 30 days waiting period shall be waived. Option for Health Shield Standard should be done before the expiry date of The existing policy.

Key Features of Health Shield

- Health Shield comes with certain additional features, which normal health insurances may not include: -

- Access to 24-hour helplines
- Cumulative bonus on renewal
- Free ambulance referral facilities
- Income tax benefits on premium paid as per section 80D of Income Tax Act
- Online access to The family's medical history, information on hospitals, illnesses and medicines

ROYAL SUNDARAM – HOSPITAL CASH

Hospital Cash Online provides you with the solution for this extra financial burden during hospitalization. Hospital Cash Online is NOT a substitute for Health Insurance, but should be viewed as a supplement cover to help you and The family members in the event of hospitalization.

Key Benefits

- Instant Coverage
- No Documentation required
- No Medical Examination required
- Daily Cash benefit of Rs.1000/- for up to 180 days
- Income Tax benefit under section 80D of the IT Act
- Double Accident benefit, Triple ICU benefit and Convalescence benefit

Eligibility

- This insurance is available to persons between the age of 1 year and 60 years at the commencement date of the Policy. However, renewal is accepted up to 70 years.

- This cover is available for Self, Spouse, Dependant Children and Dependant Parents.

Key Features

- Instant coverage
- No Medical Examination required
- No Documentation required
- Up to 180 days of Hospitalization Cash benefit
- Automatic Renewal Facility
- Double Accident benefit; Triple ICU benefit
- Income tax benefits on premium paid as per section 80D of the IT act

Key Benefit

BENEFITS	SILVER PLAN	GOLD PLAN
Illness Hospital Confinement	Rs 500 per day	Rs 1,000 per day
Accident Hospital Confinement	Rs 1,000 per day	Rs 2,000 per day
Intensive Care Benefit	Rs 1,500 per day	Rs 3,000 per day
Convalescence Benefit	Rs 7,500 lump sum	Rs 15,000 lump sum

Illness Benefit

For each 24 hour period of hospital confinement, the benefit payable is the daily sum insured as per the plan selected by customer.

Accident Benefit

This benefit is payable only in excess of first 24 hours of confinement. Benefit payable will be increased to double the illness benefit for each 24 hour period of hours of confinement, resulting from an insured person sustaining bodily injury due to road, rail or air accident. This benefit is payable up to a maximum of 21 days during the entire policy period.

ICU Benefit

Benefit payable will be increased to triple the illness benefit for each 24 hour period of hospital confinement, where an insured person is being confined to intensive care unit for a maximum of 21 days during the policy period. For this purpose, the Intensive Care Unit shall be the special hospital unit for critically ill patients whose health requires continuous intensive medical care and treatment.

Convalescence Benefit

A fixed lump sum amount as per Plan chosen is payable if the confinement in hospital exceeds 21 consecutive days. This benefit is payable once in the policy period. This benefit is payable only if there is an admissible claim under any of the daily benefits.

Family Discount

A discount of 10% is offered if 3 or more persons are covered under the same policy.

BAJAJ ALLIANZ – HEALTH GUARD

Health Guard policy takes care of hospitalization expenses & also offers a wide coverage of pre & post hospitalization expenses. It is the first company to provide the higher coverage of SI 10 lacs.

FEATURES:

- The member has cashless facility at over 2400 hospitals across India
- The member can opt for hospitals besides the empanelled ones, in which the expenses incurred by him shall be reimbursed within 14 working days from submission of all documents.
- Pre and post - hospitalization expenses covers relevant medical expenses incurred 60 days prior to and 90 days after hospitalization.
- Cumulative bonus of 5 % is added to The sum assured for every claim free year. Family discount of 10 % is applicable.
- Covers ambulance charges in an emergency subject to limit of Rs. 1000 /-
- No tests required up to 45 years up to SI 10 lacs*
- 10% co- payment applicable if treatment taken in non-network hospitals. Waiver of co-payment is available on payment of additional premium
- Pre-existing diseases covered after 4 years continuous renewal with Bajaj Allianz

BENEFITS:

- In house Health Administration Team for hospitalization claims to lower turn around time
- Access to over 2400 hospitals all over India for cashless facility
- No Sub-limits applicable on room rent and other expenses
- Hassle-free claim settlement due to In-house claim administration

- Income tax benefit on the premium paid as per section 80-D of Income Tax Act as per existing IT law
- Health Check up for maximum amount of Rs. 1000 /- at the end of continuous four claim free years

COVERAGE:

- 10 lacs coverage available from 3 months up to 55 years
- Policy can be renewed up to 70 years
- In built E-opinion cover for SI 5 lacs & above

RELIANCE – HEALTH WISE POLICY

UNIQUE FEATURES

Rs. 1 lac cover for a family of two, including critical illness for Rs. 999/-

- Instant policy issuance
- 24 x 7 cashless facility and TPA support
- No medical check-up up to age of 45 years
- Income Tax benefit

Affordable Premiums

- Premiums as low as Rs 999/-per lakh for a couple
- The Family Floater benefit covers the entire family, ensuring that the cover is used optimally
- Policies are available for people up to the age of 65 years.

Convenience all the way

- No health checkups for people under the age of 45 years.
- A 24-hour cashless facility is provided at more than 3,000 hospitals across India.

The Reliance Advantage

- Separate double sum assured for listed critical illnesses.
- Pre-existing illnesses will commence after two years or four years (depending on the plan you choose) of continuous cover
- Extended coverage for pre- and post-hospitalization expenses.
- A no-claim bonus of 5% on every claim-free renewal. This can be accumulated up to a maximum of 50%.

Tax-wise

- With the Reliance Health Wise Policy, tax benefits under Section 80D of the Income Tax Act are available.

Coverage:

- **Hospitalization Expenses** – The policy will cover expenses incurred for room and operation-theatre charges, doctors' fees, cost of nursing, medical tests, medicines, blood, etc.

- **Day-Care Treatment** – The policy will cover expenses incurred towards technologically advanced treatment that does not require hospitalization for 24 hours.

- **Domiciliary Hospitalization** – We also provide cover for treatment administered at home, subject to specified conditions.

- **Pre- and Post-Hospitalization** – Reliance Healthwise covers medical expenses for treatment up to 60 days before (and up to 90 days after) the hospitalization, depending upon the plan selected.

- **Pre-existing illnesses** – Depending on the plan selected, pre-existing illnesses will be covered after two years or four years of continuous policy renewals.

- **Critical Illness** – The policy provides for separate double sum insured for treatment of ten critical illnesses listed.

- **Donor Expenses** – In the event of a major organ transplant, this policy will cover hospitalization expenses incurred on the donor.

Value-added benefits:

- Daily Hospitalization Allowance for a maximum of seven days.
- Nursing allowance for a maximum of five days.
- Reimbursement of charges towards ambulance services
- 'One-time recovery benefit' of Rs 10,000 if hospitalization exceeds ten consecutive days.
- Allowance for expenses of a person accompanying the insured, for a maximum of five days
- Reimbursement of cost of health check-up after four claim-free renewals.

Exclusions

- Any pre–existing illness for the first two years/ four years of the policy.
- Specified illnesses for the 1st year.
- Specified illnesses in the case of domiciliary hospitalization.
- Any treatment for the first 30 days from the time of inception of policy, unless due to an accident.

- Treatment related to HIV / AIDS
- Treatment due to abuse of alcohol or intoxicants.
- Vaccination and inoculation.
- Nuclear and war perils
- Naturopathy treatment

Eligibility

- Children above the age of three months and adults below the age of 65 years.
- Children between three months and five years can be covered only if one or both parents are covered.
- Maximum age to enter the Plan is 65, 60 and 55 years for Standard, Silver and Gold Plans, respectively.

TATA AIG – HOSPITAL CARE POLICY

Hospital Care takes care of all the expenses arising due to unforeseen hospitalization expenses due to accident.

Unique Features

Hospital Cash Benefit: Takes care of incidental expenses while in hospital, available in Rs. 1000/day, Rs2500/day, Rs.5000/day.

ICU Benefit: Double Hospital Cash benefit while admitted in Intensive Care Unit.

Physiotherapy Benefit: to help you recover fast during confinement in the hospital due to accidents.

Additional Features

- No medical examination is required.
- 24 hours world wide coverage.
- Covers risks of Accidental Death, equivalent to 100 times daily Hospital Cash benefit.
- Ambulance Charges

Benefits

- Accident Hospital cash daily benefit - Upto 60 days
- Acc Hosp. Cash (ICU - 2 times) -Upto 15 days
- Accidental Death-100 times of the daily benefit
- Operation Charges
- Anesthetist's Fees
- Operation Room Charges
- Surgeon Fees
- Hospital Services
- x-ray
- Pathology
- Tests Ambulance Charges (while admitting and discharging from the Hospital)
- Physiotherapy Benefit (During confinement in the Hospital upto 30 days) Premium Rates

Benefits		In Rs. Inclusive of 12.24% service tax	
Self	1017	2422	4216
Family	2798	6657	11593

Exclusions

The main exclusions to the policy include suicide, military service or operations, war, illegal act, bacterial infections, disease, AIDS, dangerous sports etc

TATA AIG – HEALTHCARE PLUS

These risks can often bring in unforeseen Hospitalization causing a financial burden on you and The family. With the escalating medical costs the charges like Operation theater, Surgeon's fees, diagnostic tests etc may turn out to be very expensive.

In some instances the hospitalization may be prolonged and may drain The savings. Besides the regular hospitalization expenses there are other incidental expenses like food, commutation by The immediate family members etc which may give sleepless nights to you and The family.

Tata AIG General Insurance introduces Hospital Care+ for the complete peace of mind from the above anxieties. The Daily Cash benefit in HealthCare+ takes care of any unexpected financial burden in case of hospitalization.

HealthCare+ is a perfect supplement to the health policy and can be taken along with any other health insurance schemes.

Key Benefits & Features

Sickness Hospital Cash - takes care of hospitalization expenses due to sickness; available in Rs. 500/day, Rs. 1000/day, Rs. 2000/day, Rs. 3000/day & Rs. 5000/day

Accidental Hospital Cash - You can also opt for accident hospital cash benefit which takes care of incidental expenses while in hospital due to accidents; available in Rs. 1000/day, Rs. 2000/day, Rs. 4000/day, Rs. 6000/day & Rs. 10000/day

Accident Medical Expense Reimbursement - This benefit takes care of reimbursement of day to day medical bills due to accidental injuries with or without hospitalization. Additional Features Hospitalization cash up to 180 days.

Guaranteed issuance. -Flexibility in choosing options; 5 convenient offer different levels of protection against hospitalization expenses.

Renewal benefit: On renewal of policy, additional 5% on the original benefit amount upto max 5 yrs.

- Waiting period of 90 days for Sickness Hospital Cash.
- Premium paid is eligible for tax exemption under Sec 80D of IT Act.
- Benefits Sickness Hospital Cash (per day)
- Accident Hospital Cash (per day)
- Accident Medical Expenses Reimbursement

- **Eligibility Criteria**

Any individual between the age of 18 to 59 years and 364 days can take this cover (Dependent children between the age of 6 months and 18 yrs or upto 23 yrs if studying in an accredited institution of higher learning and is unmarried).

The coverage can be renewed till the age of 54 years.

- **Exclusions**

1. Any pre-existing Condition, any complication arising from it, suicide, AIDS, Military service or operation, being under the influence of drugs, alcohol, war, illegal acts, dangerous sports.
2. If you are admitted to a hospital within 90 days immediately following the effective date of coverage stated in the schedule. unless hospitalization is caused by injury.
3. Pregnancy and resulting childbirth, miscarriage or Disease of the female organs of reproduction.
4. Elective, cosmetic or plastic surgery, except as a result of an injury caused by a covered condition.

5. Services, supplies, or treatment, including any period of Hospital confinement, which were not recommended, approved and certified as Medically Necessary by a Physician.
6. Routine physicals or other examinations where there are no objective indications or impairment in normal health, and laboratory diagnostic or X-ray examinations except in the course of a disability established by the prior call or attendance of a physician.

7. Dental care, except as a result of injury caused by Accident to Sound Natural Teeth while this Policy is in effect.
8. Expenses incurred in connection with weak, strained, or flat feet, corns, calluses, or toenails.
9. The diagnosis and treatment of acne.
10. Deviated transplant that are considered experimental in nature.
11. Well child-care including examinations and immunizations.
12. Expenses which are not exclusively medical in nature.
13. Any expenses incurred outside India.

Cholamandalam- HEALTH INSURANCE

Coverage

In the unfortunate event of you or The family members meeting with an illness or accident resulting in hospitalization, our Health Insurance gives you a cash free hospitalization in more than 3000 hospitals across India. Our Health Insurance also reimburses the expenses during Pre - Hospitalization and Post - Hospitalization stages of treatment.

Pre-Hospitalization: Medical expense incurred 60 days prior to the hospitalization are reimbursed. This is the longest time period offered by any Health Insurance policy in India.

Hospitalization: You will be reimbursed expenses like room and board, doctors' fees, intensive care unit charges, nursing expenses, surgical fees, operating theatre expenses, anesthesia and oxygen administration expenses.

Post-Hospitalization: Once discharged from hospital, the policy shall pay for medical expenses related to the hospitalization, for a period of 90 days after discharge. This is something unmatched by any other Health Insurance policy in India.

Day Care Procedure: The policy covers over 141 minor surgeries that require less than 24 hours hospitalization under our Day Care Procedure. These surgeries ordinarily fall outside the scope of Health Insurance Policies available in the Indian market.

Local Ambulance Service: In the event of an emergency, cover is provided for expenses incurred on ambulance services to the nearest hospital where Emergency Health facilities are available.

Cholamandalam Health Insurance policy ensures comprehensive coverage by offering value added features, at a nominal increase in premium, like:

- **General Health and Eye Examination:** You will be reimbursed the expenses incurred for general health and eye examination.
- **Hospital Daily Allowance:** In addition to hospital expenses, a daily hospital allowance will be paid for the period of hospitalization.
- **Benefits under Section - 80D**(for both individual and family health policy) **& 80B**(only for individual health insurance policy).
- Premium upto Rs 15,000 eligible under section **80B**

Exclusions Diseases, which have been in existence at the time of proposing this insurance.

- Illness that commenced during the first 30 days of inception of the first policy.

- Cataracts, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Fistula in anus, Piles, Sinusitis and related disorders, in the first year of insurance. However, on renewal, these exclusions shall not apply.

THE NEW INDIA ASSURANCE CO. LTD – MEDICLAIM

This policy provides for cashless hospitalization in India for the treatment of any illness or disease or accidental injury (not specifically excluded) suffered during the policy period. The payment of claim is made through Third Party Administrators who have been empanelled by the Company to provide hassle free admission and discharge from the Network hospital without making any payment. The reimbursement of domiciliary hospitalization claims will also be made through the TPA.

For obtaining Mediclaim Policy the proposer has to fill up the proposal form and Insured Person details form and submit two latest stamp sized colored photograph of each family member to be insured.

A family package cover can be taken covering proposer, spouse, dependent parents and two dependent children with a 10% discount in premium.

Group policies can be issued to specified groups and group discount can be availed provided group size is more than 100 members.

Premium up to Rs.10,000/- paid by cheque for this policy is entitled for tax rebate under section 80D of the Income Tax Act. Scope of Cover:

This policy becomes operative when treatment is taken as an in-patient in a hospital / nursing home in India which satisfies the following criteria:

It should be an institution established for indoor care and treatment of sickness and injury and which either

A. Has been registered as a Hospital/Nursing Home with the local authorities and is under the supervision of a registered and qualified Medical Practitioner

B. Should comply with minimum criteria as under:

i. It should have at least 15 in-patient beds (10 beds in class'C' city)

ii. Fully equipped operation theatre of its own wherever surgical operations are carried out

iii. Fully qualified Nursing Staff under its employment round the clock

iv. Fully qualified Doctor should be in charge round the clock

The policy also reimburses through TPA relevant medical expenses incurred upto 30 days prior to and 60 days after hospitalization subject to the overall sum insured.

The policy provides for Domiciliary Hospitalization expenses when medical treatment is taken for a period exceeding 3 days for an illness/disease/injury (not specifically excluded) which normally would require treatment as an in-patient in a hospital/nursing home but is actually taken whilst confined at home in India under the following circumstances:

Either the condition of the patient is such that he/she cannot be removed to the hospital/nursing home OR the patient cannot be removed to the hospital/nursing home for lack of the accommodation therein.

The policy does not cover any disease / injury which the insured is suffering from, at the time of taking the first policy. Certain specified illnesses are also excluded during the first year of insurance. In individual mediclaim policy only, there is a provision for reimbursement of

expenses incurred for a medical check-up, subject to certain limits, once every 4yrs, provided the policy is renewed without break and no claim has been preferred during this period. This payment can be claimed from TPA after submission of bills.

Add-on Covers:

The policy can be extended to cover treatment taken in Nepal and /or Bhutan with prior permission from the insurance company. The group mediclaim policy can be extended, on payment of additional premium, to cover maternity benefit i.e. expenses incurred in delivery, provided the extension is taken for all the members covered in the group

Eligibility:

The policy can be taken by any person residing in India who is between 5 and 80 yrs of age. Children between the age of 3months and 5yrs can be covered provided one or both parents are covered concurrently

Sum Insured:

Various options are available ranging from Rs.15,000/- sum insured to Rs.5lacs sum insured. Since the annual premium is based on the age of the person covered and the sum insured selected, the selection of sum insured would depend upon the premium one could afford to pay. The sum insured represents the maximum amount that would be reimbursed for medical treatment for all illnesses suffered during the policy period of one year.

In individual mediclaim policy, a cumulative bonus of 5% is given on every claim free renewal whereby the sum insured is increased by 5% on renewal provided there has been no claim in the previous policy period. Maximum cumulative bonus permissible is 50% which would be given after 10 years claim free renewal. In the event of a claim, the increased percentage will be reduced by 10% subject to minimum of the basic sum insured selected.

Claim Procedure:

In case of a claim under the policy, the Insured person should contact the Third Party Administrator whose name and address has been mentioned in the policy. The reimbursement for treatment taken in Non-Network hospital is also made through TPA.

3.11.2. Group Health Insurance Policies

The different products considered under this category are:

1. ICICI Lombard - Group Mediclaim

2. Reliance general –group Health

The parameters used for evaluating these policies are:

1. Eligibility
2. "In patient treatment
3. (Imp If any)"
4. Pre Existing diseases
5. Out patient treatment
6. Pre hospitalization
7. Post hospitalization
8. Day care procedures
9. Maternity cover
10. Dental treatment cover
11. Critical illness
12. Health check up
13. Contact lens, Hearing Aid etc
14. Floater
15. Attendant charges
16. Other than allopathic cover
17. Organ transplantation coverage

18. Organ donor/transplantation

19. Investment option

20. Premium (aged up to 35 years for Rs 3 lac SI, option of RIDER on critical illness without service tax in INR)

ICICI LOMBARD – GROUP MEDICLAIM

Scope of Cover Policy covers reimbursement of hospitalization expenses incurred for diseases contracted or injuries sustained in India.

Pre – hospitalization: Medical expenses upto 30 days

Post – hospitalization: Medical expenses upto 60 days

Policy Details Sum Insured Minimum Rs. 15,000/- and Maximum Rs. 5,00,000

Premium Premium chargeable depends upon age of the person and the Sum Insured selected. Age limit is 5 to 80 years. Children above 3 months can be covered provided one or both parents are covered concurrently

Significant Exclusions Pre Existing Diseases, Diseases Contracted During first 30 Days, Cost Of Spectacles / Contact Lenses, Dental Treatment, AIDS, Pregnancy and certain specified diseases during first year of the policy.

Group Discount

Policy can be given to Corporate Body, Institution, Association and slab wise group discount is admissible on standard premium if the group size exceeds 100. Larger the group size higher is the discount. Favourable claims experience is recognized by discount and conversely, unfavourable claims experience attracts loading on renewal premium.

Main Extension Policy can be extended to cover maternity benefits on payment of additional premium.

3.11.3. Critical Illness Insurance Policies

Need for Critical Care –

- India is home to over 60 million coronary heart patients.
- India's economic loss due to heart related disease could be $236 billion till 2015.
- At any given time there will be 3 million cancer patients in India.

The various health products considered under this category are:

1. Bajaj Allianz Critical Illness
2. ICICI Lombard Critical Care Illness
3. Reliance Critical illness
4. IFFCO Tokio Critical Illness Policy
5. Star criticare plus.

The various parameters considered for evaluating these products are:

1. Eligibility
2. In patient treatment (Imp If any)
3. Pre Existing diseases
4. Pre hospitalization
5. Post hospitalization
6. Organ transplantation coverage
7. Organ donor/transplantation
8. Premium
9. Sum insured
10. Day care
11. Domiciliary
12. Non-allopathic.
13. Transportation.

BAJAJ ALLIANZ – CRITICAL ILLNESS

The purpose of of a critical illness plan is to let you put aside a small regular amount now, as an insurance against all this happening. The statistics speak for themselves and if you become a part of them at least you will be sure that lack of money won't add to The problems. Bajaj Allianz, in its efforts to provide a customer centric solution is offering an insurance policy to cover to some of these critical illnesses like

- Cancer
- Coronary Artery bypass surgery
- First Heart attack
- Kidney Failure
- Multiple sclerosis
- Major organ transplant
- Stroke
- Arota graft surgery
- Paralysis
- Primary Pulmonary Arterial Hypertension.

Unique Features

- Very competitive premium rates
- Insured can opt for Sum Assured from 1,00,000 to Rs. 50,00,000
- Premium paid is exempt under the Income Tax section 80 D
- The product is offered from 6 to 59 years
- Medical examination may be required in some cases based on the age and the benefit amount opted by the proposer.

Advantages

The benefit amount is payable once the disease is diagnosed meeting specific criteria and the insured survives 30 days after the diagnosis.
The insured receives the amount as lumpsum so that he can plan the treatment accordingly. Expenses like donor expenses in a transplant surgery, which are not covered under normal health insurance policy, can be paid out of the amount received under this cover both in India & abroad. Claims procedure : The insured needs to submit the claim from along with certificate from the specialist confirming occurrence of the critical illness

Benefits

- Easy availability of money to take care of the medical expenses.
- All related expenses for treatment is covered.
- Most in the family can be covered.
- Frees insured of mental anxiety / stress during difficult times
- Comprehensive coverage with nominal expense

ICICI LOMBARD – CRITICAL CARE ILLNESS

Critical Care protects against loss of income on diagnosis of any of the 9 major medical illnesses and procedures. The first of its kind, it offers a lump sum benefit on diagnosis of various major diseases. Policy Coverage

Critical Care offers you a choice of coverage on both the sum insured and the tenure of the policy. You can choose the sum insured of Rs 3, 6 or 12 Lakhs over a period of 1, 3 or 5 years. The premium would be calculated accordingly.

The Critical Care Insurance shall cover, subsequent to 90 days from the policy start date, the following major medical illnesses and procedures:

1. Cancer
2. Coronary Artery Bypass Graft Surgery
3. Myocardial Infarction (Heart Attack)
4. Kidney Failure (End Stage Renal Failure)
5. Major Organ Transplant
6. Stroke
7. Paralysis
8. Heart Valve Replacement Surgery
9. Multiple Sclerosis

Accidental Death Cover In case of death of the insured due to an accident within the policy period, the nominee (mentioned in the policy) is compensated with the Sum Insured (opted at the time of policy issuance

Permanent Total Disablement (PTD) Cover Critical Care insures against the permanent and total loss of limbs, sight etc., due to an accident. The compensation (Sum insured opted for) is given as a lump sum benefit. It is to be noted that the compensation is payable only if the disablement results in inability to remain gainfully employed.

Exclusions applicable to Critical Illness: 90 Days Exclusion: Any illnesses and procedures within 90 days from start date of policy will not be covered. This clause does not apply for subsequent renewal (without a break) of this policy with us.

Permanent Exclusion

The Company shall not be liable under this policy for:

- Any Pre-Existing illness Absence of submission of Doctor's medical certificate confirming the diagnosis of Illness or Injury or undergoing of medical/surgical procedure
- Any congenital Illness or condition

- Any medical procedure or treatment, which is not medically necessary or not performed by a Doctor
- Any physical, medical or mental condition, illness, injury or treatment or service which is specifically excluded under the Policy
- Treatment relating to birth defects and external congenital Illnesses
- Birth control procedures and hormone replacement therapy
- Any treatment/ surgery for change of sex or any cosmetic surgery or treatment
- Treatment by family member and self-medication or any treatment that is not scientifically recognized

Exclusions applicable to Personal Accident: The Company shall not be liable under this policy for:

Compensation/claim under more than one of the categories specified in the Policy Coverage in respect of the same period of disablement of the Insured Person

Claims arising out of sickness/illness

Death, injury or disablement of Insured Person

a) From intentional self-injury, suicide or attempted suicide
b) Whilst under the influence of intoxicating liquor or drugs
c) Directly or indirectly caused by venereal disease or AIDS
d) Directly or indirectly caused by contributed to or aggravated or prolonged by childbirth or pregnancy or in consequence thereof.
e) Engagement in dangerous activities
f) Mounting into, dismounting from or traveling in any aircraft other than as a fare paying passenger on a scheduled flight
g) Mental disorder or psychosomatic dysfunction Permanent Total Disablement prior to commencement of the policy

Key Benefits

- **Comprehensive Cover** - Lump sum benefit on diagnosis of any of 9 Critical Illnesses, Personal Accident and Permanent Total Disablement (PTD) Cover
- **Choice of coverage** - Choose between Rs. 3, 6 or Rs. 12 Lakh sum insured and a policy duration of 1, 3 or 5 years
- Avail tax benefit under section 80D of Income Tax Act.
- No health check-up required.
- No 30 day survival period, benefit paid immediately on diagnosis

IFFCO – TOKIO – CRITICAL ILLNESS POLICY

Benefit :

Policy covers the following heads of expenses, which are normally incurred in the event of a critical illness treatment:

- Room rent and boarding expenses.
- Nursing expenses.
- Surgeon, anesthetist and medical practitioner/consultant's fees.

Cost of anesthesia, blood, oxygen, operation theatre, surgical appliances, medicines & drugs, diagnostic materials and X-ray, dialysis, chemotherapy, radiotherapy, pacemaker, artificial limbs etc. and similar expenses

Exclusions under the Policy are as follows:

- Treatment pertaining to pre-existing diseases.
- Any medical treatment due to a disease during the first 120 days of commencement of insurance cover.

- Any expense for treatment related to Human T-Cell Lymphotropic Viruses Type II (HTLV-III) or Lymphadinopathy Associated Viruses (LAV) or their mutant derivatives or variations, any syndrome or condition of a similar kind referred to as AIDS
- Treatment for ailments arising out of drug addiction or alcoholism.
- Any attempted self injury or suicide.
- War, nuclear and terrorism risks.

Eligibility:

- Employers covering their employees including dependants of the employees.
- Pre-identified segment/group where the premium is paid by the State/Central Government.
- Members of registered service clubs.
- Holders of credit cards or other financial cards.
- Holders of deposit or certificate of Banks/NBFCs.
- Shareholders of public limited companies, cooperative societies etc.
- Students/teachers of educational institutions.
- Members of any other group having common identification or interest.

Right to revise charges

The Corporation reserves the right to revise all or any of the above charges (subject to a maximum limit) except the Premium Allocation charge. The modification in charges will be done with prospective effect with the prior approval of IRDA.

CHAPTER-IV
ANALYSIS AND INTERPRETATION

CHAPTER-IV ANALYSIS AND INTERPRETATION

4.1.1 Analysis:

The analysis starts with segregating the parameters from the wordings of each and every individual, family retail health insurance policies and group health insurance policies and critical illness policies. A table was prepared by taking different insurance policies as columns and 21 parameters as rows. A right symbol was given if the policy covers a specified parameter and a cross symbol was given if the policy doesn‘t cover the parameter, like that the table was completed with right and cross symbols.

Similarly another two tables one for Group health insurance policy and one for critical illness policies were prepared. Ranking method was used for the analysis. In ranking method first the descriptive parameters like eligibility, premium and sum insured were eliminated. For the rest of the parameters a value =1‘was given for a right symbol and a value =0‘ given for the cross symbol. This would be helpful in finding how many parameters covered in each and every policy. In this way a score matrix was prepared.

The table shown below (Table-1) gives an illustrative explanation of different parameters covered in different kind of individual and family health insurance policies. After getting the scores a table of Parameters coverage in retail individual and family health insurance policies was prepared (Table-4). By using the data in table-4 a histogram was drawn with the help of Microsoft office excel tool. Similarly table-6 was prepared for Parameters coverage for critical illness policies. Another table was prepared for evaluation of policies based on number of parameters they cover.

Table-1 :Parameter vise comparison of retail policies

S.NO	PARAMETER	NAME OF THE RETAIL POLICY			
		APOLLO MUNICH – EASY HEALTH INDIVIDUAL PLAN	APOLLO MUNICH – PREMIA PLAN	APOLLO DKV –FAMILY PREMIA PLAN	ROYAL SUNDARAM-HEALTH SHIELD
1	Eligibility	91DAYS-60 Y	91d-60 y	91d-60 y	90d-60y(r-70y)
2	In patient treatment	✓	✓	✓	✓
3	Pre Existing diseases	✗	✗	✗	✓ (w.p-5y)
4	Out patient treatment	✗	✗	✗	✗
5	Pre hospitalisation	✓	✓	✓	✓
6	Post hospitalisation	✓	✓	✓	✓
7	Day care procedures	✓	✓	✓	✓
8	Domicilliary coverage	✓	✓	✓	✗
9	Maternity cover	✗	✓ (w.p-6y)	✓ (w.p-4y)	✗
10	Dental treatment cover	✗	✓ (w.p-3y)	✓ (w.p-3y)	✗
11	Critical illness	✗	✓	✓	✗
12	Health check up	✓	✓	✓	✓ (5-c.f.y)
13	Contact lens,Hearing Aid etc	✗	✓ (w.p-3y)	✓ (w.p-3y)	✗
14	Floater	✗	✓	✓	✗
15	Attendent charges	✗	✗	✗	✗
16	Other than allopathic cover	✗	✗	✗	✗
17	Emergency Ambulance cover	✓	✓	✓	✓
18	Organ transplantation	✓	✓	✓	✗
19	Cosmetic treatmentcover	✗	✗	✗	✗
20	Premium(rs)	2500-6500	6618-17869	15000-35000	na
21	sum insured	1,00,000	1-4 lacs	1-4 lacs	na

S.NO	PARAMETER	NAME OF THE RETAIL POLICY			
		IFFCO-TOKIO INDIVIDUAL MEDISHIELD	IFFCO-TOKIO SWASTHYA KAVACH FAMILY	TATA-AIG WELLSURANCE	MAX-BUPA INDIVIDUAL
1	Eligibility	5-55 y(r-70y)	91d-60y	6m-65y	no age limit
2	In patient treatment	✓	✓	✓	✓
3	Pre Existing diseases	✗	✗	✗	✓ (w.p-2y)
4	Out patient treatment	✗	✗	✗	✗
5	Pre hospitalisation	✓	✓	✓	✓
6	Post hospitalisation	✓	✓	✓	✓
7	Day care procedures	✓	✓	✓	✓
8	Domicilliary coverage	✗	✗	✗	✓
9	Maternity cover	✗	✗	✗	✓
10	Dental treatment cover	✗	✗	✗	✗
11	Critical illness	✓	✓	✓	✗
12	Health check up	✓ (5-c.f.y)	✓ (4c.f.y)	✗	✓
13	Contact lens,Hearing Aid etc	✗	✗	✗	✗
14	Floater	✓	✓	✓	✗
15	Attendent charges	✓	✓	✗	✗
16	Other than allopathic cover	✗	✗	✗	✗
17	Emergency Ambulance cover	✓	✓	✓	✓
18	Organ transplantation coverrage	✗	✗	✗	✓
19	Cosmetic treatmentcover	✗	✗	✗	✗
20	Premium(rs)	1716-34384	3150-41751	na	na
21	sum insured	1-5 lacs	2-5 lacs	2-5 lacs	2-3 lacs

S.NO	PARAMETER	NAME OF THE RETAIL POLICY			
		MAX-BUPA HEART BEAT FAMILY	BHARATI-AXA SMART HEALTH	NEW INDIA MEDICLAIM	ORIENTAL FAMILY FLOATER
1	Eligibility	no age limit	5-65y(r-75)	90d-60y	90d-60y
2	In patient treatment	✓	✓	✓	✓
3	Pre Existing diseases	✓ (w.p-2y)	✓ (w.p-4y)	✓ (w.p-4y)	✓ (w.p-4y)
4	Out patient treatment	✓	✓ (accidents only)	✗	✗
5	Pre hospitalisation	✓	✓	✓	✓
6	Post hospitalisation	✓	✓	✓	✓
7	Day care procedures	✓	✓	✓	✓
8	Domicilliary coverage	✓	✓	✗	✓
9	Maternity cover	✓	✗	✗	✗
10	Dental treatment cover	✗	✗	✗	✗
11	Critical illness	✗	✓	✗	✓
12	Health check up	✓	✓	✓	✗
13	Contact lens,Hearing Aid etc	✗	✗	✗	✗
14	Floater	✗	✓	✗	✓
15	Attendent charges	✗	✓	✗	✗
16	Other than allopathic cover	✗	✗	✓ (25% of s.i)	✗
17	Emergency Ambulance cover	✓	✓	✓	✓
18	Organ transplantation coverrage	✓	✓	✗	✓
19	Cosmetic treatmentcover	✗	✗	✗	✗
20	Premium(rs)	na	na	1450-20361	7140-23640
21	sum insured	2-50 lacs	50000-5lacs	1-50 lacs	1-10 lacs

S.NO	PARAMETER	NAME OF THE RETAIL POLICY			
		UNITED INDIA FAMILY MEDICARE	ICICI LOMBARD-FAMILY FLOATER	ICICI LOMBARD-HEALTH ADVANTAGE PLUS	STAR-UNIQUE INDIVIDUAL
1	Eligibility	90d-80y	5-60y	5-65y(r-70y)	18-65y(r-70y)
2	In patient treatment	✓	✓	✓	✓
3	Pre Existing diseases	✓ (w.p-4y)	✓ (w.p-4y)	✓ (w.p-2y)	✓ (w.p-11m)
4	Out patient treatment	✗	✗	✓	✗
5	Pre hospitalisation	✓	✓	✓	✓
6	Post hospitalisation	✓	✓	✓	✓
7	Day care procedures	✓	✓	✓	✓
8	Domicilliary coverage	✓	✗	✓	✗
9	Maternity cover	✗	✗	✓	✗
10	Dental treatment cover	✗	✗	✗	✗
11	Critical illness	✗	✗	✗	✗
12	Health check up	✓ (3c.f.y)	✓	✓	✗
13	Contact lens,Hearing Aid etc	✗	✗	✗	✗
14	Floater	✗	✓	✓	✗
15	Attendent charges	✗	✗	✗	✗
16	Other than allopathic cover	✗	✗	✗	✓
17	Emergency Ambulance cover	✓	✓	✓	✓
18	Organ transplantation coverrage	✗	✗	✗	✗
19	Cosmetic treatmentcover	✗	✗	✗	✗
20	Premium(rs)	na	10940-22060	15000-20000	5880-26450
21	sum insured	1-10 lacs	1-4 lacs	1-3 lacs	1-3 lacs

S.NO	PARAMETER	NAME OF THE RETAIL POLICY				
		STAR-FAMILY HEALTH OPTIMA	BAJAJ ALLIANZ-INDIVIDUAL HEALTH GUARD	BAJAJ ALLIANZ-FAMILY HEALTH GUARD	RELIANCE-HEALTH WISE POLICY	RELIANCE-MEDICLAIM POLICY
1	Eligibility	5m-60y	90d-55y(70y)	18-65y(r-80y0	90d-65y	5-80y
2	In patient treatment	✓	✓	✓	✓	✓
3	Pre Existing diseases	✓ (w.p-2y)	✓ (w.p-4y)	✓ (w.p-4y)	✓ (w.p-4y)	✓ (w.p-4y)
4	Out patient treatment	✗	✗	✗	✗	✗
5	Pre hospitalisation	✓	✓	✓	✓	✓
6	Post hospitalisation	✓	✓	✓	✓	✓
7	Day care procedures	✓	✓	✓	✓	✓
8	Domicilliary coverage	✗	✗	✗	✓	✓
9	Maternity cover	✓	✗	✗	✗	✗
10	Dental treatment cover	✗	✗	✗	✗	✗
11	Critical illness	✗	✗	✗	✗	✗
12	Health check up	✗	✗	✗	✗	✗
13	Contact lens,Hearing Aid	✗	✗	✗	✗	✗
14	Floater	✗	✗	✗	✓	✗
15	Attendent charges	✗	✗	✗	✓	✗
16	Other than allopathic cover	✗	✗	✗	✗	✗
17	Emergency Ambulance cover	✓	✓	✓	✓	✗
18	Organ transplantation	✗	✗	✗	✓	✓
19	Cosmetic treatmentcover	✗	✗	✗	✗	✗
20	Premium(rs)	5920-18105	1400-23708	5244-51403	3353	na
21	sum insured	1-5 lacs	1-5 lacs	1-5 lacs	1-2 lacs	na

Table-2 :Parameter vise comparison of Group insurance policies

S.NO	PARAMETER	GROUP INSURANCE POLICY NAME	
		ICICI-LOMBARD GROUP	RELIANCE-GENERAL
1	Eligibility	NO LIMIT	1D-80Y
2	In patient treatment	✓	✓
3	Pre Existing diseases	✓	✓
4	Out patient treatment	✗	✗
5	Pre hospitalisation	✓	✓
6	Post hospitalisation	✓	✓
7	Day care procedures	✓	✓
8	Domicilliary coverage	✓	✓
9	Maternity cover	✓	✓
10	Dental treatment cover	✗	✗
11	Critical illness	✓	✓
12	Health check up	✓	✗
13	Contact lens,Hearing Aid etc	✗	✗
14	Floater	✓	✓
15	Attendent charges	✗	✗
16	Other than allopathic cover	✗	✗
17	Emergency Ambulance cover	✓	✓
18	Organ transplantation coverrage	✗	✗
19	Cosmetic treatmentcover	✗	✗
20	Premium(rs)	50000-10M	NA
21	sum insured	50000-5 LAC	NA

Table-3 :Parameter vise comparison of Critical illness insurance policies

S.NO	PARAMETER	CRITICAL ILLNESS INSURANCE POLICY NAME				
		STAR-CRITICARE PLUS	ICICI-LOMBARD-CRITICAL CARE	RELIANCE-CRITICAL ILLNESS	BAJAJ-ALLIANZ-CRITICAL	IFFCO-TOKIO CRITICAL ILLNESS
1	Eligibility	18-65(R-70Y)	20-45Y(R-50Y)	20-50Y(R-55Y)	6-59Y	5-70Y
2	In patient treatment	✓	✓	✓	✓	✓
3	Pre Existing diseases	✓ (w.p-2y)	✓ (w.p-2y)	✗	✗	✗
4	Out patient treatment	✗	✗	✗	✗	✗
5	Pre hospitalisation	✗	✗	✗	✗	✗
6	Post hospitalisation	✗	✗	✗	✗	✗
7	Day care procedures	✗	✗	✗	✗	✗
8	Domicilliary coverage	✗	✗	✗	✗	✗
9	Other than allopathic cover	✗	✗	✗	✗	✗
10	Organ transplantation	✓	✓	✓	✓	✓
11	Emergency Ambulance cover	✓	✗	✗	✗	✓
12	Premium(rs)	4136-38991	900-75079	NA	200-30,000	2231-34384
13	sum insured	2-10 LACS	3-12 LACS	5-20 LACS	1-50 LACS	1-5 LACS

4.1.2 Test of Hypothesis (Sign Test):

This test is applicable under the following conditions.

1. The sample is done from a continuous symmetrical population.

2. The probability of getting a sample value less than mean is same as that of more than mean, which is equal to ½.

3. To test the null hypothesis, H0:μ = μ0 against an appropriate. Alternative on the basis of a random sampling, we replace the values of the sample with a "-"sign if μ is greater than the sample value and with "+" sign if μ is less than the sample value. If μ and sample value are equal then we replace the observation with 0. After changing the observed data as per the rules mentioned above, we count the following.

Number of _+' signs = m1

Number of _-_ signs= m2

Number of _0's= m3 (ignore)

In this project a nonparametric test was used to test the hypothesis i.e Sign Test. There are total 21 policies and their percentage of cover of parameters was as shown in the Table-4. Now we test the hypothesis that —Each and every retail health insurance policy covers at least 2/3(12 or 66.66%) of parameters out of 18 parameter.

Null Hypothesis (H0)= Each and every retail health insurance policy covers at least 2/3(12 or 66.66%) of parameters out of 18 parameters

Alternative hypothesis (H0) = Each and every retail health insurance policy may not cover covers at least 2/3(12 or 66.66%) of parameters out of 18 parameters

COUNT:

Number of “+” signs = 3

Number of “-“signs= 18

Number of “0” = 0 (ignore)

We have only 3 positive signs in 21 policies,

Since we get only 3 positive signs so Null hypothesis rejected.

Hence Alternative Hypothesis was accepted.

Table .4 Test of Hypothesis (Sign test)

S.NO	POLICY NAME	SCORE	PERCENTAGE	X-Xa	SIGNS
1	APOLLO DKV PREMI PLAN	13	72.2	5.562222	+
2	APOLLO DKV-FAMILY PREMIA PLAN	13	72.2	5.562222	+
3	BHARTI AXA SMART HEALTH	13	72.2	5.562222	+
4	ICICI LOMBARD-HEALTH ADVANTAGE PLUS	11	61.1	-5.54889	-
5	MAX BUPA HEALTH BEAT FAMILY	11	61.1	-5.54889	-
6	MAX BUPA INDIVIDUAL	10	55.6	-11.1044	-
7	ORIENTAL FAMILY FLOATER	10	55.6	-11.1044	-
8	RELIANCE HEALTH WISE POLICY	10	55.6	-11.1044	-
9	IFFCO TOKIO INDIVIDUALMEDISHIELD	9	50	-16.66	-
10	IFFCO TOKIO SWASTHYA KAVACH FAMILY	9	50	-16.66	-
11	APOLLO DKV- EASY HEALTH INDIVIDUAL PLAN	8	44.4	-22.2156	-
12	NEW INDIA MEDICLAIM	8	44.4	-22.2156	-
13	UNITED INDIA FAMILY MEDICARE	8	44.4	-22.2156	-
14	ICICI LOMBARD-FAMILY FLOATER	8	44.4	-22.2156	-
15	ROYAL SUNDARAM-HEALTH SHIELD	7	38.9	-27.7711	-
16	TATA AIG WELL INSURANCE	7	38.9	-27.7711	-
17	STAR UNIQUE INDIVIDUAL	7	38.9	-27.7711	-
18	STAR FAMILY HEALTH OPTIMA	7	38.9	-27.7711	-
19	RELIANCE-MEDICLAIM POLICY	7	38.9	-27.7711	-
20	BAJAJ ALLIANZ-INDIVIDUAL HEALTH GUARD	6	33.3	-33.3267	-
21	BAJAJ ALLIANZ-FAMILY HEALTH GUARD	6	33.3	-33.3267	-

4.2 Interpretation :

4.2.1 Group Health Insurance Policies:

1. Only two group insurance policies wordings are available they are:

i) ICIC- Lombard group Insurance.

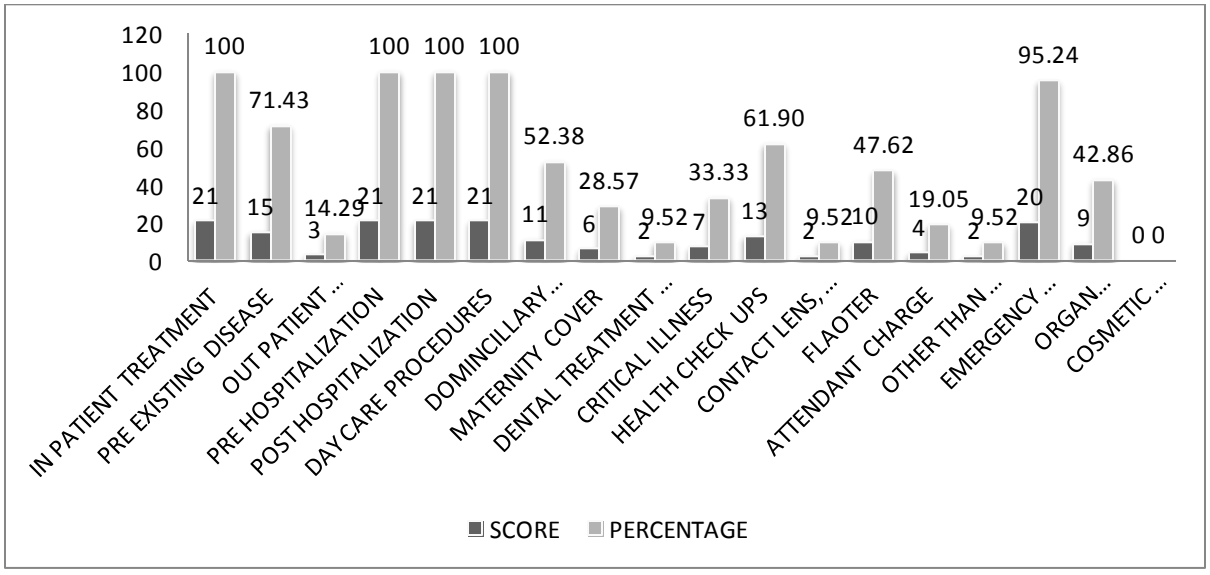
ii) Reliance General- Group Insurance.

2. The group insurance policies generally don‘t cover outpatient treatment, dental treatment, peripheral charges, attendant charges, and other than allopathic treatments and organ transplantation.

Table 5 Parameter coverage

S.NO	PARAMETER	SCORE	PERCENTAGE
1	IN PATIENT TREATMENT	21	100
2	PRE EXISTING DISEASE	15	71.43
3	OUT PATIENT TREATMENT	3	14.29
4	PRE HOSPITALIZATION	21	100
5	POST HOSPITALIZATION	21	100
6	DAY CARE PROCEDURES	21	100
7	DOMINCILLARY COVERAGE	11	52.38
8	MATERNITY COVER	6	28.57
9	DENTAL TREATMENT COVER	2	9.52
10	CRITICAL ILLNESS	7	33.33
11	HEALTH CHECK UPS	13	61.90
12	CONTACT LENS, HEARNING ALD	2	9.52
13	FLAOTER	10	47.62
14	ATTENDANT CHARGE	4	19.05
15	OTHER THAN ALLOPATIC COVER	2	9.52
16	EMERGENCY AMBULANCE COVER	20	95.24
17	ORGAN TRANPLANTATION COVERAGE	9	42.86
18	COSMETIC TREATRMENT COVER	0	0

Figure 3 Parameter coverage diagram of retail policies



4.2.2 Retail and Group Insurance Policies:

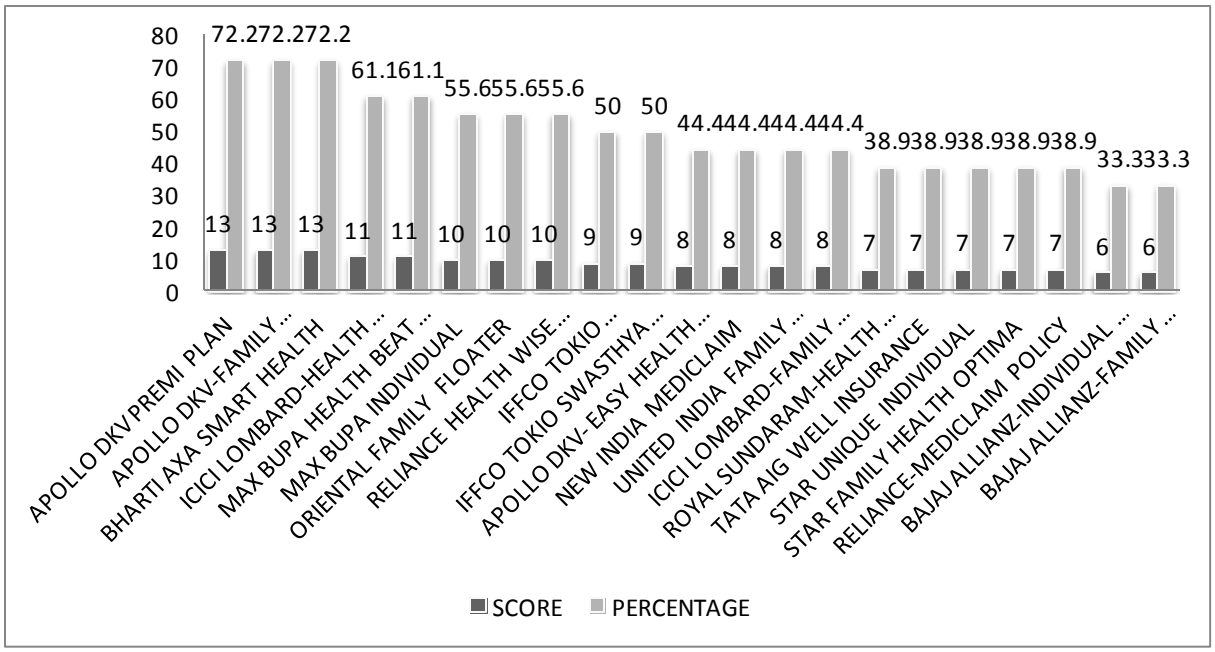
1. The general eligibility for buying a policy is varying from 91 days to 70 years and reviewed up to 75 years. Some policies don‘t have any age restrictions to buy.
2. In-Patient treatment covered in each and every policy.
3. Pre-Existing diseases covered in 15 retail policies out of e21 policies on condition that continuous renewal with the same company for 2-5 years.
4. OPD covered in only 3 policies that to for a limited amount and limited number of visits.
5. Pre and Post hospitalization and day care procedures like cataract, dialysis are covered in all policies.
6. Domiciliary treatment (treatment provided at home) is covered in 11 policies (out of 21) and there is sublimit for that service.
7. Maternity charges are covered in very less policies (5 policies out of 21 policies). On a condition that continuous renewal with the same company for 4-6 years with a sublimit.
8. Dental treatment covered in only two policies that are provided by Apollo Munich.
9. Critical illness (Diseases like cancer, organ transplantation, end stage renal failure) covered in 7 policies out of 21 policies. The premium for these policies will be bit high compared to other policies which are not covering critical illness.
10. Free health check up services is provided in 13 policies (on condition that there should be 4 claim free years). Health advantage plus is a policy provided by ICICI Lombard which gives free health check up coupons on every renewal of the policy with the company.
11. Provision for peripherals (like spectacles, contact lens, hearing aids etc) covered in only two policies (both provided by Apollo Munich). On condition that they will be covered from fourth year.
12. Floater parameter covered in 10 retail individual and family health insurance policies out of 21 policies.
13. Some policies cover even attendant charges. There are 4 policies available in the market which covers attendant charges.

14. Generally the health insurance policies do not cover other than allopathic treatments. Recently few policies were introduced (New India Insurance and Star Unique Health) which can cover other than allopathic treatment except naturopathy up to 25 % of sum insured.
15. Emergency ambulance charges were covered in all policies except Medi-claim policy provided by Reliance.
16. Organ Transplantation and donor charges are pretty expensive treatment and it is covered in only 9 policies.
17. Cosmetic treatment was not covered in any Retail Policy.
18. The sum insured for retail policies are in the range of ` 50,000- ` 10, 00,000.
19. The premium for retail health insurance policies are in the range of ` 1000- ` 51,403 which cover an individual to a family of 6 members for 1 year- 5 years.
20. In case of group health insurance policies the wordings of the policy changes as per the requirements of the company/Industry (which is opting that group insurance policies for their employee.)

Table 6 Retail policies evaluation table

S.NO	POLICY NAME	SCORE	PERCENTAGE	RANK
1	APOLLO DKV PREMI PLAN	13	72.2	1
2	APOLLO DKV-FAMILY PREMIA PLAN	13	72.2	1
3	BHARTI AXA SMART HEALTH	13	72.2	1
4	ICICI LOMBARD-HEALTH ADVANTAGE PLUS	11	61.1	2
5	MAX BUPA HEALTH BEAT FAMILY	11	61.1	2
6	MAX BUPA INDIVIDUAL	10	55.6	3
7	ORIENTAL FAMILY FLOATER	10	55.6	3
8	RELIANCE HEALTH WISE POLICY	10	55.6	3
9	IFFCO TOKIO INDIVIDUALMEDISHIELD	9	50	4
10	IFFCO TOKIO SWASTHYA KAVACH FAMILY	9	50	4
11	APOLLO DKV- EASY HEALTH INDIVIDUAL PLAN	8	44.4	5
12	NEW INDIA MEDICLAIM	8	44.4	5
13	UNITED INDIA FAMILY MEDICARE	8	44.4	5
14	ICICI LOMBARD-FAMILY FLOATER	8	44.4	5
15	ROYAL SUNDARAM-HEALTH SHIELD	7	38.9	6
16	TATA AIG WELL INSURANCE	7	38.9	6
17	STAR UNIQUE INDIVIDUAL	7	38.9	6
18	STAR FAMILY HEALTH OPTIMA	7	38.9	6
19	RELIANCE-MEDICLAIM POLICY	7	38.9	6
20	BAJAJ ALLIANZ-INDIVIDUAL HEALTH GUARD	6	33.3	7
21	BAJAJ ALLIANZ-FAMILY HEALTH GUARD	6	33.3	7

Figure 4 Retail policies evaluation diagram



4.2.3 Interpretation of Retail policies evaluation table and diagram :

1) Apollo munich – Premia Plan, Apollo munich –Family Premia Plan And Bharati-Axa Smart Health These three policies stood in first rank by covering 13 parameters out of 18.

2) ICICI lombard-health advantage plus and max-bupa heart beat family stood in second position by covering 11 parameters out of 18.

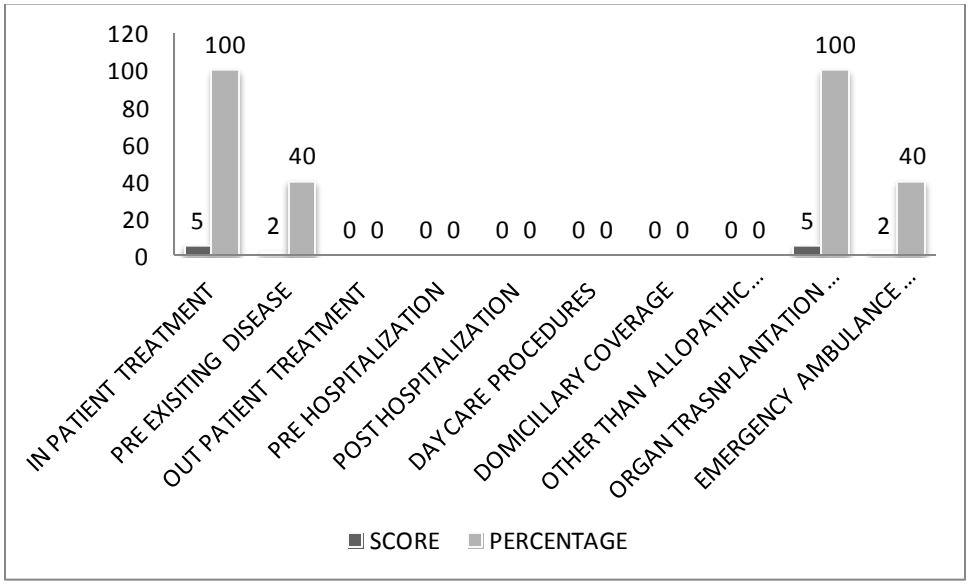
3) Max-bupa individual, oriental family floater and Reliance-health wise policy stood in 3rd position by covering 10 parameters out of 18.

4) Bajaj allianz-individual health guard and Bajaj allianz-family health guard stood in last position by covering only 6 parameters out of 18.

Table 7 parameter coverage for critical illness policy

S.NO	PARAMETER	SCORE	PERCENTAGE
1	IN PATIENT TREATMENT	5	100
2	PRE EXISITING DISEASE	2	40
3	OUT PATIENT TREATMENT	0	0
4	PRE HOSPITALIZATION	0	0
5	POST HOSPITALIZATION	0	0
6	DAY CARE PROCEDURES	0	0
7	DOMICILLARY COVERAGE	0	0
8	OTHER THAN ALLOPATHIC COVER	0	0
9	ORGAN TRASNPLANTATION COVERAGE	5	100
10	EMERGENCY AMBULANCE COVER	2	40

Figure 5 Parameter coverage for critical illness policy diagram



4.2.4 Critical Illness Insurance Policy:

1. The eligibility age to have critical illness policy is 5 to 70 years.

2. Pre existing diseases covered in two policies (Star Critical Plus and ICICI- Lombard Critical Care) after continuous renewal of two years.

3. Critical illness policies generally don‘t cover outpatient treatment, pre-hospitalization, post hospitalization and day care procedure, other than allopathic cover.

4. Organ transplantation and donor charges covered in each and every critical illness policy.

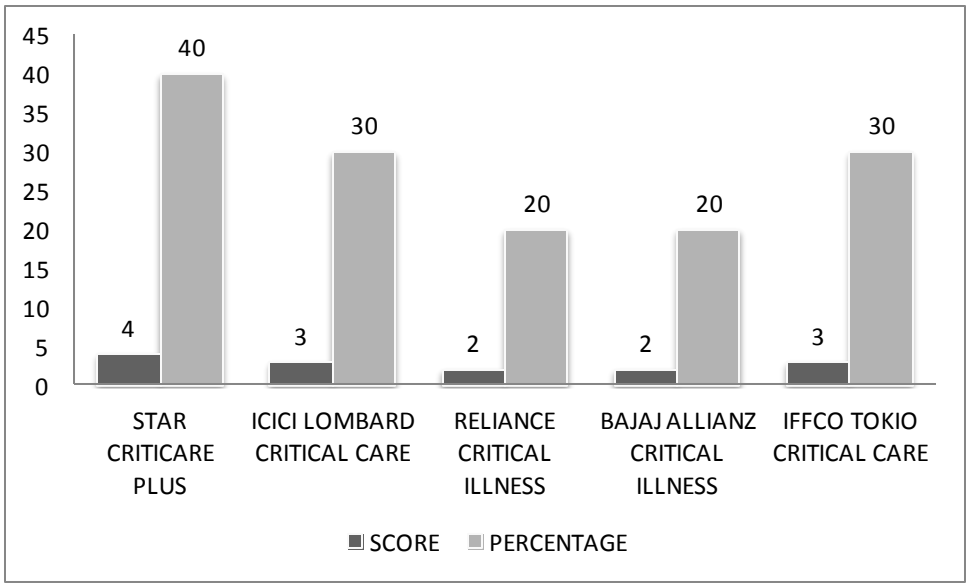
5. The sum insured for critical illness policy varies from 1 lakhs to 50 lakhs.

6. The premium for critical illness policy increases proportionately to the entry age of policy holder and it varies from ` 200/- to ` 75, 079/-.

Table 8 Critical illness policies evaluation table

S.NO	POLICY NAME	SCORE	PERCENTAGE	RANK
1	STAR CRITICARE PLUS	4	40	1
2	ICICI LOMBARD CRITICAL CARE	3	30	2
3	RELIANCE CRITICAL ILLNESS	2	20	3
4	BAJAJ ALLIANZ CRITICAL ILLNESS	2	20	3
5	IFFCO TOKIO CRITICAL CARE	3	30	2

Figure 6 critical illness policies evaluation chart



4.2.5 Interpretation of Critical illness policies evaluation table and diagram :

1) Star-Criticare Plus policy stood in first position by covering 4 parameters out of 10.

2) ICICI-Lombard critical care and Iffco-Tokio critical illness policies stood in second position by covering 3 parameters out of 10.

3) Reliance-Critical illness and Bajaj Allianz critical illness both share the third position by covering only 2 parameters out of 10.

CHAPTER-V

FINDINGS AND SUGGESTIONS

CHAPTER-V FINDINGS AND SUGGESTIONS

5.1 Facts and Findings

1) The General Insurance Companies offering cumulative bonus and discount on continuous renewal of the policy with them.

2) Some General Insurance companies had money back facility for long term policies (more than 3 years) if the insured want to drop the existing policy he holds.

3) Earlier the maternity expenses were not covered in any policy but recently some policies (Apollo, Star and ICICI Lombard) initiated the covering of maternity expenses too after continuous renewal of the policy for few years.

4) As the disease burden of lifestyle diseases like Diabetes, Cardio Vascular and Hypertension increasing predominantly day by day, the general insurance companies now concentrating on covering pre-existing diseases too in their policies. But this facility will be available only after continuous renewal of the policy with the company (i.e. 11 months to 4 years).

5) There are lots of factors considered while designing a policy and premium. They are

a) The targeted number of customer.

b) Age group of the customers .

c) Parameters to be covered etc.

6) There is a special type of insurance called reinsurance. It means insuring the insurance policies.

Eg: A Company wants to introduce a policy. And it has calculated certain premium. And only few customers had bought it and most of them utilized the policy. Ultimately the payments will be more than the premium collected. In this scenario reinsurance will bare the additional losses incurred by the policy.

7) Out Patient treatment covered in very less number of policies that to for a certain times and up to a limited amount.

8) Cosmetic treatment was not covered in any policy. The reason may be pretty expensive. And a human can be healthy and survive without that treatment.

9) Critical illness policies are specially designed to cover the expenses emerged out of critical illness treatments like cancer.
10) The dental treatment expenses covered in only two policies that are provided by Apollo Munich and rest of the policies only cover in special cases that require surgery due to accidents.

5.2 Suggestions:

1) Customers who are allergic to allopathic treatment they can go for New India Medi-Claim or Star Unique individual because these policies cover all allopathic and other than allopathic treatments except naturopathy.

2) The Insurance companies should modify the policy terms and conditions as per increment in their customer domain, so that it can reach customer expectations.

3) Policy wordings should be explained clearly before selling a policy or customers should read each and every policy terms and conditions before buying it to avoid unnecessary disappointments at the time of real need.

4) The General Insurance companies should focus on misuse of advantages provided by the policy by network hospitals and customer. A special system should be designed to take care of fraud claims.

5) The policies don‘t pay for some non-payables, which are standard exclusions like registration charges, RMO charges, baby soap and nappy pads etc. A customer should be award of all these things before buying of the policy.

CHAPTER-VI

CONCLUSION

CHAPTER-VI CONCLUSION

1)Apollo munich – Premia Plan, Apollo munich –Family Premia Plan And Bharati-Axa Smart Health These three policies stood in first rank by covering 13 parameters out of 18.

2)ICICI lombard-health advantage plus and max-bupa heart beat family stood in second position by covering 11 parameters out of 18.

3)Max-bupa individual, oriental family floater and Reliance-health wise policy stood in 3rd position by covering 10 parameters out of 18.

4)Bajaj allianz-individual health guard and Bajaj allianz-family health guard stood in last position by covering only 6 parameters out of 18.

5) Star-Criticare Plus policy stood in first position by covering 4 parameters out of 10.

6) ICICI-Lombard critical care and Iffco-Tokio critical illness policies stood in second position by covering 3 parameters out of 10.

7) Reliance-Critical illness and Bajaj Allianz critical illness both share the third position by covering only 2 parameters out of 10.

8) After testing the hypothesis by using Sign Test we come to know that ―Each and every retail health insurance policy may not cover covers at least 2/3(12 or 66.66%) of parameters out of 18 parameters.

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