BUYING HEALTH INSURANCE?

A FEW THINGS TO KNOW!

PAGE FINDER

CHAPTER I

A Quick Intro to Health Insurance

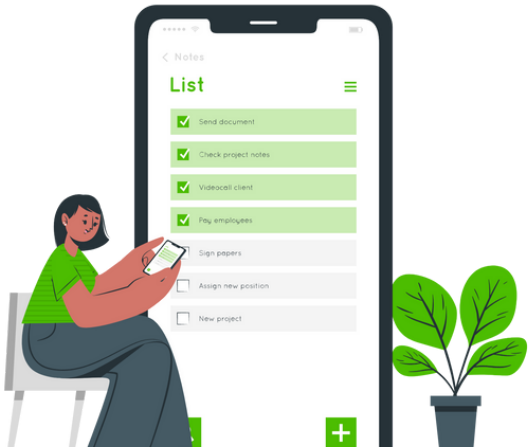
Health insurance, in the simplest sense, is a shield that protects you against medical expenses - whether planned or unplanned. A good health insurance plan helps you tackle expensive healthcare bills. It generally covers a wide range of expenses, like inpatient hospitalisation, pre and post-hospitalisation, daycare treatments, organ donations, alternative treatments, etc.

Psst! You can have a detailed look at what health insurance is in our ***An Introduction To Health Insurance eBook***.

And, with the **rising medical inflation** and **increase in lifestyle diseases**, health insurance has now become even more necessary.

But, how do you figure out the health insurance cover you need? Is there anything you should know before you buy health insurance? How does the claims process work?

Well, let's see! Here are a few things you should know before you invest in a plan!



CHAPTER II

What is the Health Insurance Coverage You Need?

Unforeseen circumstances that are beyond your control may arise in the future. It will be difficult to run from pillar to post to arrange large sums of money at a time when you're already mentally stressed. This is why you should have a health insurance cover that is adequate, not only for today but also for the future.

If you are 30 years old today and you wish to purchase a policy, keep in mind that you are purchasing it for your life and that you need to factor in inflation to come up with an adequate sum insured for at least 30 or 35 years.

Suppose the highest hospitalisation bill you could get today is Rs. 5 lakhs. You should estimate how much you will need when you reach, say, 60.

Your sum insured should be calculated based on -

- Your current age
- Estimated hospital bill
- A rough estimate of inflation (approximately 8-10%)

Using the formula -

$$\text{Sum Insured} = (\text{Current Hospital Bill} \times 1.06)^{(60\text{-Age})}$$

In the above example, with an inflation rate of 8-10% year on year, Rs. 5 Lakhs will amount to a need of around Rs. 13-15 lakhs in the future.

HOW MUCH COVER DO YOU NEED FOR A FLOATER POLICY?

A family floater is a type of health insurance where family members share a single coverage under a single policy. Imagine you buy a family floater for yourself and your wife. The both of you are undergoing treatment at the hospital at the same time. The same health insurance cover will cover both of your hospitalisation expenses.

When purchasing a floater plan for your family, you will need to use the same calculation as above to determine the sum insured. The coverage needed for a floater policy for you and your wife is 30 lakhs (15 lakhs + 15 lakhs).

CHAPTER III

Things to Keep in Mind Before Buying Health Insurance

Selecting a good health insurance plan from the wide range of options in the market can be a daunting task. You'll have to decide how much coverage you need and what customisations to select. Then, there are various plans from different insurance companies that you'll need to compare. You'll also have to check the exclusions, limitations, and long lists of terms and conditions.

While going through this arduous process, it is easy to lose track of some important aspects that can impact your policy as well as your claim in huge ways.

Don't want to miss out on any minor detail?
We're right here for you!

Here's a checklist of 10 must-knows while buying a Health Insurance plan -

#1 Analyse and understand your needs

Let's start with a question. What if we asked you and your friend what the best car in the world is? Would you both have the same answer? Most probably not.

You might like a sedan car because of its sleekness and spacious interiors. On the other hand, your friend might like a hatchback because of its affordability.

So, why not have the same approach of 'personal choice being the best' when it comes to health insurance?

Investing in an impactful financial avenue like health insurance is a personal decision that should be tailored to your needs. Everyone has their own personal needs and preferences. There is no health insurance that is best for everyone. You and your family have one-of-a-kind needs.

And, the best health insurance plan for you is the one that fits your specific wants and requirements.

#2 Adequate cover for old age

Given today's rapid healthcare inflation, you have to remember that a sum insured that might seem sufficient now might not actually be sufficient in the future. Also, as you grow older, it might become difficult to upgrade your health insurance coverage due to age and health-related reasons. Hence, it is important to buy a large enough cover that will support you in your old age.

For instance, if you think you need a health insurance cover of Rs. 5 Lakhs today, then 20 years from now you'll need a cover of around Rs. 13-15 lakhs if you factor in inflation of around 8-10%.

#3 No room-related cap

Most health insurance plans with a sum insured of less than Rs. 5 Lakhs come with room rent limits. These room rent limits can affect your entire hospital bill - not just the room's cost. How?

If you choose a hospital room with a rent that is more than what you're eligible for, the insurer will -

- Deduct the difference in room charge.
- Proportionately deduct all associated medical costs.

So, you might end up shelling out a large amount of money from your pocket because of room rent limits - despite buying adequate health insurance. Therefore, as far as possible, try to buy a policy that does not have such financial limitations.

#4 No cap on specific treatments/procedures

Some insurance companies may impose limits on specific diseases or treatments under your health insurance policy. Such limits will most likely be included in the fine print. And, if you buy a policy with such limits, you may have to pay a large amount of money from your pocket, despite having a sufficient sum insured.

For instance, Sanjay buys a health insurance plan with a sum insured of Rs. 10 Lakhs. The policy specifies Rs. 2 Lakhs as the limit for appendicitis surgery. Now, say, Sanjay gets hospitalised and undergoes appendicitis surgery - and the expenses go up to Rs. 3.5 Lakhs. In this case, the insurer will only pay Rs. 2 Lakhs because of the limit. Sanjay will have to pay the remaining Rs. 1.5 Lakhs from his pocket.

So, make sure you go through the policy terms and conditions thoroughly and compare the fine print across plans before zeroing down on one.

#5 No copayment clause

The copayment clause can impact your health insurance claim. If you buy a health plan that has a copay clause, you'll have to bear a part of the claim before the insurer starts paying.

For example, Khwahish buys a health insurance plan for her dad that has a co-pay clause of 10%. A few days later, her dad meets with an accident and is hospitalised. The total hospital bill is Rs. 1 Lakh. In this case, Khwahish will have to pay Rs. 10,000 from her pocket. The insurer will then pay the remaining amount of Rs. 90,000.

So, you should try to buy a policy without the copayment clause. In case you're not able to, look for a policy with the lowest copay - so that there are no major out-of-pocket expenses.

#6 All daycare procedures covered

A day care procedure is a medical procedure or surgery that, in the past, required a long stay at the hospital but can now be completed in less than 24 hours - thanks to developments in medical technology. Chemotherapy, radiotherapy, eye surgery, colonoscopy, etc. are some examples of day care procedures.

Now, most insurance companies list the number of daycare treatments they will cover under the policy. This number, however, can be misleading.

For instance, one insurer may include 'eye surgeries' in their list, while another insurer may segregate this further into several surgeries such as cataracts, incision of the cornea, operation of tear ducts, etc. The insurer may do this just to increase the number of treatments on the list.

So, to avoid any confusion, opt for a health insurance policy that covers all daycare procedures. This will also ensure that any new additions to this list in the future will be covered too.

#7 Organ donor costs covered

The cost of transplanting an organ, like a kidney or a liver, etc. can be super expensive. Apart from harvesting and screening the organ, there are two surgeries required - one for the organ receiver and the other for the organ donor.

Health insurance will cover your, i.e., the organ receiver's hospitalisation expenses if you ever require an organ donation in the future. But, it won't cover the organ donor's expenses such as organ screening costs, pre-hospitalisation tests, surgery costs, post-hospitalisation recovery expenses, costs arising out of any complications post-surgery, etc. You may have to pay for all these expenses out of your pocket.

However, if you opt for organ donor cover with your health insurance that covers the expenses of the donor as well, these out-of-pocket expenses can be avoided.

#8 Restoration benefit

With the escalating medical costs today, it is quite possible that you use your entire sum insured for a single major hospitalisation. If that happens, you'll not have any health coverage for the rest of the year. And in case you're covered under a family floater, other members of your family will be left without a cover for the remaining policy year.

There's a feature in health insurance policies called 'restoration benefit' that can be helpful in such a situation. It will restore or replenish your sum insured after it is exhausted in a policy year. In some policies, this feature is available by default, while in others, it is available as an optional benefit.

The restoration benefit will ensure that you or your family members (in case of floater) are not left without a cover if the base sum insured is exhausted. The terms of restoration of the sum insured may vary across insurers and products. So, ensure you understand how and when the restoration will trigger and its extent before you go ahead.

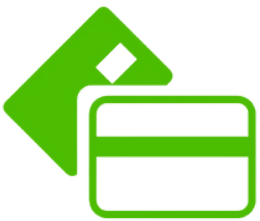
IMPORTANT THINGS TO NOTE ABOUT THE RESTORATION BENEFIT:

- Buy a plan where this benefit is available as an inbuilt feature, and not an add-on - so you don't need to pay an additional premium for an 'add-on cover'.
- Look for a plan that offers unlimited restoration, where your cover amount will get restored any number of times in a year.
- In some plans, restoration is triggered only for unrelated conditions. Meaning, say if you use your base sum insured for kidney surgery - the sum insured will be restored, but cannot be used for kidney surgery again. If you undergo hospitalisation for the same disease/ illness again in the same year, the restoration will not trigger. You can avoid this by buying a plan that allows restoration for both related and unrelated conditions.
- Restoration, in some plans, kicks in only when the entire sum insured is exhausted, while in others, it triggers even on partial exhaustion of the sum insured. To ensure you get a full cover for every hospitalisation, try to look for a plan that restores the sum insured even after partial exhaustion.
- In some policies, restoration benefit refills your sum insured up to the base policy cover. In others, the sum insured is refilled just up to the claim made by you. Try to buy a policy where the restoration is up to your base cover so you get a larger cover for every hospitalisation.

#9 Cover for non-medical expenses

Health insurance plans usually do not cover 'non-medical' or consumable costs. For instance, masks, gloves, cotton swabs, etc. will not be covered. You may have to pay for these expenses yourself. However, if you opt for a consumables cover with your health insurance, these expenses will be covered too.

During the pandemic, non-medical expenses related to gloves, masks, and PPE kits accounted for up to 25% of the total hospital bill. Keeping this in mind, buying non-medical expenses as a cover has become all the more important.



#10 Check policy conditions

Most importantly, carefully peruse the terms and conditions laid down in the policy wording or brochure. This will help you understand each nuance of the product, whether it's the inclusions, exclusions, coverage limits, offered benefits, etc.

You will be able to know what is covered and what isn't - so you don't have to go through any unpleasant situations when you actually make a claim.

CHAPTER IV

Things to Evaluate While Renewing Health Insurance

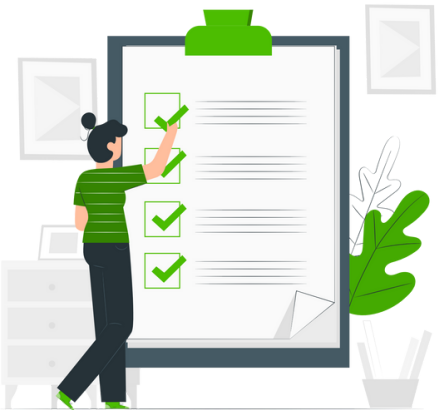
You recharge your data pack periodically because you don't want the services to stop, right? In the same way, you need to remember to renew your Health Insurance policy to keep it active.

We are living in a frightening time where cancer and diabetes are increasingly becoming household diseases. Buying Health Insurance to protect your family is definitely a step in the right direction.

But not renewing it within the grace period could lead to a lapse. And if the policy lapses, you will lose out on all its benefits and bonuses - and you surely don't want that happening.

Every insurance policy comes with an expiry date. Once a policy expires, you are not eligible for any compensation, and you cannot make any cashless/reimbursement claims in case of hospitalisation.

In simpler terms, Insurance Renewal is when you opt to extend the services of your insurance policy before it expires.



And while you're at it, here's a list of things you should evaluate:

Upgrade your sum insured

Among Asian countries, India has seen the highest medical inflation rate over the past few years. A growing population, disease prevalence, and new-age diagnostic technologies have rapidly increased healthcare costs.

Hence, renewal of health insurance is a good opportunity to assess your total coverage and see if it is enough. You should ensure that you and your family have sufficient health insurance coverage for the next 30-35 years while factoring in inflation.

For instance, Shivam has a Rs. 3 lakh family floater health cover. While renewing his policy, he needs to consider the rising costs and check if the policy will be sufficient for the whole family. If the size of the cover does not meet his requirements, renewal is the perfect time to upgrade it.

Add family members or remove them from your policy

At the time of renewal, you also have the option to add or remove members and adjust the coverage as per your family's financial needs.

For instance,

- if you recently got married and want to add your spouse to your health plan
- if there is childbirth in the family
- if an old family member covered under insurance has passed away

You are also eligible for taxation benefits by adding family members.

Explore suitable riders

Riders are add-ons that you can buy with your base health insurance plan. They provide additional benefits and help you enhance your coverage. While renewing the policy, you must also evaluate your present and future needs, and go for riders that fit them.

Some of the riders available with Health Insurance are Critical Illness Rider, Maternity Rider, Room Rent Waiver, Consumables Rider, etc. You can also check if any new rider options have been introduced by the insurer and add them to the policy during renewal if they fit your needs.

Check for changes in policy's terms and conditions

As per Insurance Regulatory and Development Authority of India (IRDAI) guidelines, insurers can change policy terms and conditions after taking prior approval from the regulator.

Therefore, before renewing your policy, it is best to sit with your financial advisor and check for any changes in the terms and conditions. Keep in mind that the insurer has to let you know about any policy changes at least 90 days before your policy is up for renewal.

Even so, it's best to be aware and conduct thorough research yourself about any alterations in the policy T&Cs. If the revised terms are not acceptable, you have the option to migrate or port your existing health insurance policy as per the IRDAI portability guidelines.

Consider the option of portability

If you feel that the services provided by your insurance company are not satisfactory, or its features and benefits don't satisfy your needs anymore, you can apply for portability.

Just like mobile network portability, you can switch to a different health insurance provider while keeping your continuity benefits. You can apply for portability by informing your insurer 45 days before the renewal date.

CHAPTER V

Health Insurance Claims

Making a health insurance claim can be a technical and tedious process, more so when you are already going through so much. This is why it's important to get it figured out beforehand. Worry not! We are here to take you through the entire process, step by step.

We'll begin by understanding the two most common methods of making a claim.

Cashless facility claimed through the hospital

This process comes into the picture when you seek treatment in a network hospital. A network hospital is one which is tied up with your insurance company.

If the hospital you have chosen is on your insurer's approved list of cashless hospitals, they will settle the medical bills directly with the hospital. It is a convenient process for you, as it saves you the trouble of tedious paperwork or paying cash upfront.

A reimbursement claim filed directly with the insurer

Under this option, you are required to pay the hospital bill and the costs of medical treatment upfront. And then, file for reimbursement claim directly with your insurer. They'll reimburse the cost as per the policy wording.

Such claims need to be made if you avail of treatments at a non-network hospital, or if your insurance company does not allow cashless claim settlements.

2 IMPORTANT STEPS TO TAKE WHEN YOU REALISE A HOSPITALISATION IS REQUIRED -

#1 Choosing the right hospital

When you meet with an emergency, you don't have the luxury to choose the best hospital. But when you have enough time on your hands to decide, you can go for a planned hospitalisation. You can select a hospital with state-of-the-art facilities, medical equipment, and healthcare resources.

You also need to check whether the hospital you have shortlisted falls within the scope of your insurance coverage, i.e., whether it is listed with the insurance company.

For instance, Niket gets diagnosed with cardiomyopathy. He knows he needs to get hospitalised in the near future to undergo open-heart surgery. Hence, he goes through the latest list of cashless hospitals on his insurer's website and chooses one. He ensures a cashless arrangement right before his hospitalisation so that when the difficult time arrives, his claims can get settled quickly.

#2 Choosing the Room Category

Health insurance policies often have a room rent limit or category limits. The insurer mentions it in your policy document for your reference. If your policy does have a room rent limit, try to go for a hospital room within it.

Otherwise, if you choose a higher-cost room/category, you might have to bear a proportionate cost of the expenses billed, in addition to the room cost difference.

- Ask your hospital for an estimated cost of total treatment, including the room rents.
- Read the fine print in the policy document carefully.
- Check the document and see which room rent limit is applicable. Make a decision accordingly.
- If you have multiple health insurance policies, check if you can claim policies that don't have room rent limits first. This way, you will be free to select the room type as per your requirements and comfort.

Now that we are aware of the types of claims that can be made, let's dive into the intricacies of their processes, one by one.

CASHLESS CLAIM PROCESS

Here are the steps involved in availing of a cashless claim settlement -

1. Reconfirm if the hospital you have chosen has a cashless arrangement with your insurance provider

- Hospitals may have varying conditions for corporate health insurance policies and personal health insurance policies.
- Hence, take a copy of your policy document with you and confirm the cashless claim availability.
- Once confirmed, ask the hospital desk for a checklist of all the documents they will require from you for a smooth process.
- Further, check for any sub-limits for specific ailments in your policy. This will give you an idea of the additional costs you'd have to bear personally.

2. Submit a Pre-Authorization Request

- Hospitals may have varying conditions for corporate health insurance policies and personal health insurance policies.
- You will be asked to fill up and sign a claims form, a part of which will be later filled out by the doctor/hospital staff.
- The insurance desk will take the process ahead with the Insurance company or Third-Party Administrator (TPA) - the agent of the health insurance corporation.

3. Keep emergency money handy

- In case your pre-authorisation approval is delayed, or the treatment is urgent and cannot wait for the final approval, the hospital might ask you to make an advance payment.
- Always keep emergency money or an active payment method handy for such situations.
- This advance will be returned to you, either completely or partially, when your cashless claim request is accepted by the insurer.

4. Submit the required documents

- Policy copy or cashless card
- All past medical records leading to the hospitalisation
- KYC for the patient
- Police FIR (in case of accidents)

5. Take care of the following steps -

- **Process the paperwork in advance**
    - In case of planned hospitalisation, submit the form at least 3-4 days prior to the admission.
    - If you are the patient, to prevent avoidable delays, send in a responsible family member to complete the paperwork before you get to the hospital.
    - In the event of an emergency situation, submit the form before one day (24 hours) of hospitalisation is completed.

- **Track the progress**
    - Upon submission of the pre-authorisation form, you can track the progress on the TPA app or website.
    - Answer all queries raised by the insurer at the earliest, which will ensure an uninterrupted claim settlement.
    - An insurance company can delay or reject an authorisation if the documents are not submitted or the queries are not answered. In such a case, you will have to go through the reimbursement process.
- **Keep copies of all documents submitted**
    - Ensure that you have a soft copy (or at least photocopies) of every document you submit, as the insurer might ask for them later.
- **Track the billing every day**
    - With a clear picture of how much the final bills could be, you can then either inform the insurer of any additional charges or use another policy if the current coverage is insufficient.
- **Keep a record of all pre-hospitalisation expenses**
    - Medical expenses incurred before the hospitalisation will have to be claimed separately with the insurer.
    - Store all the original prescriptions, bills/receipts, reports (including films) that led to the hospitalisation, since these can be claimed separately.
    - It is also important to have prescriptions from the first doctor you visited, with the problem that led to this hospitalisation, especially if they are from another hospital/clinic.
- **Keep medicine bills after purchase**
    - If you purchase medications at the hospital counter, even before getting discharged, they too will get covered under a cashless claim.

6. Be prepared for the final billing

- Once the doctor finalises your discharge date, check with the hospital insurance desk, and submit the final paperwork (including the final bill and discharge summary) to the insurance company. Do this as early as possible.
- If any documents are still pending, the insurance company will notify you. Track the progress through the insurance company's online tracker, and submit the missing documents at the earliest.
- Once all the papers are submitted, it will usually take between 2 to 6 hours to receive approval from the insurer.
- In case the final approval does not arrive or is delayed, you may have to wait at the hospital, or pay the bill upfront and claim the amount later as reimbursement.

7. Learn about the Claim Approval process

- As per the terms and conditions of your insurance plan, approved claims will show an account of the expenses approved and unapproved.
- You need to read through the claim settlement summary carefully.
- Expenses such as co-payment, proportionate deduction, exclusion for consumables, etc. need to be borne by you.

For example, if your insurance policy has a co-pay (or co-insurance) clause of 15% and your medical expenditure has amounted to Rs.60,000, you will have to pay Rs. 9,000 out of your own pocket, and the insurer will cover the remaining Rs. 51,000.

Hospitals may keep some deposit with them even after your discharge, as retention money, till they receive their payout from your insurer. Save this receipt and collect the refund once the payout has been made.

Now, coming to your second option - the Reimbursement Claim Process.

REIMBURSEMENT CLAIM PROCESS

Reimbursement can be made in three situations -

1. **For the entire treatment**: right from pre-hospitalisation to post-hospitalisation.

2. **In the case of cashless claims**: every cashless claim has a reimbursement component - for pre-hospitalisation and post-hospitalisation expenses.

3. **When claiming from two policies**: When one policy is used for a cashless claim and the remaining amount is claimed through reimbursement.

Whatever may be your situation, you need to go through the following steps -

1. Claim intimation

- In case of any situation where you need to redeem a claim amount, notify the insurance company first. Call them on their toll-free number, or send an email/SMS to inform them about the hospitalisation, within 24 hours of the admission.
- Enquire about the timeframe within which you can submit the reimbursement claim after discharge, so you are aware of the deadlines.

2. Collecting and maintaining the documents

- The speed and success of your claim entirely depend on how well you can document the process and keep the records.
- Ask your insurer for a list of all the documents you need to submit for a successful claim and start putting them together.
- From the date of discovery to the time of recovery - ensure that all documentation is properly collected and maintained.
- Include all documents - from doctor consultations, prescriptions, bills, receipts, test reports (including X-Ray or MRI films) to pharmacy bills - and everything else in a secure folder.
- To keep a track of all the medical expenses, create an Excel sheet and fill up all the costs incurred - from consultation fees to the final room rent and discharge bill.
- Fill up the claim form carefully after reading it, and provide all the details correctly.

3. Documents required to make a Reimbursement Claim

- Health card or policy copy.
- Photo ID of the insured person
- Claim form - filled and signed. A part of this form has to be filled by the hospital with the treating doctor's signature.
- All prescriptions for medicines, and medical tests including prescriptions from the first doctor you visited, with a complaint leading to this hospitalisation in original.
- All pharmacy bills in original.
- All test reports, including films & CDs (X-ray, MRI) in original.
- Hospital bill with patient details, including an itemised bill in original.
- Discharge summary from the hospital in original.
- All other original bills before the hospitalisation associated with your treatment. The bills for expenses after the hospitalisation can be claimed separately after 60 days or the time mentioned in the policy.
- Your bank details, which can be provided through a cancelled cheque for NEFT transfer of your reimbursement. Note that insurers do not send cheques, they only make online transfers.
- In case of an accident, an FIR or a medico-legal certificate or a summary of the accident may be required.

4. Make a duplicate copy of all the original documents you submit to the insurer, and retain them for your own record.

- If the insurance company raises queries, you can present copies of the documents submitted.
- Track the claim status on the insurance company's portal or app regularly to be aware of such requirements, and address them at the earliest.

5. Claim Settlement

- Your insurer will credit the amount to the bank account you provided while submitting your claim.
- They will communicate with you about the summary of deductions made.
- Go through the emails/sms you receive, and understand the deductions well.
- In case you have any doubts, you can duly raise a query with the insurance company.

This brings us to the end!

Keep these things in mind to ensure a smooth health insurance journey that caters to your needs and that you encounter zero hassles and obstacles during the ride!