# Knowledge Sharing Series

# FAQ - Health Insurance

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# Health Insurance

## Frequently Asked Questions (FAQ)

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# Section I: Basics of Health Insurance

## At what age one should take health insurance and why?

Health insurance should be taken as soon as a person starts earning. At a young age, usually there are no health related complications and the premium cost is low.

## Why so many social media posts criticising health insurance?

Do not take social media posts too seriously, especially those relating to delay / rejection of claims. We do not know the background of each case and we see only one side of the story. Moreover, the human tendency is such that social media posts are usually not given for positive experiences. This is not to say all those posts are incorrect but they are not conclusive that everything is wrong with health insurance industry.

## Why take health insurance when my employer provides me with one?

The employer provided health insurance is related to being in employment with that employer. Even assuming, in your entire career, you will have health insurance from your employer, you will be left with no health insurance after retirement. By that time you are older, may have developed health conditions and either a health insurance will be very expensive or even not available.

In the unfortunate event of loss of job and a time gap before the next job is in place, if there are any medical emergencies, one will be left with no insurance.

## Why not save the cost of premium and use the savings for treatment?

Assume the annual premium cost is Rs. 10,000 for a 25 year old person. He / she saves this, every year, in equity mutual funds giving 12% return p.a. At the age of of 60, the corpus created will be Rs 48.35 lakhs. Let us assume that at age 60 the person need to undergo a bypass surgery.

Assume the cost of bypass surgery today is Rs. 500,000 and the health care inflation is 10%. At age 60 the same procedure will cost Rs 1.41 cr whereas the corpus available is only Rs. 48.35 lakhs.

Taking the assumption further, the person is expected to live until the age of 85. All the corpus created, and may be a large part of retirement savings, has been spent on the bypass surgery at age 60. There are no resources left to meet any other medical needs for the next 25 years.

So saving for healthcare costs is not an alternative to health insurance.

## Why health insurance application asks for my family health history?

Usually health insurance documentation requires you to provide the health history of parents and siblings. This is to assess the possibility of the insured person's risk of exposure to hereditary diseases.

## Why is there a waiting period of say 30 days for any claim?

This is to protect the insurance company from claims made for already planned treatments, if any, which a person wants to cover by taking a policy immediately before the procedure.

## Can a hospital refuse cashless facility against a cashless policy?

Yes, they can. At times, a hospital may refuse to offer cashless against policies issued by a specific insurance company. This can happen if the hospital is not happy with reimbursement process of that insurance company. The hospitals usually make a public announcement of such withdrawal of cashless facility.

## Why I had to pay advance even though the insurance is cashless?

The cashless approval process takes a few hours. In times of emergency, the hospital may insist on a deposit payment, if the treatment has to

commence before getting the insurance approval. Once the insurance company approves, the hospital will refund the deposit paid.

Such advance may be needed even for planned treatment where the approval by the insurance company is lower than the estimated cost of treatment.

### Should one go through an agent or opt for online policy?

Both options are acceptable. Online policy may be a little cheaper.

### Is the claim process easier if one goes through an agent?

An agent cannot influence the claim process. So the claim process is the same irrespective of whether the policy was taken online or offline.

### How does the limit on room rent affect overall claim amount?

If there is a cap on room rent, and, the actual room rent is higher, the claim will be restricted to the capped value. Assuming such capped value is 90% of actual, then 10% of room rent as well as 10% of all other costs are also disallowed.

The hospitals charge higher costs for the same services for higher category rooms and hence the insurance company disallows a portion of costs incurred.

### Is critical illness policy a health insurance?

No. Claim under the critical illness policy is paid out on the diagnosis of any one or more of the specified critical illnesses. The claim is paid irrespective of whether any expenses are incurred or not. It is not an indemnity (i.e. reimbursement) policy but an assurance policy.

Critical illness policy can be taken as a rider to the health insurance policy or a separate policy. There is a specific cancer insurance cover also

available which is like a critical illness policy but covers specified types of cancer only.

### Does the premium in a health insurance policy increase every year?

Yes. The premium increases marginally every year as the insured gets older.

### Does premium increases if claims made?

No. Premium cannot be increased just because a claim is made.

### Can renewal of a health policy denied based on claim record?

No. The renewal of a health policy cannot be denied based on claim record. Renewal can be denied only if a fraud is established.

### What is the maximum age for renewal of a health insurance policy?

Usually the upper age limit for renewal of a health insurance policy is 85 or 90 years. However, some insurance companies offer life-long coverage.

### What is the maximum entry age limit for health insurance?

As per regulations, insurance companies should fix an entry age not less than 65 years. Many insurance companies fix the age at higher than 65 or not have any such restriction on entry age.

### I have both employer provided and personal health insurance.

Claims if any, should be made under the employer health insurance. This will ensure no claim bonus continues to accrue in your personal health policy and claim record is kept clean.

When you make claims under the employer health insurance, there is no requirement to inform your personal health insurance company of such

claims. Your future claims under the personal policy is not impacted by the past claims made under the employer's health insurance.

### Is treatment at home covered?

Domiciliary hospitalisation, under special circumstances and on the advice of doctor, is covered. Domiciliary hospitalisation refers to a condition that requires hospitalisation but due to special reasons, hospitalisation is not possible.

### Are alternative treatment methods like ayurveda covered?

This will be subject to the terms of the policy.

### Are pre and post hospitalisation expenses covered?

Yes, subject to the terms and conditions of the policy.

### Are day care procedures covered?

Usually they are covered. Refer to your policy document.

### Does smoking and alcohol consumption affect the premium?

Yes, the premium goes up.

### Is a new born baby covered?

Yes, usually after 90 days from the date of birth. Depending upon the policy terms, vaccination costs also could be covered. The infant can be included in the family floater or can be covered under a separate policy.

### Are government insurance companies good?

Yes, they are good. However, they may not have many "convenience" features of private insurers. For example, many private insurance

companies have started issuing policies without any limit on daily room rent etc. Of course, they are more expensive.

## What documents are needed while being admitted in a hospital?

Usually, the photo ID card issued by the Third Party Administrator (TPA) is good enough. As a precaution also keep the original policy document. If the policy is from a government insurance company, keep three years' policy document in original.

## If I have two policies, can I claim under both?

No, you cannot. Original hospital documents are needed to be submitted with each claim and there cannot be multiple original documents. One cannot earn a profit from insurance by making multiple claims.

# Section II: Terminologies

## What are pre-existing diseases?

These are the medical conditions already existing for an insured person at the time of taking the insurance policy.

## Are pre-existing diseases covered?

They are covered but only after a specified number of years after the policy is taken. Usually they are covered after 4 years. During such waiting period, if any medical expenditure takes place related to that condition, it has to be paid out of own resources.

## Who is a TPA?

TPA stands for Third Party Administrator. They are appointed by the insurance companies to handle paperwork during the claim process. One TPA may act on behalf of multiple insurance companies. They are located in most large hospitals to facilitate the claim process.

TPAs only handle the paperwork. They do not make decisions relating to acceptance or rejection of claims.

## What are network hospitals?

These are the hospitals approved and enlisted by the insurance company. In case of treatment at a network hospital, the claim process is easier, especially if the policy is cashless. Network hospitals may also charge lower costs to the policy holder based on their agreement with the insurance company.

## What if the treatment is in a non-network hospital?

The coverage is still available but the patient may have to pay the costs out of pocket, even if the policy is cashless. Thereafter the policy holder has to file claim for reimbursement. Since the treatment is in a non-network

hospital, there will be in depth scrutiny of all costs by the insurance company and there could be several disallowances.

## What is a “deductible”?

A fixed amount in each policy period (usually a year) or in each claim, which the insured will pay out of pocket. The insurance company will pay the balance.

## What is a “co-insurance”?

Co-insurance is when the insured will pay a fixed percentage of each claim. The insurance company will pay the balance.

## What is a “co-payment”?

Co-payment is when the insured will pay a fixed amount of each claim. The insurance company will pay the balance.

## What is the benefit of deductible, co-insurance and co-payment?

They result in lower premium. The logic is when the insured has to pay some amount out of pocket, frivolous treatments and claims will be discouraged. Bigger the deductible / co-payment / co-insurance, lower the premium.

## What is Indemnity?

Indemnity means the insurance company will reimburse the costs incurred, on the happening of the insured event, subject to overall policy limits. All health insurance plans are indemnity plans.

## What is sum insured?

Sum insured is the overall policy value limit. Under no circumstance, the insurance company will pay an amount, in a policy period (usually a year) more than the sum insured.

## What is no-claim bonus?

For each year, when no claims are made, the insurance company increases the policy value, usually by 5% at no additional premium cost. Such increases are normally capped at 50%. This limit will be reached after 10 years of no claims. After that, no bonus will be applied even if there are no claims.

In certain policies, the above principle works in the reverse manner too. If claim is made in any year, the no-claim bonus already granted is reduced by the same percentage. But the base insurance amount cannot be reduced ever.

## What are “exclusions”?

These are the treatments / circumstances not covered by the policy. The exclusions may be removed by paying additional premium. One example could be dental treatment costs.

## What is family floater?

This is a single policy covering all the members of the family. The sum insured can be claimed for the treatment off any one or more covered member. There will be no individual limit per person.

The age of the eldest person will have an impact on the premium cost for family floater policies. Therefore, senior citizens, if any, should not be included under the family floater policy but a separate insurance policy should be taken for them.

Children can be included in the floater policy only until they attain the age of 21.

## What is a top-up policy?

Top up policy can be taken where a person already has a health insurance policy, say for Rs 5 lakhs (whether own or provided by the employer) and take another policy as top-up policy for say Rs. 6 lakhs. The top-up policy, will pay claims, only if the spending in the year exceeds Rs. 5 lakhs and such excess is paid, subject to the sum insured of Rs. 6 lakhs under top-up policy.

Such top-up policies can be taken even if a person does not have any insurance and wishes to pay the first "X" amount out of pocket.

So a top-up policy is like a normal health policy with a higher deductible.

## What is Claim Settlement Ratio (CSR)?

CSR indicates the claim payment record of an insurance company. CSR is expressed as a percentage. Higher the percentage, better the settlement record. This information is available in the public domain.

## What is incurred claim ratio (ICR)?

This is value of net claims paid in a period expressed as a percentage of net premiums earned. It is calculated as net claims / net premium income. This indicates whether the insurance company is profitable or not.

Some analysts consider high ICR as a positive sign for the policy holders. This is not necessarily a correct interpretation of this ratio. A new insurance company may have high ICR as its premium income is low. Similarly, if an insurance company issues policy indiscriminately to all, the ICR could be high. ICR also does not take into account the time taken to settle claims.

Thus, ICR should be used to only understand the profitability of the insurance company and CSR should be considered from the viewpoint of the policy holder.

## What is zone based premium cost?

Certain insurance companies divide the cities / towns into zones. There are no standards for such classification and each insurance company may have its own classification. The premium rates are lower for smaller towns compared to metro cities.

There is a possibility that a person living in a small town may have to go to a metro city for treatment or may migrate to a metro city at a later date. Therefore, it is always advisable to choose the higher zone to keep treatment options flexible. Such a choice is allowed even if the policy holder resides in a smaller town.

If the policy is on a lower zone and treatment is in a higher zone, the policy holder will have to co-pay a portion of the costs incurred. Refer to the policy document to understand fully the city based premium rules.

After taking a policy, if the policyholder moves to another city / town in a different zone, the insurance company should be intimated of the same and the premium will be adjusted to the new zone.

## What is “restore benefit” or “refill” health plans?

If, in any year, due to hospitalisation and ensuring claims, if the sum insured is fully exhausted, then the insurer will restore (or refill) the sum insured for the same year. However, such restored sum insured can be used only for some other illness not connected with the first illness for which the claim was made earlier.

There are two types of restore benefits. One, the restoration happens only when the full sum insured is exhausted. In the other, the restoration is done even when only a part of the sum insured is exhausted.

Restoration benefit is more useful in the family floater policies than the individual policies. The fact that any expenses connected with the same health condition is not covered is a big dampener.

The insurance premium will be higher with the restoration benefit. However, just because the insured used the restoration benefit, the premium for the next year cannot be increased. Note that the restoration benefit can be done for a maximum amount equivalent to sum insured.

Read the fine print of the policy conditions.

## What could be a better alternative to “restoration benefits” policy?

Opt for a top-up policy which will have the same effect as a restoration policy. Moreover, in a top-up policy, there is no restriction about not claiming for the same medical condition and the sum insured can be decided by the insured and not restricted by the sum insured in the other insurance policy. Click here to read about top-up policy

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