Health Insurance Cover for Individuals

An overview to find out who gives what and how

Health insurance is a must when you consider the rising medical costs and a spurt of lifestyle diseases. A medical emergency can attack anyone, any-time and impact an individual emotionally and financially. Financial advisors, therefore, suggest that it is prudent to buy health insurance early in life. However, it is easy to say than done. Choosing a health insurance scheme that meets your requirements is not a cakewalk. Hence, we evaluated 6 health insurance companies and reviewed them on parameters including pre-hospitalization (days), post-hospitalization (days), day-care coverage, domiciliary treatment, maternity treatment among others and identified the best one for you. Read on!

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Health Insurance is an agreement between an insurance provider and an individual wherein the former guarantees to take care of certain medical costs of the latter based on the premium paid without default. The Individual health insurance plan covers only one individual, the policyholder- who will gain from health insurance.

Product Comparison Chart

A comparative study of variables is made after identifying variables based on product structure and the variables being the most important/most influential from the consumer point of view. The products were chosen basis information provided on their respective websites. They were also assigned points to differentiate the quality of the variables to arrive at the best product structure for consumer information.

Justification for Assigning Points on Chosen Variables

Once the table containing the product structure with assigned points was ready, we prepared a structured questionnaire to elicit the consumers' (end-users) feedback. After collecting all the feedbacks, we collated the data by assigning points under QoS matrix to differentiate the quality of the services rendered by the insurance companies.

CV Weightage (criteria) Points 100	Health Insurance For Individuals	Manipal Cigna/Pro Health-Protect	ICICI Lombard/ Complete Health	Religare Health/ Care	Bajaj Allianz/ Health Guard-Gold	Star Health/ Mediclas-sic-Gold	The Oriental Insurance/ Mediclaim
5	Sum Insured (Min Rs. in lakhs)	3.00 (2)	3.00 (2)	3.00 (2)	3.00 (2)	1.50 (3)	1.00 (5)
10	Sum Insured (Max Rs. in lakhs)	50.00 (7)	50.00 (7)	75.00(10)	50.00(7)	15.00 (4)	10.00 (2)
10	Max Entry Age (Yrs)	Any (10)	Any (10)	Any (10)	65 (5)	65 (5)	65 (5)
6	PED Waiting Period (in Yrs)	4 (3)	2 (6)	2 (6)	4 (3)	2 (6)	4 (3)
4	Pre-hospitalization (Days)	60 (4)	30 (2)	30 (2)	60 (4)	30 (2)	30 (2)
4	Post-hospitalization (Days)	90 (4)	60 (2)	60 (2)	90 (4)	60 (2)	60 (2)
6	Day-care coverage	Any (6)	Any (6)	Any (6)	Limited Cover (3)	Any (6)	Limited Cover (2)
4	Domiciliary Treatment	Covered (4)	NS (0)	Limited Cover (2)	NS (0)	Covered (4)	Covered (4)
6	Emergency Ambulance (in Rs.)	2K (6)	1.5K (3)	1.5K (3)	20K yrly (2)	1.5K (3)	2K (6)
4	Worldwide Emergency Cover	Yes (4)	NS (0)	No (2)	NS (0)	NS (0)	NS (0)
6	Maternity Cover (with waiting period)	No (3)	Yes (6)	No (3)	Yes (6)	NS (0)	NS (0)
4	New Born Baby Cover (with cap)	No (2)	Yes (4)	No (2)	Yes (4)	NS (0)	NS (0)
6	Policy Period	1,2,3 (6)	1,2 (3)	1,2,3 (6)	1,2,3 (6)	1,2 (3)	1 (2)
25	Consumer Feedback	13	20	8	18	15	10
Total		74	71	64	64	**53**	**44**

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Information given here have been resourced from the website/brochures/customer care as on 06.01.2020
Sum Assured and premium are dependant upon individual covers opted, entry age, a period of insurance and risk-bearing criteria
We have selected for this study only those insurance companies which offer full information in their websites
NS- Not Specified, K- 000's

CV RECOMMENDATION

BEST BUY	MANIPAL CIGNA/PRO HEALTH-PROTECT

Who should buy a health insurance plan?

- This plan is best suited for individuals with higher health risks.
- Single individuals with family members who are already insured.
- An individual who wants to earn the benefit of the sum assured rather than the floating sum assured.
- Individuals who want to renew the policy without having to worry about any age restrictions.
- An individual who wants higher protection than what is offered under a Family Floater Plan.
- A cashless facility for claim settlement can be availed under this plan.

Check for these elements in a plan

- The policy covers hospitalization charges.
- It offers lifetime renewal.
- The insurance-provider covers certain medical costs of the insured based on the premium paid.
- Tax benefits are available under Section 80 (D) of the Income Tax Act.
- The policy covers surgery costs, room rent, physician's fees, and laboratory tests.
- Pre and post hospitalization expenses are covered.
- Provides coverage for daycare expenses and domiciliary treatment.
- Maternity cover/new-born baby covers are available subject to certain limits and waiting periods wherever applicable.
- Organ donor expenses are covered.
- Emergency ambulance charges are also covered.

Reasons to buy health insurance early in your age

- The premium payable will be the lowest (buy the policy early to get the best price).
- Just banking on the employer-group cover is not sufficient.
- There is a likelihood of lifestyle-illnesses to increase as the year goes by.
- As a lot of travel by all means of communication could be required in your work, it is all the more necessary to start at an early age.
- Buying early means a more comprehensive deal while ensuring better financial planning as there is a likelihood of the insured enjoying the full benefits of the policy.

Limitations of a health insurance policy

- Too much exclusion makes the policy unsuitable to some.
- Pre-existing diseases (PED) have a longer waiting period which could hamper when the insured falls ill all of a sudden.
- Cost of spectacles, lenses, and hearing aids are not covered.
- Dental treatment is not covered in a few cases.
- Naturopathy treatment is also not covered.
- Ailments such as cataract, hernia, sinusitis, etc would not be covered before 1 year of the policy tenure.

Latest Developments in the Health Insurance Policies

1. Standardization/ Simplification of Health Insurance Policies

IRDAI, the Insurance Regulator has proposed to standardize and simplify policy wordings of standard health indemnity plans. By doing this, the Insurance Regulatory and Development Authority of India (IRDAI) wants to bring in uniformity and transparency in policy contracts. According to IRDAI's draft proposal, released on 10th January 2020, "The objective of the guidelines on 'Standardization of General Clauses in Health Insurance Policy Contracts' is to standardize the common general clauses incorporated in indemnity based Health Insurance (excluding Personal Accident (hereinafter called as PA) and Domestic /Overseas Travel) products covering Hospitalization, Domiciliary hospitalization and Daycare treatment to simplify the wordings of general clauses in the policy contracts and ensure uniformity and greater transparency."

As per the draft proposal (exposure draft), "These guidelines apply to all general and health insurers offering indemnity-based health insurance (both Individual and group) covering hospitalization, domiciliary hospitalization, and daycare treatment."

In cases where the premium payment is made in

installments (half-yearly, quarterly or monthly, as mentioned in the policy schedule/certificate of insurance) by the policyholder, the regulator has asked insurers to give their opinion on how many days grace period should be given to such policyholders as per the health insurance product offering.

The regulator has further asked the insurer to go through the existing policy wording and give opinion wherever it is required. As per the draft proposal insurers have to include/comply with policy wordings for some of the key points mentioned below:

1. Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, misdescription or non-disclosure of any material fact.

2. Claim Settlement (provision for penal interest)

The insurer has to settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document. In the case of delay in the payment of a claim, the insurer will be liable to pay interest from the date of receipt of the last necessary document to the date of payment of claim at a rate 2 per cent and above the bank rate.

3. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, or misrepresentation by the insured person. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years. Also, at the end of the policy period, the policy shall terminate and can be renewed within the grace period to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

4. Nomination

The policyholder is required at the inception of the policy to make a nomination for payment of claims under the policy in the event of the death of the policyholder.

5. Complete discharge

Any payment to the insured person or his/ her nominees or his/ her legal representative or the hospital/nursing home or assignee, as the case may be, for any benefit under the policy shall in all cases be a full, valid and an effectual discharge towards payment of claim by the company to the extent of that amount for the particular claim. As per the draft guidelines, all benefits under the policy will be forfeited in the case of fraudulent claims, and any amount already paid against such claims shall be repaid by all person(s) named in the policy.

2. Reduction of sum insured on standard health indemnity insurance to Rs 5 lakhs

IRDAI has proposed to mandate all general and health insurers to offer a standard indemnity-based health insurance product with a sum insured ranging from Rs 1, 00,000 to Rs 5, 00,000 on an individual as well as family floater basis.

There are two types of health insurance covers- indemnity and defined benefit plans. In an indemnity plan, one can claim reimbursement of actual expenses incurred up to the amount insured for specified illnesses as per the terms and conditions of the policy. In a defined benefit insurance plan, one is insured for pre-agreed specified illnesses.

The IRDAI specified that it is making this proposal to allow people to choose a suitable health insurance policy that provides coverage to basic hospitalization charges. The only differential of this standard product would be the premium rates charged by various insurers.

This is an attempt by IRDAI to standardize health insurance products so that it becomes easier for people to choose the right policy based on their needs.

Earlier in February 2019, IRDAI, in its Draft Guidelines on Standardization of Individual Health Product, had mandated all general insurers to offer a standard indemnity-based health insurance product with a basic sum insured ranging from Rs 50,000 to Rs 10 lakh. The proposed standard health product will have to be offered on an indemnity basis only.

The proposed range of Rs 1 to Rs 5 lakh is meant to cater to entry-level health insurance, as the lower sum assured means lower premium to pay for the policy. "However, this does not prevent insurers from offering much higher sum assured and, indeed, there are several insurers that offer Rs 50 lakh or higher of the sum insured. The standardized product will be added to the current range of health insurance products.

According to the draft proposal guidelines issued in February 2019, the standard health product should offer only the following mandatory covers:

I. *Hospitalization Expenses*

a) Room, boarding, nursing expenses all-inclusive as provided by the hospital/nursing home.

b) Surgeon, anesthetist, medical practitioner, consultants, specialist fees whether paid directly to the treating doctor/surgeon or the hospital.

c) Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities, and such other similar expenses. Expenses on hospitalization for a minimum period of 24 hours only are admissible. However, this time limit of 24 hours shall not apply when the treatment does not require hospitalization as specified in the terms and conditions of policy contract, where the treatment is taken in the hospital and the insured is discharged on the same day.

4. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses.
5. Expenses incurred on the treatment of cataract subject to sub-limits, if any, based on the sum insured.
6. Dental treatment necessitated due to an injury.
7. Plastic surgery necessitated due to disease or injury.
8. Domiciliary hospitalization.

II. *AYUSH Treatment*

Expenses incurred on treatment under Ayurveda, Unani, Sidha and Homeopathy systems of medicines should be covered subject to fixed and standard sub-limits based on the sum insured.

III. Pre-hospitalization expenses

Pre-hospitalization medical expenses incurred for a period not less than 30 days before the date of hospitalization should be admissible.

IV. Post-hospitalization expenses

Post-hospitalization medical expenses incurred for not less than 60 days from the date of discharge from the hospital towards consultant fees, diagnostic charges, medicines and drugs wherever required and recommended by the hospital/medical practitioner, where the treatment was taken, following an admissible claim shall be included.

V. Cumulative Bonus (CB)

Sum insured (excluding CB) shall be increased by 5 per cent in respect of each claim-free policy period (where no claims are reported), provided the policy is continuously renewed without a break subject to a maximum of 50 per cent of the sum insured (excluding CB accrued) under the current policy period.

VI. Wellness Incentives

To enable the individuals to lead longer, healthier and more productive lives, the following wellness features shall be made available to all the insured persons by duly complying with the provisions of Regulation 19 of IRDAI (Health Insurance) Regulations, 2016 and the applicable guidelines notified thereunder.

VII. Health Check-ups and Consultation Services

Under this cover, the insured person shall be made available access to the health consultations across the network providers or other empanelled hospitals of the insurer for getting periodic consultation of at least once in a policy year.

VIII. Disease Management

Under this cover, every insured person should be provided access to the professional medical services for bettering the health profile. As part of post-hospitalization services follow up care shall be made available, as part of disease management. Insurers may also provide other suitable services under this programme.

IX. Fitness Activities

Under this cover, insurers shall provide parametric indices based on the fitness regime being followed by the insured person, during the policy tenure and the reward mechanism shall be designed to incentivize the policyholders to continue with the fitness regime.

X. Outpatient Consultations or Treatments

Under this programme, the insured person should be provided services of outpatient consultations or treatments periodically or based on the pre-determined triggers contingent upon the health of the insured.

XI. No deductible features are permitted under the base cover.

XII. A standard co-pay shall be offered.

XIII. Add-ons or optional covers are not allowed to be attached to the base health cover under standard health product policy.