Vol.:8, Issue:48

Price: ₹ 100/-

PunjiTimes

September-October 2024

WE PLAN, YOU PROSPER

HEALTH INSURANCE

Meri Punji

WE PLAN, YOU PROSPER

AKG ADVISORY LLP

Corporate and Legal Consultancy Firm

www.akgadvisory.com

- Formation of Companies,Trust, Firm, Society and Offshore Entity
- Legal Matters
- FEMA and RBI
- Will
- Corporate Advisory
- Company Law and Secretarial Compliances

AKG Advisory LLP

Corporate and Legal Consultancy Firm

EXPERIENCE! CREATIVITY! RESULTS!

OUR MISSION IS YOUR SUCCESS

Exceeding Customer Expectations

ACHIEVED BY

Doing Things a Different Way

DELIVERS WITH

Speed Quality and Expertise

SOME BUSINESS ISSUES AREN'T ALWAYS WHAT THEY SEEM!

AKG ADVISORY, DOING THINGS IN DIFFERENT WAY

AKG Advisory LLP ,202, Siddharth Chambers, Kalu Sarai,(Adj. Azad Apts.) Haus Khas, New Delhi-110016

+91 9891 799 721

info@akgadvisory.com

Our Products

DMS Document Management System	DIGITAL BILLING	PayROLL www.dispayroll.com
www.dms.in.net	www.digitalbilling.co.in	www.dispayroll.com

Our Services

- Web Hosting, E-Mail Management and Allied Services
- Software Process Audit
- Custom Software Mobile App and Allied Services
- Data Analysis and Management
- Payroll Management
- IT Consulting Services

YOUR TECHNOLOGY PARTNER

digital info solutions

www.digitalsolutions.co.in

SIMPLIYING PROCESSES!

- Creating Innovative solutions with the integration of information, design and technology
- Simplifying complex processes

+ 91 7291 987007

info@digitalsolutions.co.in

106, Siddharth Chambers, Kalu Sarai, (Adj. Azad Apts.)Haus Khas, New Delhi-110016

From the

Editor's Desk

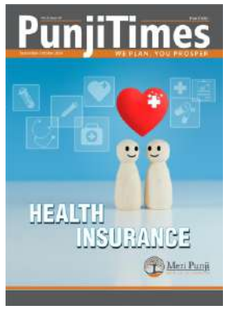
Life is unpredictable, and health emergencies can strike at any time. With the high cost of medical care, a serious illness or accident can lead to overwhelming expenses, often pushing families into financial distress. Hospitalization, surgeries, and long-term treatments can drain life savings, disrupt financial stability, and even leave families in debt.

Health insurance is not just a safety net—it is a necessity. It provides financial protection against soaring medical costs, ensuring that individuals and families receive the care they need without the fear of crippling expenses. Given the relatively low cost of health insurance compared to the skyrocketing prices of healthcare, having coverage should be an obvious choice. Yet, many remain uninsured due to a lack of awareness or misinformation, often exacerbated by misleading sales tactics.

A common concern with long-term insurance products is the reliability of insurance companies. In India, health insurers are strictly regulated by the Insurance Regulatory and Development Authority (IRDA), which mandates that companies maintain financial reserves of 1.5 times their outstanding liabilities. This ensures that claims are honoured, regardless of the insurer's financial standing.

The purpose of this edition is to shed light on the importance of health insurance, breaking down complex terms into simple concepts so that individuals can choose the right policy for their needs. Protecting your health should never come at the cost of financial ruin. For more details, consult your financial advisor.

Best,
Team Meri Punji



Punji (*noun/Hindi*) **- Capital** *meaning, wealth in the form of money or other assets owned by a person or organization or available for a purpose such as starting a company or investing.*

PunjiTimes
WE PLAN, YOU PROSPER

VOLUME: 8

ISSUE: September - October 2024

PERIODICITY: Bi-Monthly

RNI: DELENG/2017/72098

PUBLISHER: Meri Punji IMF Pvt. Ltd.

EDITOR-IN-CHIEF: Anil Kumar Goyal

WEBSITE: www.meripunji.com

EDITORIAL OFFICE:
Meri Punji IMF Private Limited
203, Siddharth Chambers, Hauz Khas,
Kalu Sarai, (Adj. Azad Apts.)
New Delhi-110016

EMAIL: info@meripunji.com

CONTENT SUPPORT:
Anil K Goyal & Associates
www.akgassociates.com

DESIGNED BY:
Digital Info Solutions Pvt. Ltd.
www.digitalsolutions.co.in

PRINTED AT:
Ess Pee Printers
1/12 and 13 DSIDC Shed, Tigri,
New Delhi-110062

PUBLISHED BY:
Meri Punji IMF Private Limited

203, Siddharth Chambers, Kalu Sarai,
(Adj. Azad Apts.), Hauz Khas,
New Delhi-110016

September-October, 2024

CONTENTS

What is Health Insurance?

Health insurance is a type of financial coverage designed to protect individuals and families from the high costs of medical care. By paying a regular premium, policyholders receive reimbursement for or direct payment of medical expenses incurred due to illness, injury, or other health conditions. It is a safety net, ensuring that healthcare needs are met without an overwhelming financial burden.

Key Features of Health Insurance

1. Financial Protection

Covers hospitalisation costs, surgery expenses, diagnostic tests, and medication.

2. Preventive Care

Many plans include routine check-ups, vaccinations, and screenings.

3. Cashless Treatment

Policy holders can receive treatment at network hospitals without upfront payment, as the insurer directly settles the bill with the hospital.

4. Flexibility

Policies can be tailored for individuals, families, senior citizens, and specific medical conditions like critical illnesses or maternity care.

5. Tax Benefits

Premiums paid for health insurance are often eligible for tax deductions under local tax laws (e.g., Section 80D of the Income Tax Act in India).

Benefits of Health Insurance

Health insurance provides a range of advantages, both financial and medical, ensuring you can access necessary healthcare services when needed like: -

Deals with rising medical costs

- People purchase health insurance policies to safeguard their finances against ever-rising medical costs.
- With a medical insurance plan, you enjoy cover for everything from ambulance charges to day-care procedures, making it easier for you to get the care you need to recover.

Critical Illness Cover

- Many health insurance policies will also offer cover for critical illnesses at an additional cost.
- These issues are often very expensive to deal with and manage, so critical illness cover is another vital benefit of having health insurance.

Easy Cashless Claims

- Every health insurance provider will tie-up with a number of network hospitals where you can enjoy cashless claims.
- This makes the entire process of receiving emergency medical care much easier. At a network hospital, you aren't really required to pay for any of the covered treatments.

How Does Health Insurance Work?

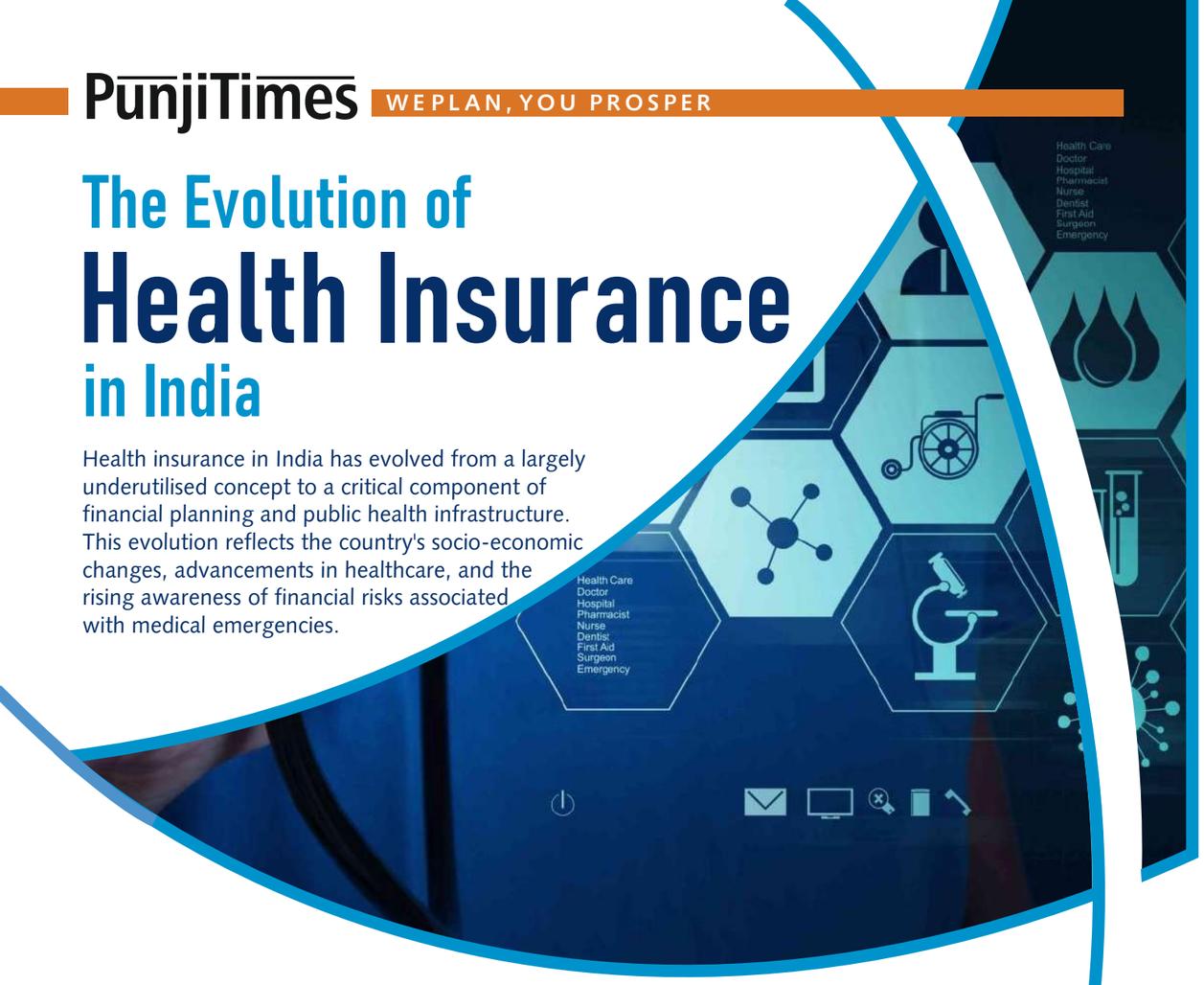
1. Policy Purchase: Individuals or employers purchase a health insurance policy with defined coverage.
2. Premium Payment: Regular premiums are paid to maintain the policy.
3. Coverage Activation: In case of medical needs, policyholders can claim coverage for eligible expenses either through reimbursement or cashless treatment.
4. Claim Settlement: The insurer evaluates the claim based on policy terms and settles the approved amount.

Types of Health Insurance

1. Individual Health Insurance: Covers a single person for medical expenses.
2. Family Floater Plans: Provides coverage for an entire family under a single premium.
3. Critical Illness Insurance: Offers a lump sum payment for diagnosed critical illnesses like cancer or heart disease.
4. Group Health Insurance: Provided by employers to their employees, often with basic coverage.
5. Top-Up Plans: Additional coverage over and above the base policy.

The Evolution of Health Insurance in India

Health insurance in India has evolved from a largely underutilised concept to a critical component of financial planning and public health infrastructure. This evolution reflects the country's socio-economic changes, advancements in healthcare, and the rising awareness of financial risks associated with medical emergencies.



The Early Years: Beginnings of Health Insurance in India

The origins of health insurance in India can be traced back to the 1940s, with the introduction of the **Employees' State Insurance Scheme (ESIS)** in 1948. ESIS aimed to provide healthcare and social security to workers in organized sectors.

For decades, health insurance was limited to government-led initiatives targeting industrial workers and specific demographic groups. Private health insurance was almost non-existent, with limited awareness among the general population.

The 1980s-1990s: The Entry of Private Players

The liberalisation of India's economy in the early 1990s marked a turning point for the insurance sector. Before liberalisation, the General Insurance Corporation of India (GIC) and its subsidiaries dominated the health insurance landscape.

The entry of private insurance companies in the mid-1990s introduced competition, innovation, and customer-centric policies. Companies like ICICI Lombard and New India Assurance began offering comprehensive health insurance products tailored to individual and family needs.

The Role of IRDAI: Regulation and Expansion

The establishment of the Insurance Regulatory and Development Authority of India (IRDAI) in 1999 was a milestone in the evolution of health insurance. IRDAI introduced regulations to ensure transparency, fairness, and accountability in the insurance sector. Key developments during this period included:

- Standardisation of policy terms and conditions.
- Introduction of cashless hospitalisation through partnerships with hospitals.
- Encouragement of health insurance portability to enhance consumer choice.

The 2000s: Technology and Innovation

The early 2000s saw significant advancements in technology, transforming the way health insurance was marketed and delivered. The rise of InsurTech start-ups, online comparison platforms, and digital claim processing streamlined the customer experience.

During this period, products catering to diverse needs—such as critical illness policies, family floater plans, and senior citizen health insurance—gained popularity.

The Government's Role in Universal Healthcare

The launch of Ayushman Bharat in 2018 by the Government of India was a landmark event. Touted as the world's largest government-funded health insurance scheme, Ayushman Bharat aimed to provide health coverage of ₹5 lakh per family annually to over 10 crore vulnerable families.

Other notable government initiatives include:

- Rashtriya Swasthya Bima Yojana (RSBY).
- Jan Arogya Bima Policy.
- State-specific schemes like Tamil Nadu's Chief Minister's Comprehensive Health Insurance Scheme.

The COVID-19 Impact: A Catalyst for Change

The COVID-19 pandemic in 2020 underscored the importance of health insurance, driving a surge in demand. Key changes during this period included:

- Introduction of COVID-specific policies like Corona Kavach and Corona Rakshak.
- Increased adoption of telemedicine and digital health services.
- Greater awareness about health insurance across rural and urban areas.

The India Health Insurance Industry is poised for continued growth, fuelled by a combination of factors:

- **Rising Healthcare Costs:** The on-going increase in healthcare costs underscores the critical need for health insurance, driving market demand.
- **Government Initiatives:** The government's commitment to expanding health insurance coverage through initiatives like the Ayushman Bharat Yojana and Pradhan Mantri Jan Arogya Yojana (PMJAY) will continue to drive market expansion.
- **Technological advancements:** Technological innovations, such as telemedicine and AI-powered claim processing, are expected to further enhance the customer experience and streamline operations, contributing to market growth.
- **Changing Lifestyle:** The changing lifestyle of the population, with an increase in lifestyle diseases, is likely to drive demand for health insurance as individuals seek financial protection against potential health risks.

The Road Ahead: Towards Universal Health Coverage

The future of health insurance in India lies in achieving universal health coverage. Key steps in this direction include:

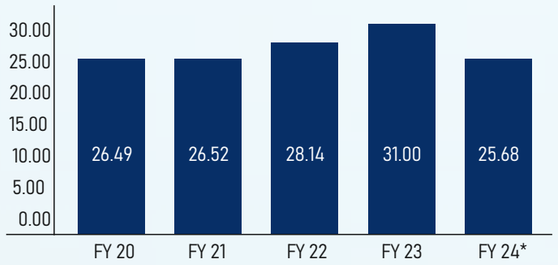
- Expanding the reach of government schemes.
- Promoting public-private partnerships.
- Enhancing customer awareness and financial literacy.

With a growing middle class, increased health consciousness, and government initiatives, health insurance is poised to become a fundamental pillar of India's healthcare system.

Market Overview

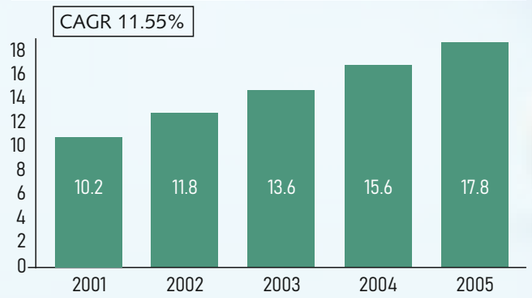
As of 2024, the Indian healthcare sector is one of India's largest employers as it employs a total of 7.5 million people.

Gross premiums written of non-life insurers (US $ Billion

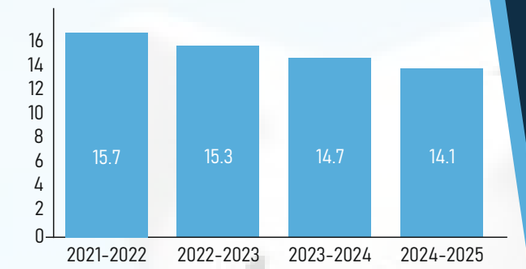


Note*-Until December 2024*

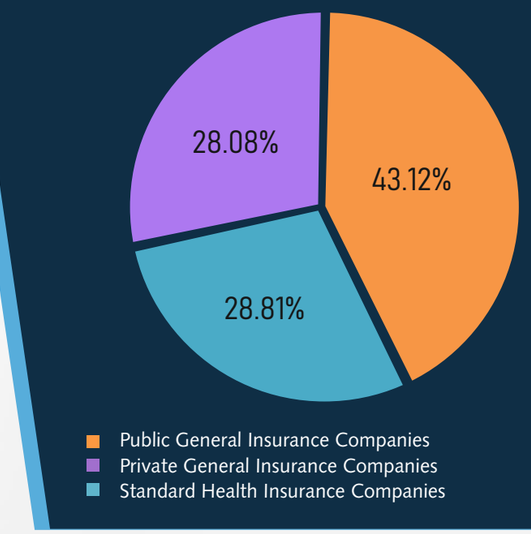
India Health Insurance Market Size (billion)



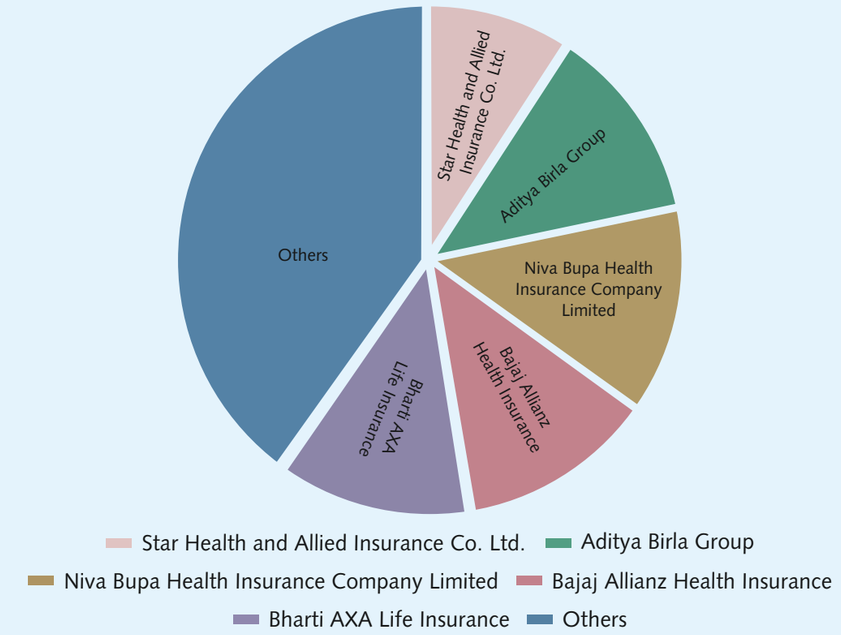
India Health Insurance Market Size (%)



Market Share of Insurance Companies



India Health Insurance Market Leading Players



India's public expenditure on healthcare touched 2.1 % of GDP in FY23 and 2.2% in FY22, against 1.6% in FY21, as per the Economic Survey 2022-23.

India's public expenditure on healthcare touched 1.9 % of GDP in FY24, against 1.6% in FY23, as per the Economic Survey 2023-24

Health Insurance Terminology

Understanding health insurance can be complex due to the technical jargon used in policies. Listed below are key health insurance terms to help in better navigation of polices.

Basic Terms

- **Policyholder –** The individual who purchases and owns the health insurance policy.
- **Insured Person –** The individual(s) covered under the health insurance policy.
- **Premium –** The amount paid periodically (monthly, quarterly, or annually) to maintain health insurance coverage.
- **Sum Insured –** The maximum amount an insurer will pay for covered medical expenses in a policy year.
- **Policy Term –** The duration for which the insurance policy is valid.

Coverage & Benefits

- **Inpatient Hospitalization –** Covers expenses when the insured is admitted to a hospital for more than 24 hours.
- **Day-care Procedures –** Covers medical procedures that do not require 24-hour hospitalization (e.g., cataract surgery, chemotherapy).
- **Domiciliary Treatment –** Covers medical treatment taken at home due to the inability to move to a hospital (subject to policy conditions).
- **Pre-Hospitalization Expenses –** Covers medical expenses incurred before hospitalization, typically up to 30-60 days.
- **Post-Hospitalization Expenses –** Covers expenses incurred after hospitalization, usually for follow-up treatment (30-90 days).
- **Ambulance Cover –** Reimburses expenses for ambulance transportation during emergencies.
- **Maternity Cover –** Covers maternity-related expenses, including delivery and prenatal/postnatal care, as per policy terms.
- **Newborn Cover –** Extends coverage to a newborn child from birth (offered in select policies).

Exclusions & Limitations

- **Waiting Period –** The time during which certain conditions or treatments are not covered (e.g., pre-existing diseases typically have a 2-4 year waiting period).
- **Pre-Existing Disease (PED) –** Any medical condition diagnosed or treated before purchasing the policy, usually subject to a waiting period.
- **Sub-Limits –** Caps placed on specific treatments or expenses within the policy (e.g., a ₹50,000 limit for cataract surgery).
- **Exclusions –** Specific conditions, treatments, or situations not covered by the policy (e.g., cosmetic surgery, self-inflicted injuries).

Claim Process & Settlement

- **Cashless Treatment –** When the insurer directly settles the hospital bill without the insured having to pay upfront (available at network hospitals).
- **Reimbursement Claim –** The insured pays medical expenses out-of-pocket and later submits a claim for reimbursement.
- **Network Hospital –** Hospitals tied up with the insurer where cashless treatment is available.
- **Non-Network Hospital –** Hospitals not partnered with the insurer, where expenses must be paid out-of-pocket and later claimed.
- **Claim Settlement Ratio (CSR) –** The percentage of claims settled by an insurer out of the total claims received in a given period.
- **Grace Period –** The extra time given after the premium due date to renew a policy without losing coverage (typically 15-30 days).

Financial Terms

- **Deductible –** The fixed amount the insured must pay out-of-pocket before the insurance company starts covering expenses.
- **Co-payment (Co-pay) –** The percentage of the medical bill that the policyholder must pay, while the insurer covers the rest.
- **No Claim Bonus (NCB) –** A reward for not making any claims in a policy year, usually in the form of a higher sum insured or premium discounts.
- **Room Rent Limit –** The maximum amount the insurer will pay for hospital room charges; exceeding this can result in additional costs.

Specialised Features & Add-ons

- **Critical Illness Cover –** Provides a lump sum amount upon diagnosis of serious illnesses like cancer, heart attack, or stroke.
- **Super Top-up Plan –** An additional policy that covers medical expenses beyond a specified threshold once the deductible is met.
- **Personal Accident Cover –** Provides financial support for accidental death, disability, or injury.
- **Wellness Benefits –** Rewards or discounts for maintaining good health, such as free health check-ups or premium discounts for a healthy lifestyle.

Regulatory & Legal Aspects

- **Insurance Regulatory and Development Authority (IRDAI) –** The governing body overseeing the insurance sector in India, ensuring policyholder protection.
- **Portability –** The ability to switch from one insurer to another without losing policy benefits like waiting periods for pre-existing conditions.
- **Free-Look Period –** The initial 15-30 day period after purchasing a policy, allowing cancellation with a refund if unsatisfied.
- **Lifetime Renewability –** The ability to renew a policy for a lifetime without age restrictions, as per IRDAI regulations.

Types Of Health Insurance In India

Health insurance plays a huge role in financial planning, offering protection against unexpected medical expenses. With various health insurance products available, it's essential to understand the options to choose the right plan.
In India, health insurance policies are designed to cater to diverse healthcare needs, ensuring that individuals and families have access to quality medical care.

Types of Health Insurance Plans	Suitable For
Individual Health Insurance	Individuals
Family Floater Health Insurance	Entire Family- Self, Spouse, Children, and Parents
Critical Illness Insurance	Provides lump sum compensation upon diagnosis of serious diseases such as cancer, heart attack, stroke, kidney failure, and organ transplants.
Senior Citizen Health Insurance	Citizens of age 65 and above
Top Up Health Insurance	This insurance plan is beneficial when the sum insured of the existing policy gets exhausted.
Personal Accident Insurance	Covers accidental injuries, disability, and death due to an accident.
Disease-Specific (M-Care, Corona Kavach, etc.)	Suitable for those who are suffering from pandemic-manifested conditions or prone to one.
Group Health Insurance	For a group of employees
Overseas Health Insurance	Covers medical emergencies, hospitalization, and evacuation costs while traveling abroad.
Government Health Insurance Schemes	Several government-sponsored schemes provide affordable or free healthcare to different sections of society

Individual Health Insurance

Provides coverage for a single person under the policy.

Covers hospitalization expenses, pre- and post-hospitalisation costs, surgery, medicines, and doctor consultations.

Ideal for individuals without dependents or those who want separate coverage.

Best for:

- ✔ Young professionals
- ✔ Individuals seeking customized coverage

Family Floater Health Insurance

A single policy covering multiple family members (spouse, children, parents).

The sum insured is shared among all insured members.

More affordable than individual policies for each family member.

Best for:

- ✔ Families with dependents
- ✔ Cost-effective coverage for the entire household

Critical Illness Insurance

Provides lump sum compensation upon diagnosis of serious diseases such as cancer, heart attack, stroke, kidney failure, and organ transplants.

Helps cover long-term treatment costs, hospital bills, and non-medical expenses.

Can be purchased as an add-on (rider) to a regular health policy or as a standalone plan.

Best for:

- ✔ Individuals with a family history of critical illnesses
- ✔ Those seeking high-value coverage for life-threatening diseases

Senior Citizen Health Insurance

Specifically designed for individuals aged 60 years and above.

Covers age-related medical conditions, hospitalisation, critical illnesses, and preventive health check-ups.

Premiums are higher due to increased health risks, but tax benefits are available.

Best for:

- ✔ Retired individuals and elderly parents
- ✔ Those seeking coverage for age-related ailments

Top-Up & Super Top-Up Health Insurance

Top-Up Plan: Covers expenses beyond a pre-defined deductible limit (the amount you pay before insurance kicks in).

Super Top-Up Plan: Works like a top-up but covers multiple claims in a year once the deductible is met.

Ideal for enhancing existing health coverage at a lower cost.

Best for:

- ✔ Individuals with basic health insurance who want additional coverage
- ✔ Those looking for cost-effective higher coverage

Personal Accident Insurance

Covers accidental injuries, disability, and death due to an accident.

Provides lump sum compensation in case of total or partial disability.

Can be purchased as an add-on or standalone policy.

Best for:

- ✔ Individuals with risky jobs (drivers, construction workers, etc.)
- ✔ Anyone looking for financial security in case of accidents

Disease-Specific Health Insurance

Designed to cover treatment for specific illnesses such as diabetes, cancer, heart diseases, or kidney diseases.

Offers higher coverage for the targeted disease, ensuring better financial protection.

Best for:

- ✔ Individuals diagnosed with or at high risk for certain diseases
- ✔ Those seeking focused coverage on chronic illnesses

Group Health Insurance (Corporate Health Insurance)

Offered by employers to their employees as part of company benefits.

Covers basic hospitalization expenses and sometimes includes maternity benefits.

Premiums are usually lower as they are shared by the employer and employees.

Best for:

- ✔ Employees in private and government sectors
- ✔ Small and large businesses

Overseas Health Insurance (Travel Health Insurance)

Covers medical emergencies, hospitalization, and evacuation costs while travelling abroad.

Includes benefits like lost luggage cover, trip cancellation, and personal accident coverage.

Best for:

- ✔ Frequent travellers
- ✔ Students and professionals going abroad

Government Health Insurance Schemes

Several government-sponsored schemes provide affordable or free healthcare to different sections of society:

Ayushman Bharat – PMJAY: ₹5 lakh coverage for low-income families.

ESIC (Employees' State Insurance Scheme): Covers employees earning up to ₹21,000/month.

CGHS (Central Government Health Scheme): For government employees and pensioners.

State health schemes (e.g., Mahatma Jyotiba Phule Jan Arogya Yojana, Dr. YSR Aarogyasri).

Best for:

- ✔ Low-income families and workers
- ✔ Government employees and pensioners

How to Choose the Best Health Insurance Plan?

Selecting the best insurance plan can be difficult, given the various factors to be considered and the multiple options available across companies.

Some points to help you make the best choice are listed below:

1 Assess Your Healthcare Needs

- Consider your **age, medical history, and lifestyle** to determine your health risks.
- If you have **a family**, opt for **a family floater plan** that covers all members.
- If you have **pre-existing conditions**, check the waiting period and coverage for those illnesses.
- Consider future needs, such as maternity coverage or coverage for aging parents.

2 Choose the Right Coverage Amount (Sum Insured)

- With rising healthcare costs, a coverage amount of at least **₹5–10 lakhs per person** is recommended.
- If you live in **a metro city**, opt for **higher coverage** due to expensive medical treatments.
- Consider a **super top-up plan** to enhance coverage at a lower cost.

3 Check What the Policy Covers

- **Inpatient hospitalization** (treatment requiring 24+ hours of hospitalization).
- **Pre- and post-hospitalization** expenses (e.g., doctor visits, tests, follow-ups).
- **Day-care procedures** (treatments like cataract surgery, dialysis, chemotherapy).
- **Domiciliary hospitalization** (treatment at home due to medical conditions).
- **Organ donor expenses** if you may need an organ transplant.
- **Ambulance charges** for medical emergencies.

4 Look for Minimal Waiting Period for Pre-Existing Diseases

- Most policies have a **2–4 year waiting period** for pre-existing conditions.
- If you have diabetes, hypertension, or other chronic illnesses, **choose a plan with the shortest waiting period.**
- Some policies offer **zero waiting period or reduced waiting with extra premium.**

5 Check Sub-Limits & Room Rent Capping

- Some policies impose sub-limits on specific treatments (e.g., ₹50,000 cap for cataract surgery).
- Room rent limits can increase your out-of-pocket expenses. Choose a policy with no room rent cap or a higher limit.

6 Compare Claim Settlement Ratio & Insurer Reputation

- A high **Claim Settlement Ratio (CSR)** (above 90%) indicates the insurer is reliable in settling claims.
- Check the **claim process—cashless or reimbursement** and ease of documentation. Read reviews about the insurer's **customer service and claim settlement speed.**

7 Check for Lifetime Renewability & Portability

- **Lifetime renewability** ensures continuous coverage, especially in old age.
- **Portability** allows you to switch to a better policy without losing accumulated benefits.

8 Consider Additional Benefits & Add-ons

- **No Claim Bonus (NCB):** Increases sum insured for every claim-free year.
- **Maternity Cover:** If planning a family, choose a plan covering pregnancy expenses.
- **Critical Illness Rider:** Provides a lump sum if diagnosed with serious illnesses like cancer or heart attack.
- **Wellness Benefits:** Discounts for maintaining a healthy lifestyle.

9 Compare Premiums but Don't Choose Just the Cheapest

- A lower premium may mean fewer benefits, higher co-pays, or exclusions.
- Choose a policy that offers the best balance of coverage and affordability.
- Use online comparison tools to evaluate multiple plans.

10 Read Policy Terms & Conditions Carefully

- Understand exclusions (what is not covered).
- Check the grace period for renewing a lapsed policy.
- Be aware of any co-payments or deductibles required.

PunjiTimes

How to Make a Health Insurance Claim

Health insurance claims can be made in two ways:

1. Cashless Claim Process
2. Reimbursement Claim Process

1. Cashless Claim Process

A cashless claim allows policyholders to receive medical treatment at a network hospital without paying upfront. The insurance company settles the bill directly with the hospital. However, this facility is available only at hospitals that are part of the insurance provider's or Third-Party Administrator's (TPA) network.

Steps to Make a Cashless Claim

Before Hospitalisation (Planned Treatment)

- **Check Network Hospitals:** Review the list of network hospitals covered under your policy, available on the insurer's website or from the TPA.
- **Pre-Authorisation Request:** Inform the hospital's insurance desk about your policy. Submit the pre-authorisation form with necessary medical documents.
- **Approval from Insurer/TPA:** The hospital sends the request for approval, which the insurer reviews within a stipulated time.
- **Receive Confirmation:** Once approved, the hospital proceeds with treatment under cashless coverage.

Emergency Hospitalisation (Unplanned Treatment)

- Inform the Hospital & Insurance Provider: Get admitted to a network hospital and notify the insurance desk.
- Submit the Pre-Authorisation Form: The hospital submits the form with initial medical reports for urgent approval.
- Approval Process: The insurer/TPA verifies the request and provides a decision within a few hours. If approved, treatment proceeds under cashless coverage.

After Hospitalisation

- The hospital submits all medical bills and documents directly to the insurer/TPA.
- The insurer reviews and settles the approved claim amount with the hospital.
- Any expenses not covered under the policy must be paid by the patient.

2. Reimbursement Claim Process

If the insured chooses a hospital outside the insurer's network or if cashless approval is not granted, they must pay for treatment upfront and later claim reimbursement.

Steps to Make a Reimbursement Claim

Before Hospitalisation (Planned Treatment)

- Understand Policy Terms: Read the policy document carefully to understand coverage, exclusions, and required documents.
- Inform the Insurer: Notify your provider about planned hospitalisation as per their guidelines.

During Hospitalisation

- Keep all original hospital bills, prescriptions, diagnostic reports, and invoices.
- Obtain a detailed discharge summary from the hospital.

After Hospitalisation

- Submit the Claim Form: Download, fill out, and submit the claim form with supporting documents.
- Documents Required:
  - Duly filled and signed claim form
  - Discharge summary from the hospital
  - Original hospital bills and receipts
  - Medical prescriptions and pharmacy bills
  - Diagnostic test reports (e.g., X-rays, blood tests, scans)
  - Doctor's consultation papers and treatment details
  - Insurance policy copy and identity proof
  - Bank details for claim settlement
- **Submit the Claim:** Submit documents within the insurer's stipulated timeframe (usually 15-30 days post discharge).
- **Claim Approval & Settlement**
  - The insurer reviews and verifies the claim.
  - Additional information may be requested if necessary.
  - Upon approval, the claim amount is reimbursed to the insured's bank account.
  - If rejected, the insurer provides a reason for rejection.
- **Claim Settlement Process**
  - Insurers must approve hospital discharge requests within 3 hours to avoid delays. Extra charges for beyond 3 hours have to be borne by the insurer.
  - If a patient passes away, the insurer must expedite processing and ensure immediate release of the body.
- **100% Cashless Claim Settlement**
  - Insurers should aim for full cashless claim approvals.
  - Emergency cases must get approval within 1 hour.
  - Help desks in hospitals assist with cashless requests.

Digital Pre-Authorization

- Insurers must allow online pre-approval for treatments to avoid confusion about coverage and payments.

Clear Rules for Claim Rejection

- Claims can only be rejected with approval from a senior review committee.
- If rejected or reduced, insurers must provide a clear written reason citing policy details.

- **Documentation Requirements for Claim Settlement**

  Proper documentation is crucial for smooth claim processing. According to IRDAI guidelines, required documents include:

  - Claim Form: Duly filled form from the insurer.
  - Medical Reports: Diagnosis, treatment details, and prescriptions.
  - Hospital Bills: Original bills and receipts from the healthcare provider.
  - Discharge Summary: A detailed summary from the hospital.
  - Policy Document: A copy of the health insurance policy.
  - Identity Proof: Valid ID of the policyholder.

  Ensuring complete and accurate documentation expedites claim processing and reduces delays.

- **Important Tips for a Smooth Claim Process**
  - Read the policy document upon receiving it to understand the claim process.
  - Keep copies of all medical documents, bills, and reports.
  - Inform the insurer promptly when hospitalisation occurs.
  - Follow prescribed claim submission timelines.
  - If a claim is rejected, review the reason and, if necessary, file an appeal with additional supporting documents.
- **Non-Contestability of Claims**
  - No health insurance policy or claim shall be contestable on grounds of **non-disclosure** or **misrepresentation** after **60 months** of continuous coverage—except in cases of **fraud**.
- **Final Authorisation for Discharge**
  - The insurer must grant final discharge authorisation within 3 hours of receiving the hospital's request. Policyholders should never be made to wait.
  - If there is a delay beyond 3 hours, the insurer bears any additional hospital charges.
- **Claim Settlement Timeline**
  - **Cashless Claims:** Must be processed within the prescribed timelines.
  - **Reimbursement Claims:** Must be settled within 15 days of document submission.

1 What is health insurance?

Health insurance is a type of coverage that pays for medical and surgical expenses incurred by the insured. It may also provide coverage for other health-related expenses such as outpatient treatment, ambulance charges, or maternity care, depending on the policy.

2 What are the different types of health insurance policies in India?

Individual Health Insurance: Covers only the individual policyholder.
Family Floater Policy: Covers the entire family under one sum insured.
Critical Illness Insurance: Provides a lump sum pay-out in case of diagnosis of serious diseases like cancer, heart attack, etc.
Top-up Plans: Additional coverage over and above an existing policy, at a lower premium.
Group Health Insurance: Offered by employers to employees, typically with lower premiums.

3 When does my coverage start once I have taken the policy?

Your coverage usually starts once your policy is approved and your first payment is made. Some types of insurance may have a waiting period before it begins. Always check your policy documents for the exact start date.

What is the eligibility for health insurance?

4

Eligibility criteria may vary by insurer and policy, but generally covers from birth to death. However, individual policies can be taken from

- Individuals from 05 to 65 years of age are eligible.
- Children below 5 years are covered as family policy
- Above 25 years of age generally Insurance companies insist on separate policies.

Can I buy health insurance if I already have a medical condition?

5

Yes, but health insurers may impose a waiting period or exclude the pre-existing condition from coverage for a certain period. Some insurers also offer policies that cover pre-existing conditions after a waiting period.

What does 'sum insured' mean?

6

The sum insured is the maximum amount that an insurance company will pay for the treatment of the policyholder in a year. It determines the financial protection against medical expenses.

Does insurance premium amount depend upon the city or place from where you are buying the same. Does it affect where I can get treatment?

7

Yes, the insurance premium can sometimes depend on the city or location where you live, as health care costs may vary by region. For example, premiums might be higher in cities with more expensive medical facilities or a higher cost of living.

The location does not affect where you can get treatment.

How does paying the premium in instalments impact coverage?

8

While paying the premium in instalments does not generally affect the coverage provided, there are some important things to consider:

- **Policy Continuity:** If you miss an instalment payment, there is a risk of policy lapse, which could result in a loss of coverage until the premium is paid.
- **No Claim Bonus (NCB):** Some insurers may not offer the same No Claim Bonus (NCB) benefits if you opt for instalment payments and fail to pay on time, potentially reducing the overall benefit or premium discount.
- **Extra Charges:** Some insurers may charge slightly higher premiums for instalment payments due to administrative costs or interest. This could result in paying more over the course of the policy term compared to an upfront annual premium.

What happens if a claim is filed before all premium instalments are paid?

9

If a claim is filed before all premium instalments are paid, the insurance company will assess whether the policy is in force. If the policy is in force, insurer will process the claim, but will deduct the all-due installments of premiums from the claim amount. It is crucial to ensure that all instalments are paid on time to avoid such situations.

What is Grace Period?

10

Grace period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of preexisting diseases. Coverage is not available for the period for which no premium is received.

What is the waiting period in health insurance?

11

The waiting period refers to the time a policyholder must wait before being able to claim insurance benefits. Some common waiting periods include:

- 30 Days – No claim except accidental
- 2 Years – Specific diseases
- Pre-existing disease waiting period: Typically, 2-4 years for coverage of pre-existing conditions.
- Maternity benefits waiting period: Usually 2-4 years before maternity claims are covered.
- Life Long Exclusions

What is the coverage in your policy?

12

- **Hospitalisation:** Covers medical expenses for inpatient treatment like surgeries, room rent, and doctor's fees.
- **Pre- and Post-Hospitalisation:** Expenses incurred before and after Hospitalisation, such as tests, consultations, and medications.
- **Maternity:** Covers pregnancy-related expenses, childbirth, and sometimes newborn care.
- **Daycare Procedures:** Includes treatment that doesn't require overnight Hospitalisation, such as certain surgeries.
- **Ambulance Services:** Covers emergency ambulance transport to the hospital. Critical Illnesses: Provides coverage for severe illnesses like cancer, heart disease, and kidney failure.
- **Pre-existing Diseases:** Some policies cover pre-existing conditions after a waiting period.
- **Preventive Care:** Some plans cover regular check-ups, screenings, and vaccinations.

Make sure to review your specific policy to know the full range of coverage, limits, and exclusions.

Can I have two health insurance providers?

13

Yes, you can have two health insurance providers, known as dual coverage. One acts as primary, paying first, and the other as secondary, covering leftover eligible costs. Make sure both insurers coordinate benefits to avoid issues.

How can beneficiaries be added or removed from the policy?

14

Beneficiaries can be added or removed from a health insurance policy through the following steps:

1. **Contact the Insurer:** Reach out to your insurance provider via their customer service or online portal.
2. **Provide Necessary Documents:** Submit documents like identity proof, relationship proof, or a marriage/birth certificate for adding beneficiaries. For removal, a written request or specific forms may be required.
3. **Policy Endorsement:** The insurer will process your request and issue an endorsement reflecting the updated beneficiaries.
4. **Timing Matters:** Changes can usually be made at the time of policy renewal, but some insurers allow mid-term updates under specific circumstances.

What happens when one beneficiary passes away?

If a beneficiary passes away, you should inform your insurance provider as soon as possible. You'll need to provide a death certificate and any necessary documents.

The insurer will update the policy by removing the deceased beneficiary and may allow you to add a new one. If the deceased was the policyholder, the nominee can claim any pending benefits. Always update your beneficiaries to keep everything accurate for future claims.

15

16

Can someone be added in the place of the person who has died?

No, you cannot add someone in place of the person who has died in a health insurance policy. Once a policyholder passes away, their coverage ends.

Are autism/other genetic illnesses covered?

Coverage for autism and genetic illnesses depends on your health plan. Many policies cover therapies like speech or behavioural therapy for autism, while genetic illnesses may have limited coverage.

17

18

What are pre-existing diseases?

These refer to medical conditions, illnesses, or injuries that the insured individual has been diagnosed with, treated for, or shown symptoms of before purchasing the health insurance policy. These conditions are critical in determining policy eligibility and coverage terms. Coverage for pre-existing diseases is subject to a longer waiting period, typically ranging from 2 to 4 years, depending on the insurer and policy terms.

What is the difference between "hospital room rent" and "Hospitalisation expenses"?

Hospital room rent refers to the cost of the hospital room where the patient is admitted, which may vary based on the class of room (shared or private).

Hospitalisation expenses cover the overall cost of medical treatments, including surgery, tests, medications, doctor's fees, and other related expenses.

19

20

What is not included in the policy?

Health insurance policies usually exclude: -

- Any hospital admission primarily for investigation diagnostic purpose
- Infertility Treatment
- Treatment outside India
- Circumcision, sex change surgery, cosmetic surgery & plastic surgery
- Refractive error correction, hearing impairment correction, corrective & cosmetic dental surgeries
- Substance abuse, self-inflicted injuries
- Hazardous sports, war, terrorism, civil war or breach of law

Are OPD charges covered in the policy?

Whether OPD (Outpatient Department) charges are covered depends on your health insurance plan. Some policies include coverage for OPD visits, such as doctor consultations, tests, and minor treatments, while others may exclude it.

It's important to review your policy to understand what's covered under OPD and any associated limits or conditions.

21

22

Does the policy routine check-ups tests?

Once in the policy year routine test can be done.

- **Preventive Health Check-ups:** Some policies cover annual health check-ups or screenings to detect early signs of disease.
- **Add-ons:** You can opt for additional riders or plans that include coverage for routine tests.

How do I file a claim under health insurance?

To file a claim, follow these general steps:

1. Inform the insurer about the Hospitalisation or treatment.
2. Submit the required documents, such as medical bills, diagnosis reports, and claim forms.
3. If applicable, opt for the cashless facility at a network hospital.
4. Wait for the insurer to process and approve the claim.

23

24

What is a cashless claim?

A cashless claim allows policyholders to receive treatment in network hospitals without paying upfront. The insurance company directly settles the bill with the hospital, subject to the terms and conditions of the policy.

Will I get the claim if I am admitted to a non-networking hospital?

Yes, you will get the claim if you are admitted to a non – networking hospital, but the hospital should not be blacklisted.

You can get a claim if you are admitted to a non-network hospital, but it will be processed as a reimbursement claim instead of a cashless claim. This means you will need to pay the hospital bills upfront and then submit the necessary documents (such as bills, receipts, and discharge summaries) to your insurance provider for reimbursement.

25

26

What is a Moratorium Period

No health insurance policy or claim shall be contestable on grounds of **non-disclosure** or misrepresentation after **60 months** of continuous coverage, i.e . the Moratorium Period—except in cases of **fraud**.

How the policy premium determined. Is it the same every year?

The premium for a health insurance policy is determined based on factors like your age, medical history, coverage amount, and the type of plan you choose. It may not be the same every year; premiums can increase due to factors like inflation, changes in your health, or updates to the insurer's pricing. Always check with your insurer for potential changes in premium rates.

27

28

Does the policy include current diseases or only pre-existing diseases?

Yes, the policy includes current diseases or only pre-existing diseases.
Health insurance policies usually cover both current and pre-existing diseases, but there are differences:

1. **Current Diseases**: Any illness that arises after the policy starts is generally covered right away, as long as it's within the terms of the policy.
2. **Pre-existing Diseases**: These are illnesses or conditions you had before buying the policy. Most policies cover them after a waiting period, which can range from 1 to 4 years, depending on the insurer and the plan.

29

In case of an emergency who do we need to contact?

In case of an emergency, you should contact your health insurance provider's emergency helpline or customer service number, which is typically listed on your insurance card. For assistance call 24 hours help-line no. or Toll-Free no. The company might have a specific number for Senior Citizens.

Is the policy valid PAN India.

30

Yes, health insurance policies are valid across India, meaning you can use them at hospitals and clinics anywhere in the country. However, it's important to check with your insurer for any network restrictions or specific terms that may apply in certain regions.

31

What if I went to blacklisted hospital in the emergency then will that be covered in health insurance?

If you go to a blacklisted hospital in an emergency: -

- **No Cashless Facility:** You won't be able to use the cashless claim option, as the hospital is not eligible for such arrangements with your insurer.
- **Reimbursement Possibility:** Some insurers may consider reimbursing the expenses if it's a genuine, unavoidable emergency. You will need to provide detailed documentation, such as medical reports, bills, and proof of emergency, to support your claim. However, this is not guaranteed and depends on the insurer's policy.
- **Out-of-Pocket Payment:** If reimbursement is not allowed, you'll have to pay the medical bills entirely on your own.

What is a No Claim Bonus (NCB)?

32

A No Claim Bonus is a reward provided by insurers for not making any claims during the policy year. It can lead to a premium discount or an increase in the sum insured for the next year.

33

What is the coverage in day care treatment?

Day care procedures are surgeries that do not require Hospitalisation beyond 24-hours. A common assumption is that standard health policies only cover treatments requiring extended hospital stays. However, most health insurance plans also include coverage for day care treatments that need less than 24 hours of hospitalisation but can still drain your finances. So, it is important to know if your mediclaim policy covers all or limited day care procedures.

Are Organ donor benefits covered?

34

Organ donor benefits are covered under many health insurance policies in India, but the extent and terms of coverage may vary by insurer. These benefits are designed to cover the medical expenses associated with organ donation for a transplant procedure.

Are ambulance services covered under insurance?

Ambulance services are typically covered under health insurance policies, but the extent of coverage and conditions can vary.

Types of Ambulance Coverage

1. **Emergency Ambulance Services:**
   - o Coverage is provided for emergency transportation to the hospital due to severe illness or injury.
   - o Includes expenses for basic life support (BLS) or advanced life support (ALS) ambulances, depending on the medical necessity.
2. **Non-Emergency Ambulance Services:**
   - o Some policies also cover non-emergency medical transportation, such as for patients requiring transfer between hospitals or for post-treatment visits.
   - o Coverage for this is less common and may have specific restrictions.

Key Features of Ambulance Coverage

1. **Monetary Limits:**
   - o Most policies impose a cap on ambulance charges, e.g., ₹2,000 to ₹5,000 per Hospitalisation.
   - o Some high-end or comprehensive policies may offer unlimited coverage.
2. **Coverage Type:**
   - o Policies usually cover ground ambulance services, but certain plans also include air ambulance services for critical emergencies.
3. **Pre-authorization:**
   - o Some insurers require pre-approval for non-emergency ambulance use, especially for inter-hospital transfers or air ambulance services.
4. **Inclusions and Exclusions:**
   - o The ambulance must be medically necessary and prescribed by a doctor for expenses to be claimable.
   - o Expenses for ambulances used for non-medical purposes (like transportation without a medical emergency) are typically excluded.

35

Points to Check in Your Policy

1. **Coverage Limits:**
   - o Review the monetary cap and ensure it aligns with typical ambulance charges in your locality.
2. **Cashless or Reimbursement:**
   - o Check if the policy allows for a cashless facility for ambulance services or if you need to pay upfront and file for reimbursement.
3. **Hospital Network:**
   - o Confirm that the hospital is part of the insurer's network, as it often simplifies claim processes for ambulance expenses.
4. **Add-ons:**
   - o Some policies offer enhanced coverage for ambulance services through optional riders. Importance of Ambulance Coverage
     - o Financial Relief: Covers high costs of emergency transport, especially in metropolitan cities or remote areas.
     - o Life-Saving Access: Ensures timely access to medical facilities in critical situations.

36

Does insurance cover new born babies? What is the process?

- **Maternity Coverage:** If maternity benefits are included, they often come with a waiting period of 9 months to 4 years.
- **For the new Born Baby:** Newborn health insurance ensures that your baby is covered in the pre- and postnatal period, before and after the delivery. This covers expenses incurred towards treating a newborn baby when the insured mother is hospitalised for delivery. The costs incurred by the baby during and after birth up to 90 days from the delivery date are also covered under the newborn health coverage.

Benefits of Health Insurance Cover for Newborns: -
This covers expenses incurred for the newborn during and post-birth up to 90 days.

What is AYUSH?

AYUSH stands for Ayurveda, Yoga & Naturopathy, Unani, Siddha, and Homeopathy, which are traditional and alternative medicine systems practiced in India. These systems focus on holistic well-being, natural healing, and preventive healthcare.

Coverage for AYUSH Treatments

1. **Included in Base Policies:**
   - Many health insurance plans include AYUSH treatments as part of the standard coverage, provided they are availed at government-recognized or accredited AYUSH hospitals or centers.
2. **Optional Riders:**
   - Some insurers offer AYUSH coverage as an add-on or optional benefit for an additional premium.
3. **Monetary Limits:**
   - Coverage for AYUSH treatments is often subject to sub-limits or caps, such as 10–25% of the sum insured or a fixed amount per year.
4. **Network Hospitals:**
   - AYUSH treatments are typically covered only when taken at hospitals listed in the insurer's network or those certified by relevant authorities.

37

38

What is a deductible?

The amount you must pay for healthcare services before your insurance starts to contribute. Typically, higher deductibles lead to lower premiums, and the opposite is true. A deductible does not reduce the Sum Insured. (Insurers to define whether the deductible is applicable per year, per life or per event and the manner of applicability of the specific deductible.

What is a co-payment clause?

A co-payment clause means the policyholder has to bear a certain percentage of the medical expenses while the insurer covers the rest. For example, a 10% co-payment means the policyholder will bear 10% of the expenses, and the insurer will pay 90%. This is applicable for every claim made.

What is the advantage of Co Payment

- Result in lower premiums, as the policyholder assumes more of the financial responsibility for medical expenses.

39

40

What is Cumulative Bonus?

Cumulative Bonus means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

What are Top-Up Plans in Health Insurance?

A **Top-Up Plan** is an additional health insurance policy that provides coverage once medical expenses exceed a predefined deductible limit. It acts as a cost-effective way to increase your health insurance coverage without significantly increasing premiums.

41

42

What is Recharge?

If you use up your entire sum insured during a claim, the insurance company will "recharge" or refill the sum insured amount so you can use it for future claims within the same policy year.

When is Recharge Done?

1. Recharge is done automatically once your initial sum insured is exhausted due to one or more claims. It applies to new, unrelated claims and usually doesn't cover the same illness or condition for which the original claim was made.

Benefits:

a. Ensures continuous coverage even if you've exhausted your sum insured.
b. Helps manage unexpected medical expenses during the same policy period.

Always check your policy terms, as recharge benefits may have conditions or limits.

43

44

What is health insurance portability?

Health insurance portability allows you to switch your health insurance provider to another insurer while retaining the benefits of your existing policy.
This includes:

- **Waiting period:** The new insurer must honour the waiting period already served under your old policy.
- **Pre-existing conditions:** Coverage for pre-existing diseases that have been covered by your previous insurer may continue with the new policy.
  Portability Benefits: If you switch insurers using the health insurance portability option, the waiting period already served for PEDs with the existing insurer is credited to the new policy.

When to apply for Portability?

A policyholder desirous of porting his/her policy to another insurance company shall apply to such insurance company to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the premium renewal date of his/ her existing policy.

45

46

Are health insurance premiums eligible for tax deductions?

Under Section 80D of the Income Tax Act, 1961, premiums paid towards the upkeep of health insurance policies are eligible for tax deductions.
For a policy for yourself, your spouse, your children and parents below the age of 60, you can claim a deduction of up to INR 25,000 per year from your taxable income.
If you've also purchased a policy for a parent who is over the age of 60, you can claim an additional deduction of INR 50,000.

Meri Punji

WE PLAN, YOU PROSPER

Every individual is unique and so are his or her investment needs. Investment planning must always be aligned with one's goals. Hence, our approach is to help you chalk out an investment strategy that is best fit for 'you'.

We see ourselves as educators rather than advisors. Our endeavor is to build awareness about the various kinds of investment products in the market. After all, an informed decision is always a better decision.

info@meripunji.com
203, Siddharth Chambers, Hauz Khas, Kalu Sarai, (Adj. Azad Apts.), New Delhi - 110016

www.meripunji.com