Is your insurance company listening to you?

If your complaints have not been addressed by your insurance company, please contact

IRDA Grievance Call Centre

Toll Free No.: 155255

to register your complaints and track their status or you may email us at complaints@irda.gov.in

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Handbook on Health Insurance

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1. About this handbook

This handbook is designed by the Insurance Regulatory and Development Authority (IRDA) as a guide on **Health Insurance** and gives general information only. No information given herein replaces or overrides the terms and conditions of an insurance policy.

Please approach a duly licensed agent or a broker or an insurance company registered with IRDA for specific information regarding a policy or for any other additional information.

2. Health Insurance

The term **'Health Insurance'** relates to a type of insurance that essentially covers your medical expenses. A health insurance policy like other policies is a contract between an insurer and an individual / group in which the insurer agrees to provide specified health insurance cover at a particular "premium" subject to terms and conditions specified in the policy.

- **What a Health Insurance policy would normally cover**

  A Health Insurance Policy would normally cover expenses reasonably and necessarily incurred under the following heads in respect of each insured person subject to overall ceiling of sum insured (for all claims during one policy period).

  a) Room, Boarding expenses
  b) Nursing expenses
  c) Fees of surgeon, anesthetist, physician, consultants, specialists
  d) Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines, drugs, diagnostic materials, X-ray, Dialysis, chemotherapy, Radio therapy, cost of pace maker, Artificial limbs, cost or organs and similar expenses.

- **Sum Insured**

  The Sum Insured offered may be on an individual basis or on floater basis for the family as a whole.

- **Cumulative Bonus (CB)**

Health Insurance policies may offer Cumulative Bonus wherein for every claim free year, the Sum Insured is increased by a certain percentage at the time of renewal subject to a maximum percentage (generally 50%). In case of a claim, CB will be reduced by 10% at the next renewal.

- **Cost of Health Check-up**

  Health policies may also contain a provison for reimbursement of cost of health check up. Read your policy carefully to understand what is allowed.

- **Minimum period of stay in Hospital**

  In order to become eligible to make a claim under the policy, minimum stay in the Hospital is necessary for a certain number of hours. Usually this is 24 hours. This time limit may not apply for treatment of accidental injuries and for certain specified treatments. Read the policy provision to understand the details.

- **Pre and post hospitalization expenses**

  Expenses incurred during a certain number of days prior to hospitalization and post hospitalization expenses for a specified period from the date of discharge may be considered as part of the claim provided the expenses relate to the disease / sickness. Go through the specific provision in this regard.

- **Cashless Facility**

  Insurance companies have tie-up arrangements with a network of hospitals in the country. If

policyholder takes treatment in any of the net work hospitals, there is no need for the insured person to pay hospital bills. The Insurance Company, through its Third Party Administrator (TPA) will arrange direct payment to the Hospital. Expenses beyond sub limits prescribed by the policy or items not covered under the policy have to be settled by the insured direct to the Hospital. The insured can take treatment in a non-listed hospital in which case he has to pay the bills first and then seek reimbursement from Insurance Co. There will be no cashless facility applicable here.

- **Additional Benefits and other stand alone policies**
  Insurance companies offer various other benefits as "Add-ons" or riders. There are also stand alone policies that are designed to give benefits like "Hospital Cash", "Critical Illness Benefits", "Surgical Expense Benefits" etc. These policies can either be taken separately or in addition to the hospitalization policy.
  A few companies have come out with products in the nature of **Top Up** policies to meet the actual expenses over and above the limit available in the basic health policy.
- **Exclusions**
  The following are generally excluded under health policies:
  a) All pre-existing diseases (the pre-existing disease exclusion is uniformly defined by all non-life and health insurance companies).

b) Under first year policy, any claim during the first 30 days from date of cover, for sickness / disease. This is not applicable for accidental injury claims.
c) During first year of cover – cataract, Benign prostatic hypertrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Congenital Internal diseases, Fistula in anus, piles, sinusitis and related disorders.
d) Circumcision unless for treatment of a disease
e) Cost of specs, contact lenses, hearing aids
f) Dental treatment / surgery unless requiring hospitalization
g) Convalescence, general debility, congenital external defects, V.D., intentional self-injury, use of intoxicating drugs / alcohol, AIDS, Expenses for Diagnosis, X-ray or lab tests not consistent with the disease requiring hospitalization.
h) Treatment relating to pregnancy or child birth including cesarean section
i) Naturopathy treatment.

The actual exclusions may vary from product to product and company to company. In group policies, it may possible to waive / delete the exclusions on payment of extra premium.

- **No short period policies**
  Health insurance policies are not issued for less than one year period.

3. FAQs on Health Insurance

Q. What is Health Insurance?

Ans. The term health insurance is a type of insurance that covers your medical expenses. A health insurance policy is a contract between an insurer and an individual /group in which the insurer agrees to provide specified health insurance cover at a particular "premium".

Q. What are the forms of Health Insurance available?

Ans. The commonest form of health insurance policies in India cover the expenses incurred on Hospitalization, though a variety of products are now available which offer a range of health covers, depending on the need and choice of the insured. The health insurer usually provides either direct payment to hospital (cashless facility) or reimburses the expenses associated with illnesses and injuries or disburses a fixed benefit on occurrence of an illness. The type and amount of health care costs that will be covered by the health plan are specified in advance.

Q. Why is Health Insurance important?

Ans. All of us should buy health insurance and for all members of our family, according to our needs. Buying health insurance protects us from the sudden, unexpected costs of hospitalization (or other covered health events, like critical illnesses) which would otherwise make a major dent into household savings or even lead to indebtedness.

Each of us is exposed to various health hazards and a medical emergency can strike anyone of us without any prior warning. Healthcare is increasingly expensive, with technological advances, new procedures and more effective medicines that have also driven up the costs of healthcare. While these high treatment expenses may be beyond the reach of many, taking the security of health insurance is much more affordable.

Q. What kinds of Health Insurance plans are available?

Ans. Health insurance policies are available from a sum insured of Rs 5000 in micro-insurance policies to even a sum insured of Rs 50 lakhs or more in certain critical illness plans. Most insurers offer policies between 1 lakh to 5 lakh sum insured. As the room rents and other expenses payable by insurers are increasingly being linked to the sum insured opted for, it is advisable to take adequate cover from an early age, particularly because it may not be easy to increase the sum insured after a claim occurs. Also, while most non-life insurance companies offer health insurance policies for a duration of one year, there are policies that are issued for two, three, four and five years duration also. Life insurance companies have plans which could extend even longer in the duration.

A **Hospitalization policy** covers, fully or partly, the actual cost of the treatment for hospital admissions during the policy period. This is a

wider form of coverage applicable for various hospitalization expenses, including expenses before and after hospitalization for some specified period. Such policies may be available on individual sum insured basis, or on a family floater basis where the sum insured is shared across the family members.

Another type of product, the **Hospital Daily Cash Benefit policy,** provides a fixed daily sum insured for each day of hospitalization. There may also be coverage for a higher daily benefit in case of ICU admissions or for specified illnesses or injuries.

A **Critical Illness benefit policy** provides a fixed lumpsum amount to the insured in case of diagnosis of a specified illness or on undergoing a specified procedure. This amount is helpful in mitigating various direct and indirect financial consequences of a critical illness. Usually, once this lump sum is paid, the plan ceases to remain in force.

There are also other types of products, which offer lumpsum payment on undergoing a specified surgery **(Surgical Cash Benefit)**, and others catering to the needs of specified target audience like senior citizens.

Q. What is cashless facility?

Ans. Insurance companies have tie-up arrangements with several hospitals all over the country as part of their network. Under a health insurance policy offering cashless facility, a policyholder can

take treatment in any of the network hospitals without having to pay the hospital bills as the payment is made to the hospital directly by the Third Party Administrator, on behalf of the insurance company. However, expenses beyond the limits or sub-limits allowed by the insurance policy or expenses not covered under the policy have to be settled by you directly with the hospital.

Cashless facility, however, is not available if you take treatment in a hospital that is not in the network.

Q. What are the tax benefits I get if I opt for Health Insurance?

Ans. Health insurance comes with attractive tax benefits as an added incentive. There is an exclusive section of the Income Tax Act which provides tax benefits for health insurance, which is Section 80D, and which is unlike the section 80C applicable to Life Insurance wherein other form of investments/ expenditure also qualify for the deduction.

Currently, purchasers of health insurance who have purchased the policy by any payment mode other than cash can avail of an annual deduction of Rs. 15,000 from their taxable income for payment of Health Insurance premium for self, spouse and dependent children. For senior citizens, this deduction is higher, and is Rs. 20,000.

Further, since the financial year 2008-09, an

additional Rs 15,000 is available as deduction for health insurance premium paid on behalf of parents, which again is Rs 20,000 if the parents are senior citizens.

Q. What are the factors that affect Health Insurance premium?

Ans. Age is a major factor that determines the premium, the older you are the premium cost will be higher because you are more prone to illnesses. Previous medical history is another major factor that determines the premium. If no prior medical history exists, premium will automatically be lower. Claim free years can also be a factor in determining the cost of the premium as it might benefit you with certain percentage of discount. This will automatically help you reduce your premium.

Q. What does a Health Insurance policy not cover?

Ans. You must read the prospectus/ policy and understand what is not covered under it. Generally, pre-existing diseases (read the policy to understand what a pre-existing disease is defined as) are excluded under a Health Insurance policy. Further, the policy would generally exclude certain diseases from the first year of coverage and also impose a waiting period. There would also be certain standard exclusions such as cost of spectacles, contact lenses and hearing aids not being covered, dental treatment/surgery (unless requiring

hospitalization) not being covered, convalescence, general debility, congenital external defects, venereal disease, intentional self-injury, use of intoxicating drugs/alcohol, AIDS, expenses for diagnosis, x-ray or laboratory tests not consistent with the disease requiring hospitalization, treatment relating to pregnancy or child birth including cesarean section, Naturopathy treatment.

Q. Is there any Waiting Period for claims under a policy?

Ans. Yes. When you get a new policy, generally, there will be a 30 days waiting period starting from the policy inception date, during which period any hospitalization charges will not be payable by the insurance companies. However, this is not applicable to any emergency hospitalization occurring due to an accident. This waiting period will not be applicable for subsequent policies under renewal.

Q. What is pre-existing condition in health insurance policy?

Ans. It is a medical condition/disease that existed before you obtained health insurance policy, and it is significant, because the insurance companies do not cover such pre-existing conditions, within 48 months of prior to the 1st policy. It means, pre-existing conditions can be considered for payment after completion of 48 months of continuous insurance cover.

Q. If my policy is not renewed in time before expiry date, will I be denied for renewal?

Ans. The policy will be renewable provided you pay the premium within 15 days (called as Grace Period) of expiry date. However, coverage would not be available for the period for which no premium is received by the insurance company. The policy will lapse if the premium is not paid within the grace period.

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

Ans. Yes. The Insurance Regulatory and Development Authority (IRDA) has issued a circular making it effective from 1st July,2011, which directs the insurance companies to allow portability from one insurance company to another and from one plan to another, without making the insured to lose the renewal credits for pre-existing conditions, enjoyed in the previous policy. However, this credit will be limited to the Sum Insured (including Bonus) under previous policy. For details, you may check with the insurance company.

Q. What happens to the policy coverage after a claim is filed?

Ans. After a claim is filed and settled, the policy coverage is reduced by the amount that has been paid out on settlement. For Example: In January you start a policy with a coverage of Rs 5 Lakh for the year. In April, you make a claim of Rs 2 lakh.

The coverage available to you for the May to December will be the balance of Rs.3 lakh.

Q. What is 'Any one illness' ?

Ans. 'Any one illness' would mean the continuous period of illness, including relapse within a certain number of days as specified in the policy. Usually this is 45 days

Q: What is the maximum number of claims allowed over a year?

Any number of claims is allowed during the policy period unless there is a specific cap prescribed in any policy. However the sum insured is the maximum limit under the policy.

Q. What is "health check" facility?

Some health insurance policies pay for specified expenses towards general health check up once in a few years. Normally this is available once in four years.

Q: What do you mean by Family Floater Policy?

Family Floater is one single policy that takes care of the hospitalization expenses of your entire family. The policy has one single sum insured, which can be utilised by any/all insured persons in any proportion or amount subject to maximum of overall limit of the policy sum insured. Quite often Family floater plans are better than buying separate individual policies. Family Floater plans takes care of all the medical expenses during sudden illness, surgeries and accidents.

Policyholder Servicing Turnaround Times as prescribed by IRDA

Service	Maximum Turn Around Time
General	
Processing of Proposal and Communication of decisions including requirements/issue of Policy /Cancellations	15 days
Obtaining copy of the proposal	30 days
Post Policy issue service requests concerning mistakes/refund of proposal deposit and also Non-Claim related service requests	10 days
Life Insurance	
Surrender value/annuity/pension processing	10 days
Maturity claim/Survival benefit/penal interest not paid	15 days
Raising claim requirements after lodging the Claim	15 days
Death claim settlement without Investigation requirement	30 days
Death claim settlement/repudiation with Investigation requirement	6 months
General Insurance	
Survey report submission	30 days
Insurer seeking addendum report	15 days
Settlement/rejection of Claim after receiving first/addendum survey report	30 days
Grievances	
Acknowledge a grievance	3 days
Resolve a grievance	15 days

5. If you have a grievance:

The Consumer Affairs Department of the Insurance Regulatory and Development Authority (IRDA) has introduced the Integrated Grievance Management System (IGMS) which is an online system for registration and tracking of grievances. You must register your grievance first with the insurance company and in case you are not satisfied with its disposal by the company, you may escalate it to IRDA through IGMS by accessing www.igms.irda.gov.in. In case you are not able to access the insurer's grievance system directly, IGMS also provides you a gateway to register your grievance with the insurer.

Apart from registering your grievance through IGMS (i.e., web), you have several channels for grievance registration-through e-mail (complaints@irda.gov.in), through letter (address your letter to Consumer Affairs Department, Insurance Regulatory and Development Authority, 3rd Floor, Parishram Bhavan, Basheerbagh, Hyderabad:4) or simply call IRDA Call Centre at **Toll Free 155255** through which IRDA shall, free of cost, register you complaints against insurance companies as well as help track its status. The Call Centre assists by filling up the complaints form on the basis of the call. Wherever required, it will facilitate in filing of complaints directly with the insurance companies as the first port of call by giving information

relating to the address, telephone number, website details, contact number, e-mail id etc of the insurance company. IRDA Call Centre offers a true alternative channel for prospects and policyholders, with comprehensive tele-functionalities, serving as a 12 hours x 6 days service platform from 8 AM to 8 PM, Monday to Saturday in Hindi, English and various Indian languages.

When a complaint is registered with IRDA, it facilitates resolution by taking it up with the insurance company. The company is given 15 days time to resolve the complaint. If required, IRDA carries out investigations and enquiries. Further, wherever applicable, IRDA advises the complainant to approach the Insurance Ombudsman in terms of the Redressal of Public Grievances Rules, 1998.

Disclaimer:

This handbook is intended to provide you general information only and is not exhaustive. It is an education initiative and does not seek to give you any legal advice.