CARE HEALTH INSURANCE LIMITED

ANTI-FRAUD POLICY

(CHIL/POL/135/001)

Prepared by:	Reviewed by:	Approved by:
Corporate Manager - Fraud Control Unit	Head- Claims and Underwriting	Board of Directors
Signature:	Signature:	Signature:

1.0 Policy:

CHIL and its affiliates are dedicated to conduct business in an ethical and legal manner. The CHIL Anti - fraud policy is designed towards prevention, detection and reporting of fraud and abuse of the Health insurance system. The CHIL fraud Policy mandates that all employees and contracted members of CHIL comply with applicable CHIL standards.

2.0 Policy Purpose:

The purpose of this policy is intended to affirm that CHIL seeks to prevent healthcare fraud and abuse. And to inform CHIL employees, agents, contractors and network members regarding existing CHIL policies and procedures to prevent fraud and abuse in the healthcare insurance contracts.

The purpose of the policy is to create a climate for the prevention and detection of irregularities, control breakdown and unethical activities.

Outline the key roles and responsibilities in respect of control and implementation, identification, investigation and reporting of these irregularities.

The policy shall be read in conjunction with Guidelines on Outsourcing Activities of Insurance

Companies issued by IRDA in February 2011 and other relevant Company Policies.

3.0 Scope:

The policy applies to all stakeholders transacting with CHIL, directly or indirectly with Care Health Insurance Limited including but not limited to employees and ex-employees, contractual Manpower, intermediaries, providers including but not limited to health care providers, diagnostic centers, third party Administrators, suppliers, contractors and CHIL Customers. Scope of the policy will cover all situations where CHIL and its members could actually suffer a loss, be it financial, reputation or to any other factor.

Under the CHIL Anti - Fraud Policy, a fraud is committed when a person:

a. Having actual knowledge of wrongful act and / or Acting in deliberate ignorance of the truth or falsity of information.
b. Mis-represents, Falsify, distorts, conceals, suppresses, and / or alters any material fact, information, or unauthorized alteration of any document or account belonging to the Company.
c. Misappropriation of funds, securities, supplies or other assets by fraudulent means for etc. for financial gain of self or others.
d. Willful suppression of facts / deception in matters of appointment and placements of employees, contractors, providers, suppliers, consultants, TPA etc.

e. Disclosing / sending confidential and proprietary information to third party without permission.
f. Mis-utilization of company funds and assets.
g. Destruction, disposition, removal of records or any other assets of the Company with an ulterior motive to manipulate and misrepresent the facts so as to create suspicion / suppression cheating as a result of which objective assessment/decision would not be arrived at.
h. Knowingly presenting a false and fraudulent claim for payment and approval.
i. Any other act that exposes the company to Financial or Reputational Risk

4.0 Definition

Claim: A formal request to an insurance company asking for a payment based on the terms of the insurance policy. Insurance claims are reviewed by the company for their validity and then paid out to the insured or requesting party (on behalf of the insured) once approved.

Corruption: Dishonest or fraudulent conduct by those in power, including but not limited to bribery and favour to gain financial benefit.

Fraud: The intentional deception or misrepresentation that an individual knows to be false or does not believe to be true and makes, knowing that deception could result in some unauthorized benefit or monetary and financial loss to the company It may be noted that these loss includes direct as well as indirect loss.

Waste: Acting with gross negligence or reckless disregard for the truth in a manner those results in any unnecessary cost or any unnecessary consumption of a healthcare resource.

Abuse: Those incidents that is inconsistent with accepted medical or business practices, Improper or excessive.

Policy: An insurance contract issued by the company to the customer agreeing to the terms and conditions of the product.

5.0 Types of Fraud and Potential Areas of Fraud:

Basis, the nature of business and operations of CHIL, following are the potential areas of Fraud and the types of fraud that each of the areas are exposed. However, these are only indicative and the policy does not restrict itself to these.

A. Provider Based:

I. Billing for goods or services not rendered or provided.
II. Performing inappropriate or unnecessary procedures/ services like consultations, diagnostic tests etc.
III. Charging for equipment/supplies never ordered.
IV. "Double Billing" - charging more than once for the same service, for
V. example by billing using an individual code and again as part of an automated or bundled set of tests.
VI. Misrepresentation of facts / willful non - disclosure of facts.
VII. Withholding PED details to advantage of patient.
VIII. Altering summary details to prevent rejections.

B. Agent /Sales Team Based:

I. Agents filling out information on proposal form without consent or knowledge of the proposer.
II. Agents or insurance representatives offering CHIL products along with other benefits, prizes without the knowledge of CHIL.
III. Agent or insurance representative telling the proposer that something is not usually covered but a variation can be made.
IV. Agent or insurance representative stating instead of renewing old policy new policy has to be purchased.
V. Agent operating without a valid license
VI. Agent did not disclose any or all information, documentation, data or know - how disclosed to him by insurer which are of confidential nature.
VII. Agent places the Insurer under any legal obligation which is not within the scope of the
VIII. express authority granted by the Insurer in the Contract
IX. Agent accepts risks of any kind; make, modify or discharge contracts; extend the time for the payment of any premium; waive forfeitures or any of the Insurer's rights or requirements;
X. Agents violating provisions laid down by Insurance Regulatory and Development Authority of India (IRDAI) or any other applicable laws.

C. Customer:

I. Customer fraud can involve alteration of bills or creation of claims, submission of claims for ineligible dependents, and misrepresentation in response to specific questions on the claim forms.
II. Using Someone else's insurance card

III. Forging prescription ,bills or any other document with intention to wrongfully gain from such forgery.
IV. Knowingly enrolling someone not eligible for coverage under their policy or group coverage.
V. Providing misleading information.
VI. Altering billed amount for service.
VII. Altering service date.

D. Internal:

I. Mis-representing pre-employment data at time of appointment.
II. Internal employees found to be involved in various unethical practices which pose both financial and reputational risk.
III. Mis-selling of policies by Mis - representing the benefits under the policy, concealment of facts material to the policy disclosed by the insured, siphoning part of whole of premium etc.
IV. Colluding with providers and agents for staging and approving claims which are liable to be rejected as per policy terms and conditions.
V. Commissions / Kick-backs / incentives from vendors, suppliers, employees and authorizing or receiving payments for goods or services not rendered.
VI. Providing incorrect, misleading, distorted or misrepresented information or document to the company that can cause financial or reputational loss to the company.
VII. Destruction, disposition, removal of records or any other assets of the Company with an ulterior motive to manipulate and misrepresent the facts so as to create suspicion / suppression / cheating as a result of which objective assessment / decision would not be arrived at.
VIII. Claiming for expenses not actually incurred.
IX. Siphoning part or whole of the premium.
X. Depositing /Routing premium in any account or method which is against ethical business practices

XI. Knowingly using account / e-wallets / credit / debit card or any other means of payment other than the policy holder / prospective policy holder.
XII. Accepting cash from policy holder / insured for any purpose unless expressly authorized by the company.

6.0 Responsibilities:

a) Network members, agents, suppliers and customers are responsible and accountable for:

I. Not instigating or participating either actively or passively in fraud or irregular acts.
II. Preventing fraud and irregular conduct
III. Ensuring that they understand and operate controls to mitigate fraud or irregular conducts
IV. Reporting actual or potential fraud or irregular conduct as soon as they become aware of it, to either their manager or another manager within CHIL.
V. Assisting in the investigation of any fraud or irregular conduct
VI. Providing affidavits on information within their personal knowledge should they be so required.
VII. Testifying in disciplinary or court proceeding should this be required.

b) Management is responsible for:

I. With assistance of internal audit and other management resources, ensuring that effective controls are implements and operated and that the continuity and effectiveness of controls are upheld in order to prevent, deter or detect fraud or irregularities.
II. The culture of honesty and integrity is recognized and upheld.
III. Reporting all actual or potential fraud prevention committee to ensure that appropriate disciplinary, civil and criminal action is taken.
IV. Working with internal audit and the fraud prevention committee to ensure that appropriate disciplinary, civil and criminal action is taken.
V. Ensure due diligence is exercised while appointing employees, contractual manpower, providers, TPAs and intermediaries.
VI. Provide support and resources for effective fraud prevention remedies.

c) Employees

I. Employees are expected to explain the products and its benefits in a true and fair manner
II. No financial transactions should be managed or done by the employee which are not as per the company policy
III. No medical condition of the customer should be hidden or should be asked to be hidden

IV. No active participation in the Pre - Policy medical check-up needs to be there on part of the employee
V. Any action through collusion with external or internal stakeholders to harm the commercial interests and reputation of the company
VI. Make available all the records and documents for proper adjudication.

7.0 Investigation of Suspected Frauds

7.1. Other than Internal Fraud

a. Initial Identification of potential fraud through:

I. Retrospective reviews of areas
II. Service Calls/Inquiries from Members, Vendors and / or Providers
III. Reports from Members, Providers, Clients or other sources (i.e., billing staff, etc.)
IV. Data Analysis Reports
V. Whistle blower.

b. Evaluation of complaint

I. Evaluation of all supporting documentation
II. Review historical data for any previous referrals with similar reasons / patterns
III. Review case with all appropriate internal resources
IV. Decide on action
V. No evidence of fraud or abuse: Findings are documented and results reported back to the referral source
VI. Potential fraud and / or abuse

c. Documentation and Inputs

I. Gather pertinent documents
II. Review documentation. Involve all Departments as necessary.
III. Case Findings and Action Plan established

d. Action Plan

Action Plan is elaborated as under basis the different areas of fraud and entities involved

7.2. Handling Internal Fraud:

The employee related fraud shall be handled as per the process defined in the Whistle Blower Policy of the Company.

8.0 Action:

It is the responsibility of the individual or network member to comply with this policy, where there is uncertainty the individual should act than risk the failure to comply. Failure to comply is subject to disciplinary and possible criminal or civil action. It would be up to the discretion of CHIL to decide on the severity of Fraud that has occurred and based on the same appropriate action will be taken. These actions will not be restricted to the ones stated in the stages below.

S.No.	Fraud Proven Against	Nature of Fraud	Disciplinary Authority	Disciplinary action
i.	Healthcare Service Provider (Hospital, Pharmacy, Diagnostic Centre, etc.)	False Billing and coding, Manipulation of claims etc.	Head Claims , Director of Services and Head - Investigation	Warning / Counsel / Black Listing / Termination of agreement / Recovery / Reporting to police / Industry through established channels like GIC
ii.	Customer (Individual & Group)	Misrepresentation, Manipulation of claim documents, False Claim etc.	Head Claims , Director of Services, Head-Investigation, Head-Legal	Cancellation of Membership / Repudiation of Claim / Recovery / Reporting to police / Industry through established channels like GIC Portal
iii.	Sales Agent / Advisors	Premium theft, Forged signature, Submitting Fraudulent documents / tampering with Documents etc.	Chief Operating Officer, Zonal Sales Manager, Head-Legal Head-HR	Warning / Counsel / Terminate On / Recovery / Reporting to police / Industry through established channels like GIC Portal
iv.	Service Partners (TPA, etc.)	Misrepresentation, Manipulation of claim documents etc.	Head Claims , Director of Services and Head - Investigation	Warning/Black listing / Termination of agreement / Recovery / Reporting to police / Industry through established channels like GIC Portal

v.	Vendors / Suppliers	False / Double Billing etc.	Chief	Warning / Blacklisting / Termination of agreement / Recovery / Reporting to police / Industry through established channels like GIC Portal.
vi.	Employees (Full - Time and Contractual)	Forgery and Tampering of any document or information, Receiving commission and kickbacks, Nondisclosure of material information that can cause financial or reputation risk to co, data theft and leakage, siphoning part of whole of premium, mis-selling, knowingly using accounts,credit / debit cards, payment wallets other than that of policy holder	Chief Risk Officer and Head of Human Resources	Warning / Suspension / Termination / Recovery / demotion / change of location and vertical
vii.	Combination Of Above	All above	Combination of the above (as the case may be)	All above

*Responsibility for taking action on proven fraud shall be given to an individual with a level of authority at least one level higher than anyone potentially involved in the matter (e.g. If the Head of Department is involved then the authority would be the Director)

9.0 Coordination with Law enforcement Agencies:

The Fraud control unit post discussion with the Chief Risk officer of the company shall coordinate with the law enforcement agencies for reporting on fraud and action to be taken thereon. The law enforcement agencies shall include Police, Medical Councils of India, State Medical Councils and other statutory and regulatory bodies.

10.0 Framework for Exchange of Information:

The Fraud Control Unit shall share the necessary information on fraud thorough various mechanisms and platforms laid down by the regulator and other statutory bodies such as Fraud Risk Mitigation Portal developed by the General Insurance Council

11.0 Review Committee:

A Review Committee which will meet in the succeeding month of end of every quarter will be established and will consist of the following individuals:

I. Chief Executive Officer
II. Chief Finance Officer
III. Chief Risk Officer
IV. Head- HR
V. Head-Legal
VI. Head-FCU
VII. Business Heads as required

The fraud committee will review the cases of fraud of each department every quarter and will also suggest further actions that need to be taken. They will also review any further changes that need to be done to fraud policy adopted.

12.0 Fraud Awareness Program

Fraud awareness is very critical for the successful implementation of the Anti-Fraud Policy. The areas through which the awareness will be spread through the organization and its partners:

- Posters / EDM
- Content summary
- Employee induction
- Sharing of Information related to Fraud with the department heads
- Anti-Fraud policy has been made available on company website for reference of all the stakeholders.
- Anti-Fraud Policy has been made available on Employee Portal (HRIS) for reference of all the employees.

13.0 Authorization and Review

This policy is reviewed on October 27, 2023. It can be reviewed by Head-Claims and Underwriting and by the Board/ Board Level Committee, on an annual basis or more frequently, as required.

14.0 AMENDMENT HISTORY:

Sl. No	Details of Amendment	Date	Prepared By	Reviewed By	Approved By
1.0	Anti-Fraud Policy	28/07/2014	Siddhartha Kansal	Manish Dodeja	Anuj Gulati
1.1	Anti-Fraud Policy	28/07/2015	Siddhartha Kansal	Manish Dodeja	Anuj Gulati

1.2	Anti-Fraud Policy	26/07/2016	Siddhartha Kansal	Manish Dodeja	Anuj Gulati
1.3	Anti-Fraud Policy	29/04/2017	Siddhartha Kansal	Manish Dodeja	Anuj Gulati
1.4	Anti-Fraud Policy	30/07/2018	Siddhartha Kansal	Manish Dodeja	Anuj Gulati
1.5	Anti-Fraud Policy	06/08/2019	Dr.(Maj)Khush Preet Singh Oberoi	Manish Dodeja	Anuj Gulati
2	Change the Format as ISO	14/08/2020	Dr.(Maj)Khush Preet Singh Oberoi	Manish Dodeja	Anuj Gulati
3	Organisation name change	03/11/2020	Dr.(Maj)Khush Preet Singh Oberoi	Manish Dodeja	Anuj Gulati
4	Change in authority(Prepared By & Approved By)	01/11/2021	Ritesh Kapoor	Manish Dodeja	Board of Directors
5	Fraud awareness programme (Point 12) updated	07/11/2022	Ritesh Kapoor	Manish Dodeja	Board of Directors
6	Change in Authorization (Prepared by)	27/10/2023	Sushant Sharma	Manish Dodeja	Board of Directors