Health insurance pays for specific medical and surgical expenses that the insured member incurs. A health insurance policy is a contract between an insurance company and insured member or family or group wherein the insurance company agrees to provide specified coverage in return of a pre-decided fee called premium.

Due to changing lifestyle and eating habits we have become more prone to diseases, which has increased the financial burden for high cost medical needs. To add to that, if there is a need of a medical treatment one would need to be financially strong to support the required expenses as most people cannot afford to pay the high cost of health care on their own. With a right Health Insurance cover, you can not only take care of your medical expenses and but also get timely medical care without impacting your hard earned savings.

Some basic benefits of having health insurance are:
- It provides a substantial medical cover for a small fee called premium
- Right sum insured provides timely and quality medical care
- It gives tax benefits on the premium paid for health insurance, under section 80D of the Income Tax Act

Your employer will bear medical expenses only till the time you are employed with them. If you switch jobs, start something on your own or retire, you may or may not be covered under any policy. And if covered, chances are the coverage might not be sufficient or might come with conditions. So it is always good to have your own health insurance – for yourself and your family.

Moreover, a health insurance policy can also act as a supplement to your existing employer’s medical cover in case the cost of a particular medical treatment is higher than your existing coverage.

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**Why do I need Health Insurance?**

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**Why do I need a health insurance policy when I am covered under my employer’s group policy?**

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Moreover, a health insurance policy can also act as a supplement to your existing employer’s medical cover in case the cost of a particular medical treatment is higher than your existing coverage.

**What are the different types of Health Insurance policies available?**

**Individual Health Insurance** – As the name suggests, an individual health insurance policy covers a person only. It pays for hospitalization and medical expenses incurred towards treatment of an illness or injury as specified in the policy document.

**Family Floater** – This type of health insurance plan covers all the family members (self, spouse and children) for one Sum Insured under a single policy. Many health plans covers Dependent parents – under floater policy.

Along with these there are options like Personal Accident Insurance, Critical Illnesses Insurance and Hospital Cash that can be taken as add-ons or individual policies. Choice can be based on individual age, family status, and health condition as to what type of policy or rider may be most suitable.
Senior Citizen Insurance – The older you grow, the more difficult it becomes to get a regular health insurance cover. Therefore, Senior Citizen Health Insurance is meant to specifically address the hospitalization/medical needs of the elder individuals. Such plans are provided on certain conditions and/or exclusions.

Critical Illness Insurance - The insurance company pays a lump sum amount to the insured member in case he/she is diagnosed with any one of the specified critical illnesses. Once the Sum Insured is paid, the policy ends.

Personal Accident Insurance - 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.

Hospital Cash Insurance- Hospital cash is a daily fixed allowance that one is entitled to in case of hospitalization. The daily cash allowance can be used to cover miscellaneous expenditures that may otherwise not be covered in a health plan. One may take hospital cash along with a regular health policy.

Can I and my family be covered under the same policy if we are staying in different cities in India?

Yes, you and your family can be covered under the same family policy even if you are staying in different cities in India. You just need to make sure that the network hospitals are available at both the places for ease of claiming the cashless facility.

Does health insurance cover me for maternity or pregnancy related expenses?

Many health plans do not cover maternity or pregnancy related medical expenditures though some plans offer this cover for people who have been already insured with them for a continued duration that may range from 2- 4 continued policy years depending upon the type of plan opted.

Does health insurance cover consultation and diagnostic charges?

Not all the consultancy charges and diagnostic tests are covered in a health policy. Most insurance plan covers it only if:

- Consultation and diagnostic charges are part of an on-going treatment for which you have been admitted to hospital.
- They result in diagnosis of a situation for which you have to be admitted to hospital.

If the tests conducted are not related to the hospitalization for a specific treatment then they might be excluded.

Can I buy more than one health policy?

Yes, you can buy more than one health policies provided you declare the same to the insuring companies. Each insurer shall make the claim payments independent of payments received under similar policies. It is on your discretion to choose the policy under which you want to claim. If claim amount is within limits of Sum Insured then claim will be settled. If claim amount exceeds the Sum Insured under chosen policy then balance amount will be settled by the other insurance company.

Do I need to undergo a medical examination before buying health insurance?

For buying a new health policy, medical examination may be required for people over 45-55 years of age depending upon the plan or policy and on declaration of pre-existing disease.

Can I seek treatment at home and be reimbursed for it under health insurance?

Yes, it is possible to seek treatment at home and be reimbursed for it, the treatments are called as domiciliary treatment, provided basic policy conditions for the same are fulfilled:

- The person is not in a condition to be shifted to the hospital.
- The person cannot be accommodated in the hospital for lack of beds or other infrastructure.

It is always better to seek advice from the company representative regarding such issues as they are always treated as exceptions.
There are certain medical treatments that do not require you to get admitted to the hospital for more than a few hours like dialysis or chemotherapy etc. Such treatments are called day-care procedures. Many of these are covered under the health insurance plans.

What are day-care procedures? Are they covered by my health policy?

When one falls sick, one usually consult a physician and gets relevant investigations done. On physician’s advice, one gets hospitalized for further management of the sickness if required. Such medical expenses incurred before hospitalization are called Pre-Hospitalization expenses.

One gets a major part of the treatment during hospitalization, but some part of the treatment extends beyond the hospitalization, which may involve follow-up visits to the doctor, medicines to be taken or further investigations to be done. Such medical expenses are called Post-Hospitalization expenses.

What are day-care procedures? Are they covered by my health policy?

What are pre and post hospitalization expenses?

Generally health Insurance policy are available for a duration of one year and needs to be renewed thereafter, though some plans are available for a duration of two or three years.

What is the minimum and maximum policy duration?

Sum Insured is the maximum amount of money the insurance company pays towards the claim. You can select the Sum Insured at the time of buying the policy or at the renewals.

What is Sum Insured?

If during a policy period you exhaust your entire sum insured and still require hospitalization, the insurance company refills the full Sum Insured for that particular year.

What is Sum Insured restoration?

Co-pay or Co-Payment is the percentage of the total medical expenses that you have to bear from your own pocket. For example, if your hospital bill is Rs. 80,000 and co-pay mentioned in your insurance policy is 10%; you would have to pay 10% of Rs. 80,000 i.e. Rs. 8,000 and the rest Rs. 72,000 will be paid by the insurance company.

What is co-pay?

This is the amount that you have to pay towards your claim, before insurance company pays. For example, if your health insurance claim comes around Rs. 50,000 and deductible mentioned in your insurance policy is Rs. 7,000, you will have to pay Rs. 7,000 first, following which insurance company will pay the remaining amount of Rs. 43,000 towards your health insurance claim.

What is deductible?

A health card is like an identity card which comes along with the Policy. Using this card you can avail cashless hospitalization facility at any of the network hospitals of your health insurance company.

A health card carries the contact details of the TPA. In case of an emergency, you can use the contact details for seeking assistance.

What is a health card?

After buying a health insurance policy you can review the policy document for 15 days, from the date of receipt of the policy. This period is called Free look period. If, during this period you disagree with any of the terms or conditions mentioned in the policy, you can cancel the policy by giving reasons for objection. Following this, insurance company shall refund the premium, provided no claim was made under that policy.

What is ‘Free Look Period’?

Maintaining continuity is important to avail the long term health insurance benefits. When you take a health insurance, and renew it regularly, you start getting continuity benefits that prove to be invaluable over the time:

Why should I maintain continuity in health insurance?
- 30 days waiting period is waived off on renewal.
- Disease exclusions for the 1st year and 2nd year are waived off on 1st and 2nd renewals respectively.
- You start getting no claim benefits, if no claims have been made in previous policy.
- Pre-existing diseases are covered after 3-4 continued policy years.
- Maternity cover may be there only after 2-4 continued policy years if available.
- Some insurance companies offer free health check-ups/discount coupons after four continuous policy years without claim.

**What is waiting period?**

Insurance companies cover certain medical procedures, treatments after a specified duration only. The waiting period for different treatments can vary anywhere between 1 to 4 years. For more details on waiting period of your policy, please refer product details and product policy wordings.

**What is cashless facility?**

Cashless facility allows the insured to be treated at network hospitals without paying in cash at the time of hospitalization. To avail this facility, the insurer or the assigned TPA must be informed in advance in case of planned treatment and within a stipulated time in case of emergencies.

**Why do I need reimbursement if my insurers provide facility of cashless treatment?**

In some instances, it may be required to take the insured to a hospital that is not a network hospital. In such cases the insured can claim the medical expenditure within a stipulated time of the commencement and completion of the treatment.

**What are network hospitals and why should I look for them?**

Insurance companies has tie-up with certain hospitals, which are known as network hospitals. These are hospitals where, if you are admitted, you need not to get worried about arranging the money required for your treatment, as insurance company will directly bare the cost of treatment in case of hospitalization.

**What is room-rent capping?**

Hospital charges rent on the room that one takes at the time of hospitalisation. Some insurance companies put a cap or a limit on how much a person is eligible for the room rent per day at the hospital. One needs to compare it with the rates of the hospitals one visits. These norms may vary for each health insurance plan you opt for.

**What happens if I do not make a claim in the whole year?/ what is no claim bonus?**

When the insured sticks to one company, he is assured certain benefits over the years in case of no claim. Some offer more sum insured and others offer some reduction in future premiums. Some insurers may stick to the same premiums but may offer other kind of benefit or services like free health check-ups as continuity benefit.

**What is loading?**

In a health insurance policy, loading is the amount that is added to the premium based on the age, pre-existing conditions, or current health status etc.

**What are add-ons?**

To cater to specific requirements of individuals and families insurance companies provide customisation of a medical policy by giving add-on benefits like critical illness policy or personal accidental benefit or hospital cash to the main policy on additional premium. Opting for these add-ons time adds to the sum insured in critical situations.
What is TPA?
A Third Party Administrator (or TPA) works as an intermediary between the insured and the insurance company. It mainly processes insurance claims and determines insured’s eligibility for availing the treatment.

What are exclusions?
Exclusions list diseases consultations, tests, and hospitalisations that are not covered in a policy. For example, some policies cover OPD costs, ambulance costs and tests, others don’t. The exclusions list of different plans may vary. Still there are certain permanent exclusions that need to be looked into:
- Abuse of intoxicant or hallucinogenic substances like drugs and alcohol.
- Hospitalization due to war or an act of war or due to a nuclear, chemical or biological weapon and radiation of any kind.
- Items of personal comfort and convenience.
- Experimental, investigative and unproven treatment devices and pharmacological regimens.
- Expenses which are mainly cosmetic in nature.

What is a pre-existing disease?
Pre-existing illnesses are the medical condition, ailment, or injury prior to inception of your first health insurance policy. These may be conditions for which you had symptoms, were diagnosed with, or received treatment for, before buying health insurance. If insurance company once accepts your proposal then they are covered after specified time period as per policy terms and conditions, which varies across plan to plan and company to company.

How does the insurance company decide if a disease is pre-existing?
When you fill the proposal form for your health insurance you need to declare any medical/health conditions you have and also need to declare family medical history. Based on these details the insurance company decides if you have a pre-existing disease. It is done in good faith as per the declaration made by you.
It is advisable to fill the details true to your knowledge as a claim may be denied if the situation is found to be otherwise or you have not disclosed the correct details, at a later stage.

Am I entitled to buy health insurance if I have a pre-existing problem?
It is insurance company’s discretion to accept or reject your proposal if you have a pre-existing problem. If the case is accepted then there might be a loading on premium or a waiting period for that condition to be covered in a health policy as per the company norms.

I am a foreign national. Am I entitled to buy a policy in India?
Anyone living in India or visiting India for employment, education, or even tourism is entitled to buy health insurance here provided the person is not visiting here for medical tourism or for treatment. The coverage area is limited to India. Waiting period for the insurance to be effective remains the same (30 days) so it is not advisable for those on a short visit.

What happens if I want to cancel my health policy?
If you wish to cancel your policy before the end date of the policy, your insurance will cease to exist and a part of your premium will be refunded to you as per the Terms of policy cancelation mentioned in the policy document and may vary from plan to plan.

Does a company have a right to deny health insurance to a person?
Yes, a company can deny health insurance to a person based on certain conditions like pre-existing diseases, general health conditions or age or scope of the coverage.

What determines the premium of my health insurance?
Age of the person to be insured and the amount of cover required are the two main factors that decide the premium of health insurance. There might be other factors like health conditions, pre-existing diseases covered etc.
Should single men and women choose an individual policy with good maternity benefits?

Individual policies usually do not carry maternity benefits. But, there are some policies that cover maternity benefits after certain waiting period. These benefits may only be availed by women as the cover is valid for the insured individual. On the other hand, when men get married, they may include their partner in their existing individual policy by converting it to a family floater policy. They may then avail maternity benefits for wife after certain waiting period, depending upon the plan opted.

Who should choose maternity benefit in their policy?

Maternity benefits may be an important feature in your health insurance policy if you are availing it as a couple (family floater) and are planning to conceive within 2-4 years. Remember, you must choose the policy, in which the waiting period co-incides with your family planning.

What is Convalescence Benefit?

After a long period of hospitalization, an insured may not be able to get back to work immediately. This means there may be a loss of income. At this point of time, he/she may need extra funds to take care of the household expenses, medicines, etc. Convalescence benefit is an additional benefit offered with health insurance to take care of such expenses.

During the course of treatment can I change my hospital?

Yes, you are allowed to change the hospital on the grounds of better treatment and services, but you need to first inform Insurance Company who will evaluate your case on the basis of policy terms and conditions.

Can I transfer my policy from one insurance company to another without losing the renewal benefits?

Yes. As per Insurance Regulatory and Development Authority (IRDAI), you can avail portability option, where-in the insured can transfer his/her health insurance policy from one insurance company to another and from one plan to another. Thus, not losing the renewal credits for pre-existing conditions, available in the existing policy.