Health Insurance Definitions & Terms

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Everyone wants the best for themselves a for the family, however in the jargons used the policies and in the literature available over the place pertaining to health insuran it would be wise to be in informed consum and know common terms and definitio pertaining to health insurance before y narrow down your search for the best hea insurance plan for yourself or for any meml in your family.

Find definitions of common terms a definitions for some of the key words used insurance plans over here. The hea insurance glossary here serves as a gu and dictionary to help you, the consumer understand common terms used in hea insurance and make you a knowledgea person - an informed user!

Health Insurance Defintions and Terms Glossary

- **Agent**
  An agent is appointed by the insurer to conduct business on behalf of the insurance company. An agent must hold a license issued by the IRDA.
- **Claim**
  The process of applying to the insurer for reimbursement of the expenses incurred for treatment is called “filing a claim”. Usually, this process is handled by a service provider to the health insurance company. This service provider is called a “Third Party Administrator”
- **Cashless Claim**
  As the term suggests, the insured can make a claim without paying any cash upfront.
  The insurer or its Third Party Administrator have tie-ups with network of hospitals and nursing homes called a “network hospital”(see below) across the country. The insured can get themselves admitted in these specified network hospitals and take treatment for the disease contracted without any cash payment to the hospital at the time of discharge.
  However cashless mediclaim settlement is subject to the limits and sub limits which is subject to the sum insured of the policy.
- **Coverage Amount**
  Coverage amount is the maximum amount payable in the event of a claim. It is also known

as “sum insured” and “sum assured”. The premium of the health insurance policy is dependent on the coverage amount chosen by you.

- **Critical Illness Policy**
  A Critical Illness is a serious possibly terminal disease, which is strictly defined by the insurer. Conditions such as cancer, multiple sclerosis, major organ transplants are deemed as “Critical Illness”. Most critical illness policies provide for the payment of a lump sum benefit if the policyholder is diagnosed as suffering from one of a number of specified terminal conditions.
- **Cumulative Bonus**
  Each claim free year ensures that you get a benefit known as “cumulative” bonus - it is similar to “no claim discount”(see below) in concept. The only difference being that instead of giving an upfront discount, the health insurance company adds more benefits for the same premium paid. However, the overall amount of these benefits will not exceed a certain percentage as specified in the policy.
- **Disability Insurance**
  Disability insurance is a form of insurance that pays a monthly income to the insured when he suffers from total or partial disability. This disability could have been caused due to either illness or injury, but affects his capacity to work and consequently earn.
- **Domiciliary Hospitalization**
  Domiciliary Hospitalization is the treatment of the patient is carried out at home. This needs to be as per the doctor's recommendation. Most health insurance companies do cover domiciliary hospitalization subject to a certain limit depending on the sum insured.
- **Exclusions**
  Exclusions are diseases and conditions for which medical expenses are not covered by the health insurance policy. Exclusions can be of two types – Permanent and First year. Permanent exclusions are never ever covered by the policy for example, AIDS or expenses incurred on cosmetic surgery. First Year exclusions are ailments which are not covered for the first year of health insurance cover, but are covered subsequently for example surgery for cataract is usually not covered in the first year but is covered starting the second year.
- **Floater Policy**
  A floater policy is issued with a single sum insured covering number of individuals. Simply put, it is a one premium and one policy for all members of the family. The cover can be used any member of the family any number of times. For example, there are four members in your family- you, your spouse and your two children. You purchase a family floater policy with a sum insured of Rs 500,000. This means that if you fall sick and utilize Rs 200,000 in treatment- the balance Rs. 300,000 can be utilized by any member of the family including yourself. Your total expenses across the family would however be capped at Rs. 500,000.
- **Good Faith**
  Good Faith is a minimum standard to get into a contractual arrangement. It requires both the buyer and seller in a transaction to act honestly toward each other and to not mislead or refrain from providing critical information to the other party. In the context of health insurance in India, it requires you to disclose all relevant personal information like previous disease history to the insurer before buying insurance.
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Group Insurance
A firm or an association may buy a policy to insure members of a group. For example a Company may take a policy to cover a large group of its employees.

- **Insurance**
  Insurance is a contract in which an individual or entity, pays the insurance company in return for the insurance company bearing the risk of loss against specified conditions. The individual receives reimbursement against losses from an insurance company. The company pools the clients' risks to make payments more affordable for the insured.
- **IRDA**
  IRDA stands for “Insurance Regulatory and Development Authority”. It was established in 1999 under an act of Parliament to promote and regulate the insurance industry in India including all its constituents like Insurance Companies, Agents and Brokers.
- **Moral Hazard**
  Moral Hazard is a term used in insurance to describe the phenomena where the customer may seek an undue advantage, as a result of buying insurance or where the customer has not acted in good faith and has provided misleading information to the insurance company.
- **Network Hospital**
  Network Hospitals are hospitals and nursing homes which are associated with the “Third Party Administrator” (see below). Cashless mediclaim is facilitated through this network of hospitals as the TPA directly pays these hospitals.
- **No Claim Discount**
  No Claim Discount is a discount on the Basic Premium if there is a claim free year of the policy. If the insured does not make any claim on his policy, then he gets a discount from 5% to 25% on basic Premium for every claim free year.
- **Overseas Medical Policy (OMP)**
  An overseas mediclaim policy is issued to persons who undertake trips abroad for business or pleasure or for educational purposes. The policy terms are similar to plain vanilla mediclaim policy with no pre-existing disease coverage and similar exclusions as well. The only difference being that it is applicable in the country of travel and not India.
- **Personal Accident Policy**
  Personal Accident Policies are issued as fixed benefit policies whereby specified sums are paid on the occurrence of specified events. These events could be death or disability. This payout is not related to the expenses incurred. For Example: Shyam has a personal accident policy. He meets with an accident and is permanently disabled. He would automatically get 100% of the sum insured and this would be in no way linked to the expenses he has incurred in treatment of the same.
- **Policy**
  A policy is a stamped document which is evidence of the contract of insurance between the insurer and the insured. The policy encapsulates the benefits and features of the policy.
- **Pre-existing Disease**
  A pre - existing disease is any ailment or disease that a person is already suffering from at the time of purchasing health insurance.
- **Premium**
  Premium is the amount paid by the insured (the buyer) to the insurer for the policy. Simply

put, it is the cost of the insurance policy.

- **Proposal**
  Proposal forms are used to give the insurance company full particulars of the risk against which insurance protection is desired. This proposal form is the basis of the health insurance policy. Any misrepresentation or non-disclosure of facts would make the insurance null and void.
- **Proposer**
  Proposer is the insured who seeks protection against loss he may suffer due to happening of a contingency.
- **Renewal**
  Health insurance policies are usually annual contracts. At the end of the policy period, the policy has to be renewed by the insurers. But renewing a contract of insurance is at the discretion of the insurer. There should be continuous renewal of the policies. If there is a break in insurance, the insured would lose the benefits of insurance in the event of any contingency.
- **Reimbursement**
  Under a Health Insurance policy, the cost of various hospital charges (such as bed charges, medicines, lab tests, surgeon's fees etc) are paid back to the insured who makes the claim. In other words, the insured pays the (hospital) expenses incurred, but thereafter gets reimbursed by the insurance com.
- **Third Party Administrator (TPA)**
  Third Party Administrators are the authorized claim settling agents of the Insurer. They scrutinize the expenses incurred vis-a-vis coverage under the policy. And ensure compliance of the policy terms and conditions and warranties and subject to the limit of sum insured. The insured needs to interact with them for settlement of claims. The TPA also empanels hospitals to be part of the network to facilitate cashless settlement of claims.