What is a Medical Insurance (Family Floater) Policy
This policy covers expenses incurred by an insured member of a family in a hospital in India towards treatment of an illness, disease or accident.

**Why is Medical Insurance needed**
Lifestyle diseases are on the rise. Some of us are additionally exposed to occupational health hazards. Despite all precautions, we do run the risk of contracting an illness or meeting an accident. Healthcare is expensive. Technological advancement in treatment of most diseases has rendered cost of treatment beyond the means of most of us. In an unfortunate situation, where we face an expensive treatment, we either have to draw from our savings or borrow money. Medical insurance provides much needed financial relief.

**What is insured**
Room, Boarding charges, nursing charges, fee payable to surgeon/ anesthetist / specialists/ consultants, the cost of anesthesia / diagnostic tests / medicines/ blood/ oxygen/ appliances like pacemaker/ artificial limbs/ organs/ operation theatre charges/ dialysis /chemotherapy / radiotherapy and similar such expenses are covered.

**What is not insured**
Ordinarily the following conditions or expenses are not insured by most insurance companies in India. But some of these exclusions can be covered after a specified period or on payment of additional premium.

1. Pre-existing diseases i.e. Any condition, ailment or injury or related condition(s) for which insured person had signs or symptoms and/or was diagnosed and/or received medical advice/treatment within 48 months prior to his/her health policy with the company. Pre existing diseases will be covered after a maximum of four years since the inception of the policy.
2. Any disease contracted during the first 30 days of inception of policy except in case of injury arising out of accident.
3. Certain diseases such as cataract, piles, hernia, and sinusitis etc. are excluded for specified periods if contracted or manifested during the currency of the policy.
4. Injury or Diseases directly or indirectly attributable to War, Invasion, Act of Foreign Enemy, and War like operations.
5. Cosmetic, aesthetic treatment unless arising out of accident.
6. Cost of spectacles, contact lenses and hearing aids.
7. Dental treatment or surgery of any kind unless requiring hospitalization.
8. Charges incurred at Hospital or Nursing Home primarily for diagnostic, x-ray or laboratory examinations, without any treatment.
9. Naturopathy or other forms of local medication.
12. Diseases such as HIV or AIDS.
13. Expenses on vitamins and tonics unless forming part of treatment for disease or injury as certified by the attending physician.
14. Convalescence, general debility, run-down con

**Which are the diseases which are covered after first year/ second year**
The expenses on treatment of certain diseases such as cataract, hernia, piles, sinusitis, benign Prosthetic Hypertrophy, Hysterectomy for Menorrhagia or Fibromia etc. which are excluded for specified periods can be insured subsequently.

**Add-on Insurance Covers**

Insurance companies in India, offer certain add-on covers either free of any charge or at additional premium. Some examples are as follows.

1. Ambulance Charges for shifting the insured from residence to hospital.
2. Ayurvedic/Homeopathic and Unani system of medicine up to a limit
3. Pre-hospitalization expenses
4. Post-hospitalization expenses
5. Domiciliary hospitalization

**Are maternity-related expenses insured**

Most insurance companies do not cover maternity and related conditions but some companies have specific plans which cover maternity after specified waiting periods generally 2-4 years.

**What are Pre-Existing Diseases**

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**What is Pre and Post hospitalization treatment**

Medical Expenses incurred immediately before or after the Insured Person is hospitalised, provided that (1) such Medical Expenses are incurred for the same condition for which the Insured Person’s Hospitalisation was required, and (2) the In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company. Most insurance cover pre and post hospitalization treatment for 30 and 60 days respectively.

**What is Domiciliary Hospitalization**

Domiciliary hospitalization means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances.

1. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
2. the patient takes treatment at home on account of non availability of room in a hospital.

**Who can be insured**

Most insurance companies cover the proposer, spouse and two dependent children in a family. The maximum age up to which one can take insurance is ordinarily 60 years but some insurance companies also insure those who exceed this age limit.

**Floater Sum Insured**

Sum insured is an amount chosen by a customer as the limit up to which he can claim hospitalization expenses in a year for self or for other insured family members. Floater Sum insured means the Sum Insured as specified for the proposer under a policy and is available for any or all the members of his/her family for one or more claims during the tenure of the policy.
How is premium calculated
Premium charged by an insurance company depends on the sum insured, family size, age, past claims experience etc. Some insurance companies have divided the country into various zones and charge the premium based on the geographical zone in which the insured undertakes to seek hospitalization.

What is Cumulative Bonus
Cumulative Bonus is an increase in the Sum insured by a specified percentage, offered by insurance companies without charging any premium, for every claim free year, subject to a certain maximum. An important point to be remembered is that the policy should be renewed without a break to avail of the cumulative bonus.

Is there an Income Tax exemption on the premium
Premium paid for medical insurance policy is eligible for tax deduction under section 80 D of the Income Tax Act. As per current IT rules you can get an exemption as follows.
1. up to a maximum sum of Rs.15,000/- from your taxable income under Section 80-D for Health Insurance Premium paid for self, spouse, dependent children
2. Additional exemption of up to Rs. 15,000/- if you pay the medical insurance premium of parents. This exemption limit goes up to Rs 20,000/- if the parents are above 65 years in age

Typical Claims Procedure
An insured patient has to show his / her health card at hospitals for identification and verification of insurance particulars. Post-verification, the line of treatment and the charges there for are fixed by a hospital and the same are conveyed to the insurance company (or TPA). The TPA authorizes the treatment, based on the policy conditions, limits and sub-limits, and treatment is dispensed by hospitals. On conclusion of treatment the patient is discharged and the hospital bills are settled by the TPA directly.

Duration of Hospitalization
An insured patient has to be hospitalized for a minimum period of 24 hours consecutively in in-patient care for a claim under a Medical insurance policy to be admissible. This restriction, however, does not apply to Day Care Treatment, where such admission could be for a period of less than 24 consecutive hours.

Day Care Treatment
Day care treatment refers to medical treatment, and/or surgical procedure which is (1) undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and (2) which would have otherwise required a hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

Cashless Facility
Cashless facility means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved. Most insurance companies in India provide cashless claims facility either directly or through a Third Party Administrator (TPA). Cashless facility means that a claimant does not have to pay upfront, up to available policy limits and sub-limits, to a hospital for the treatment availed.
Third Party Administrator (TPA)
Licensed by IRDA, TPAs are engaged by the insurance companies to facilitate cashless facility at empanelled hospitals. The TPAs authorize expenses for treatment and settle the charges directly with the hospitals.

Panel Hospitals
Most insurance companies have empanelled, directly or through a TPA, hospitals and nursing homes for providing cashless service to their customers. Names of these hospitals are widely publicized on the websites of the insurance companies or the TPAs engaged by them.

Health Cards
These are cards issued by an insurance company or a TPA for identification of the family members insured under a policy. Some insurance companies issue health cards with the photographs also.

Portability
A policy holder can shift his / her insurance from one insurer to another for any reason by exercising the portability option. Portability means the right accorded to an individual health insurance policy holder (including family cover) to transfer the credit gained by the insured for pre-existing conditions and time bound exclusions if the policyholder chooses to switch from one insurer to another insurer or from one plan to another plan of the same insurer, provided the previous policy has been maintained without any break.