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PERSONAL FINANCE - INSURANCE

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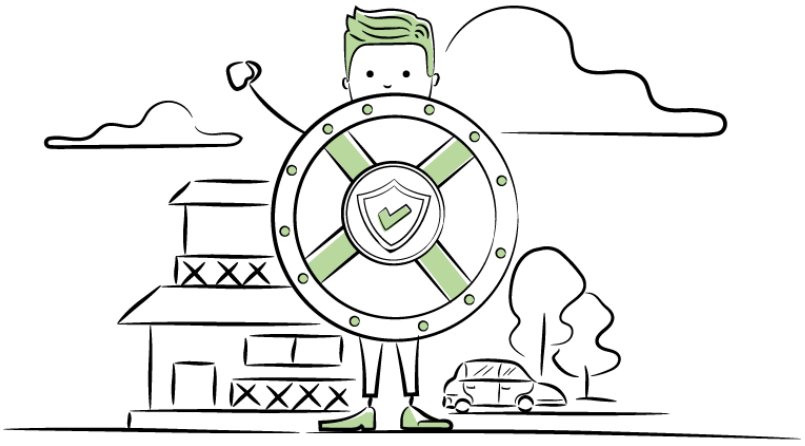

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Chapter 1

Introduction

1.1 – Overview

This chapter is authored by Shrehith from Ditto.

Most people in this country live on a tight budget. They don't have a large savings corpus. They don't have an emergency fund. They don't have a lot to fall back on. Even those with better financial security are wholly unprepared to deal with the odd curveball life throws at you.

But this isn't their fault per se. If anything, this isn't a fault at all. People shouldn't spend every waking minute of their life thinking of all the possible things that could go wrong. And they shouldn't be living in a constant state of worry and panic. It would be a sorry way to live. However, throwing all caution to the wind wouldn't be prudent. As any good driver would argue—"Eyes firmly planted on the street but for the occasional glance at the rearview mirror."

You, too, would do well to check the rearview mirror every time.

Consider, for instance, a trip to the hospital. It can drain you physically. It can drain you mentally. And it can drain you financially. The prospect of healing from physical and mental trauma is already daunting. But to deal with a massive financial burden as you're recovering from a debilitating illness can be crippling. Some would argue that this is an isolated experience. That the government aids individuals who genuinely need the money. However, reality tells a very different story. Individuals in their capacity bear two-thirds of all medical costs. In some areas, it can be as high as 90%. You don't get much help from outside, and even when you do, you have to work hard for it.

In most cases, a single hospitalization can wipe out years of savings. In other cases, it can push people into a debt trap. And it's not just the hospitalization you have to worry about. You'll often have to contend with various diagnostic exams before doctors can determine what's wrong. Post-hospitalization, you'll have to contend with medication costs. Modern treatments are costly, and medical inflation usually peaks at 7–8% yearly.

To put it simply, falling sick can be an expensive affair. And it also has the potential to upend your life altogether. It can prevent achieving true financial independence and strike havoc at any point in your life.

Unless that is, you have a comprehensive health insurance plan.

This nifty insurance product can take care of all your pesky medical bills, and you won't have to pay a bomb. It can stave off a crisis and help you achieve financial independence. It is a lifesaver; you'd expect most people to spend good money on a comprehensive health policy.

However, that isn't happening. Most people don't consider these things worthwhile, and even those who do, penny-pinch when buying a health insurance plan. And if you're wondering why this may be the case, let me explain.

1.2 – A game of cat and mouse

The basic tenets of a health insurance contract are relatively straightforward. Of course, you pay a small fee (a premium) every year to cover all future medical expenses, subject to some reasonable restrictions.

However, despite the seeming simplicity here, there are infinitely many possibilities to consider. When you try to parse these possibilities, you'll begin to see why people despise the prospect of buying health insurance. It's a chore. A complicated mess of conditions and exclusions. A product that will abandon you when you need it the most.

What should have been a lifesaver is thought of as a needless distraction.

But perhaps it doesn't have to be this way. Maybe the reason why people feel let down by health insurance products is that they're party to an unequal contract. Think about it. When you accept the health insurance proposal, you're signing off on an agreement you probably haven't even read thoroughly. On the other hand, insurance companies have spent countless hours pouring through every detail and word in the document.

They have lawyers drafting policies that give them an extra edge during payouts. You don't have that.

They have dedicated teams working on fine-tuning benefits. You don't have that either.

They have experience on their side. You have none.

So it should be no surprise that you are at a disadvantage here.

Some would suggest that the only alternative here is to draft a custom contract with the insurer, where you can dictate terms and conditions.

But that is not feasible. Insurance contracts have to be standardized. It's the only way insurance companies can sell policies to a large group of individuals. They will turn their back on you if you insist on a custom contract. That means your

only option is to work within the confines of this standardized document. It would help if you found ways to come out of this transaction relatively unscathed even though the odds are stacked against you.

This brings us to this module.

Unlike most health insurance guides that try and walk you through the definitions, this one will be structured differently. Instead of elaborating on the terms and conditions, we will explain the logic behind imposing them in the first place. It's like the title suggests—This is a game of cat and mouse. When the gong strikes and the claim is made, you want to extract every penny, and the insurer wants to keep every penny. The only problem—the insurer has a well-defined strategy to mitigate risk on their end, but you don't have one.

So the objective here is to equip you with a blueprint. A blueprint that will walk you through the many ways in which insurers and their affiliates protect their interests. A blueprint that will offer you a sneak peek into their minds, so you know what to do when you have to make your purchase.

As Sun Tzu once said—The opportunity to secure ourselves against defeat lies in our own hands, but the enemy himself provides the chance of defeating the enemy.

And while insurance companies aren't quite the enemies here, they are worthy adversaries who will not accept defeat lying down. They are prudent. They are diligent, and most importantly, they are prepared.

So it's time you do the same.

Chapter 2

Perverse Incentives

2.1 – Filling the application right

This chapter is authored by Shrehith from Ditto.

A few months ago, a young chap came to us seeking help—completely distraught after his rejected claim. The individual in question had bought a policy from a family friend—an agent. At the time, the man had intimated to the agent that he had been diagnosed with throat cancer a few years prior. The treatment had been deemed a success, and he was in complete remission.

But he was still sceptical of getting his hands on a comprehensive policy considering the stigma surrounding cancer. To his relief, however, the agent assured him that he would get his health policy without much issue.

And he did!

So by the time he approached us, he had already held the policy for five years. And according to our estimates, we had paid close to ₹86,000 in premiums—a substantial sum. These were the case facts. So, at first sight, it made no sense to us that the insurer had denied paying out his claim. However, he soon confessed that the insurer repudiated the claim after contesting that his pre-existing condition hadn't been disclosed earlier. That they were forced to reject the claim citing non-disclosure of medical history.

Okay, that should explain it then. This is a matter of non-disclosure—an open and shut case. Insurance companies are not obligated to pay when customers don't act in good faith.

So we were just about to break the bad news when he interjected again. In a rather curt tone, he argued that he had disclosed his condition to the agent but couldn't find a mention of it in his policy document. He was perplexed by this oversight. But as soon as he divulged this new detail, we knew what had happened.

Humans are notoriously rigid, but throw some incentives in the mix, and they'll become pretty malleable. It's one of the reasons why the insurance industry is built on a very competitive incentive structure. It's a product few people want to buy. So you have to have a rather extravagant commission structure. Agents (including us) get paid a lot of money when we make a sale. And sometimes, these incentives can turn perverse—forcing these people to do the most despicable things.

The agent in question had played a dirty trick. He knew that our man was unlikely to get a health plan with his past medical history. Insurance companies don't mention this explicitly, but it's an unsaid rule within the retail industry.

Cancer patients are a no-go, even if they are in remission. No matter how high you push the premiums, it's unlikely to compensate for the substantial risks insurance companies will likely take when they cover somebody diagnosed with cancer. And while this may come as a surprise to some of our readers, industry incumbents (including agents) have known this detail forever.

So you'd expect them to be honest with this information. However, that isn't always the case. Some agents will tell you no such thing. They'll convince you it's not a problem. They want to make the sale come what may. And if they believe suppressing material facts will help you land a policy, they'll do just that. Sure, the insurer may stumble on this nefarious scheme. But that doesn't happen all the time. And once the policy is issued, the agent stands to make a windfall, at least until you find out that it's all a sham.

In this case, the agent in question likely concealed this detail to profit off the unsuspecting individual. He filled out the application for the customer without any mention of cancer. Now, consider that most insurance companies call customers and conduct an independent evaluation if a pre-existing disease is mentioned. But without any declaration, they'll likely issue the policy without further intervention. In other cases, agents may coach their customers to hide sensitive details. They'll tell them it's a non-issue and coerce them to follow their cues. And if it's a family friend—as was the case with our customer, most people wouldn't think twice.

Another gimmick they pull off is the infamous age-premium discount. When customers push for a discount, agents are left with no choice but to comply. But insurance companies seldom offer such discounts. So agents do the only thing they can. They fill out the application—only they take your age and cut it down by ten years. 50 instead of 60, 25 instead of 35. It looks like an honest mistake, but it's not. The premiums meanwhile drop substantially. It seems like a bargain at the price point, but it's only because the agent lied on your proposal form.

This is why it's imperative for you always to double-check the application. If it's an online platform, you'll likely have to do it on your own or at least prompt a

sales executive to fill it for you. You'll have to be doubly careful if it's an offline agent. Seek out the application and check for any discrepancies. Mistakes can creep in despite vigilance. So spend some time combing through the application, especially if you feel something is amiss. You can even call the insurer directly if you have any additional concerns. But never trust anybody implicitly. Because their incentives may not bode well for your ambitions.

Chapter 3

The nudge

3.1 – Understanding protection, cover amount and premiums

This chapter is authored by Shrehith from Ditto.

An average human spends about 8 hours of his day sleeping. About an hour each day eating. A few hours are working, and a good chunk is doing nothing significant. Most days aren't very eventful. They look the same. They feel the same, and people go to bed expecting this routine to persist.

We are like chickens. A chicken fed daily has no reason to believe it won't be provided tomorrow. The chicken's experience will have it convinced that the feeding exercise will continue perpetually. That life will move on just as it did yesterday. But that isn't true. The hand that feeds the chicken will one day wring its neck. And life will never be the same.

It's an example that illustrates a classic problem that plagues the human mind—Our lived experience gives us a false sense of security. It distorts our perception of risk. And when bad things do happen, we are wholly unprepared to deal with them.

When we ask people to pick a cover while buying a health insurance policy, most people choose a sum no more significant than ₹2–3 lakhs. Ask them to justify this response, and they'll often fall back on their lived experience. Hospitalisations are rare. And when they happen, it's the usual suspects doing the damage—Malaria, a broken bone, or lousy appendicitis. Medical expenses seldom exceed the ₹2–3 lakh mark, and a cover above this sum seems needless.

But this isn't a good way to think about health insurance. Sure, ₹2–3 lakhs isn't a modest sum by any account. But it isn't a life-changing sum either. If you're ever hospitalised for an ailment, you will likely be able to put together this kind of money without an insurer. It won't be pleasant, and it most certainly won't be easy. But it's something that you can hope to cobble together if you need the cash.

What will cripple you, however, is the bone marrow transplant that costs ₹25 lakhs. Or the recurring cancer treatment that can push you to the brink of financial ruin. Your only option then is to binge on debt or crowdfund your treatment—Seek help from friends and family. If that doesn't do, you'll have to settle for the public healthcare system and see what they can do for you.

This sequence of events can fundamentally alter the course of your life. It can leave you battered and bruised. So most agents will nudge you to consider a cover that adequately protects you from these difficulties. They'll draw up a

comprehensive list of treatments that cost well over ₹50 lakhs and goad you into considering a hefty cover. They'll even draw up an imaginary use case—of a confident Ramesh who opted for a measly cover of ₹ five lakhs and then went bankrupt as he tried to recover from a rare neurological problem.

And while all this may seem like prudent advice, it is, unfortunately, a con.

This time, the hypothetical agent was nudging you to consider an alternative to optimise his income. And not necessarily your health outcomes.

The reality is—we aren't like chickens at all. Chickens can't compute likelihoods and probabilities. We do. And even if rare events can upend our lives altogether, we can approximate the possibility of such an event ever transpiring.

Sure, there is a case to be made that the relatively inexpensive treatments (₹1–2 lakhs) aren't the ones you should be worried about. That it's cancer and the transplants that do the most damage. But ask yourself this—How expensive do these treatments get? What kind of money do people usually shell out when recovering from such ailments?

In our experience, even the more expensive treatments hardly ever breach the ₹20 lakh mark. You'd have to struggle to find a comprehensive list of treatments that will cost you more. You could raise a massive bill by staying in a deluxe room at a luxurious hospital. But in most cases, people are prudent with their spending.

When they find out their treatment could cost a lot of money, they find a hospital (and a room) that fits their budget. So the likelihood of racking up a ₹50 lakh bill is so remote that it may not even be worth considering at the moment.

Also, the agent's reasoning is riddled with logical inconsistencies.

At best, the idea that a ₹50 lakh cover will protect you from all difficulties is dubious. What if you had to avail a treatment that costs well over a crore? What if such treatments can only be availed outside India? What if it's a disease that insurance companies don't cover at all?

Sure, you could try and optimise for these use cases. But it's a never-ending cycle. I could always draw up a list of diseases and scenarios where your insurance wouldn't protect you, and you would have to try and source a policy that does.

There is no end to this. The truth is that no cover can protect you from all tragic outcomes, and the agent, in this case, is simply trying to extract a higher premium by heightening your anxiety.

Also, in most cases, health insurance policies offer you significantly higher protection than you may have imagined. For instance, with a comprehensive approach, you could get a base cover of say ₹ ten lakhs, a no-claim bonus that could add another ₹ ten lakhs in a couple of years, and a restoration benefit that would offer you an additional ₹ ten lakhs worth of protection.

All in all, you'd be covering for most exigencies by picking a cover anywhere between ₹10–20 lakhs without spending a fortune. Now some people will read this: "If you can get ₹30 lakhs worth of protection with a ₹10 lakh cover, why not go for something lower?"

You could. But bear in mind that healthcare costs don't stay the same. They increase at about 6–7% every year, and within just a few years, the ₹5 lakh cover may seem wholly inadequate. You could also try and beef up your body at the time, but bear in mind that insurance companies will only let you do this if you're in tip-top shape.

If you've made massive claims in the past or you have a heart condition, insurance companies may not afford you that opportunity. So if you're seeking comprehensive protection for at least the next ten years, then a ₹5 lakh cover may not cut it.

But is there a case to be made for a little cover? Is there no utility once you go lower? Well, of course not. As you get older, the risk of hospitalisation increases somewhat disproportionately, and your premium could jump manifold if you

already have pre-existing conditions. So, a minor cover may make sense for older folks if the tips look prohibitive.

Also, if you're in no position to pay these premiums consistently yearly, it most certainly makes sense to pick a more petite figure.

Remember, the last thing you want to do is buy a policy, pay those premiums diligently for a couple of years and then forego it altogether because you can't put up the tips. We routinely hear from people who abstain from their policy after falling short of funds. On some occasions, you could attribute this misfortune or a tight budget.

On other events, it's entirely attributable to the impossible burden of ever-increasing premiums. And while you should be worried about both outcomes, the latter often catches people off-guard. Health insurance premiums don't stay the same. Instead, they keep changing as you renew your policy each year.

- Every year, your premiums will increase 4–6% to counter inflation. As costs of treatments keep rising each year, your insurer will bump up your premiums by a similar margin to compensate for the added costs.
- Your premiums could also increase if you are transitioning between different age bands. Think of it this way—Some insurers will seek higher compensation from a 36-year-old but settle for a lower sum while dealing with people between 25 and 35. However, as you grow older and cross the 35-year-old threshold, they will bump up your premiums to compensate for the added risk you carry. Insurers will have their price chart for different age bands, and they will adjust your premiums as you transition between them.
- If the insurance company has priced a policy at dirt-cheap levels, they may alter the pricing structure once they figure they can't turn a profit. Do note that they can't increase prices arbitrarily but instead have to work with the

regulator if they're to accomplish this. But it can happen and sometimes come out of the blue.

- What insurers can't do is increase your premiums because you claimed in any given year. It's essentially an urban myth.

But regardless, you will be expected to pay higher premiums each year, and if you aren't confident about your ability to come good on this sum, you may want to consider a lower cover. After all, some protection is better than no protection, and a health insurance policy will always protect you, no matter the surface.

On the flip side, if you're still worried about the other rare events that can cost a bomb, know that there are inexpensive options like Super Top Ups, which offer substantial protection at an affordable price. We'll talk more about those later. But for now, we'll wrap this chapter by saying this much—There's nothing wrong in picking a policy with a cover of ₹50 lakhs or a crore. If it offers you peace of mind, do it right now. But if you're only doing it because an agent told you, you must have another conversation with that individual.

Chapter 4

Skin in the game

4.1 – Understanding co-payment and room rent restrictions

This chapter is authored by Shrehith from Ditto.

Skin in the game—It's an idea propounded by many people, but none more so than the trader-philosopher-statistician Nassim Nicholas Taleb. To have skin in the game is to seek symmetry.

If you get hurt, I get hurt. If you succeed, I succeed.

When you apply this simple maxim to a business arrangement, it will likely benefit both parties. Look at all the examples around you. A pilot will likely heed safety instructions if her life is on the line. A chef will probably keep a clean station if he has to eat the food he cooks. A footsoldier is likely to follow a general if the general is leading from the front. Your incentives and penalties align with those you intend to work with. That's when you truly have skin in the game.

But in the insurance business, things aren't so straightforward. When you buy a health insurance policy, there's a pure transfer of risk, i.e. the insurance company is expected to compensate you fully during a medical emergency. You can decide to splurge if you so wish, and insurance companies will be obligated to pay for every expense you incur. You have no skin in the game once you've bought the policy. And from an insurer's point of view, this is a massive problem. They want you to be accountable in some way. They want you to be penny-pinching at the hospital even if you won't be paying the bill yourself. They want you to have some skin in the game, and to this extent, they devise clever schemes to protect their downside.

Consider, for instance, this case study.

You're about to buy health insurance, and the agent pitches a policy with a cover totalling ₹5 Lakhs. The price is reasonable, at ₹7000 a year, but you want to haggle some more. And that's when he drops the big surprise. He promises to cut down the premium by 25% (roughly ₹1800/year) if only you agree to a 20% co-payment clause. We will talk about what this means, but right now, you're caught up in the moment. Saving ₹1800 is a big deal, so you sign off on the agreement without giving it a second thought.

Unfortunately, nine months later, you suffer an accident. You're hospitalised and need extensive care, and the bill adds up to ₹2 Lakh. No problem. You've got insurance. However, the insurer only pays ₹1,60,000. They ask you to pay the remaining ₹40,000 out of pocket and remind you of the co-payment clause.

See, when you signed off on the contract, you promised to share the load with the insurer. You wilfully declared that you'd pay 20% of the bill if you were hospitalised. And now, you have to pay up.

When you start doing the math, you begin to see how lopsided this arrangement is. You saved ₹1,800, sure. But you had to pay ₹40,000 because of the co-payment clause. It would take ~22 years of premium savings to make up for this fatal mistake. On the flip side, this is a massive victory for the insurer. Not only did they manage to save ₹40,000, but they also got you to penny-pinch. Once you realise you're obligated to pay 20% of the bill, you'll cut back on all the frivolous expenses. You'll book cheaper rooms.

You'll second guess optional procedures. You will request hospital personnel to be prudent with their spending. But it would help if you didn't have to do any of these. It would help if you only were thinking about making a full recovery and not penny-pinching at your most vulnerable moment.

If anything, co-payments seldom make sense unless they are mandatory or you're buying a policy for someone old with pre-existing diseases. In which case, a co-payment clause can bring down premiums drastically. But otherwise, you're better off simply opting out of this seeming "bargain."

The other trick up an insurer's sleeve is the room rent allocation. Often, policies will have a cap on room rent—the kind of money you can spend renting a hospital room. Imagine the cap is set at 1% of your sum insured. 1% of ₹5 lakh insured is ₹5,000 each day. That's not a lot. But what if you're hospitalised and want a pick a better room—one that costs ₹10,000 a day?

Well, of course, you could. But you have to do the math again.

You'll be staying here for a couple of days. So that means you'll have to pay an extra ₹10,000 (2 days*5000). That's not a lot, but two days later, you're discharged, and your insurance company drops a bombshell.

You'll have to pay an extra ₹25,000.

What?

Well, their carefully worded policy document notes that most services rendered in your room, including surgeon fee, consultant fee, other diagnostic exams, etc., will not be covered fully. Instead, they'll only pay a part of it because you picked a too expensive room.

How much will they pay? Well, here's their math. The cap on room rent was fixed at ₹5,000, remember? Your actual room rent stood at ₹10,000. So they'll cover half your room rent and half the cost of all the services rendered in your room. For instance, if you have to undergo an operation, the surgeon's fee adds up to ₹50,000. They'll only pay ₹25,000. The rest is on you.

These rental caps are a big no-no, and people now realise this. This is why insurance companies are getting creative while going about their business. Now, most insurers impose restrictions on the kind of rooms you can pick. Say—a single private room and nothing fancy.

If you prefer something more expensive, you may have to co-pay a part of the bill. And while a single private room could do just fine, you may want to consider a comprehensive plan with no such restrictions. You tend to get better care when you're admitted to a more expensive room. You'll have more attendants. You'll have round-the-clock service, and you could also get a family member to stay with you. It's not a dealbreaker. But it's still food for thought.

Bottom line—Saving a couple of a thousand rupees by opting for a plan with co-pay and room rent caps may seem like a bargain at the time of purchase. However, if you have the money, you would do well to stay away from these items.

Chapter 5

Dunning Kruger effect

5.1 – Understanding medical declarations, pre-existing diseases and loading charge

This chapter is authored by Shrehith from Ditto.

The Dunning–Kruger effect is a hypothetical cognitive bias that alludes to something like this—People, on certain occasions, tend to overestimate their ability even when they may have little to no expertise on the subject matter. You've probably been in this position before—You're talking to somebody about

cricket, and they're waffling nonsense with the utmost confidence. You want to stop them right there and humble them. But that would be not nice. So you let it be.

But if we did the same thing in this line of work, i.e. if we let it be, then that would have catastrophic consequences for everyone involved. The stakes in the insurance business can be pretty high, and we must course correct when customers walk on this dangerous path. For instance, many people we spoke to (when building the insurance business) routinely talked about how they could outwit insurers if push came to shove.

Let me illustrate this with an example.

Imagine you've got diabetes and have been on medication for a few years. If you're trying to get a comprehensive plan, insurers will want to know about your condition. They may even conduct an independent evaluation to see if it's that bad. And once they're through with all the checks, they'll impose a few restrictions.

For starters, they'll likely impose a pre-existing disease waiting period. It's a cool-off period (usually 2–4 years) during which insurers will not pay for complications arising out of said pre-existing condition. In this case—diabetes. And they may even impose an extra charge—called a loading charge to compensate for the risk they'll be taking on while insuring a diabetic patient.

You may have to pay more—10–20% of what regular healthy folks your age pay to get the same plan. In fact, loading charges go up as high as 150% on rare occasions when you have an individual diagnosed with multiple illnesses.

However, armed with this information, you could now try and outwit the insurer. Even worse, you may think it's prudent not to make any declarations regarding pre-existing conditions in the first place.

After all, how will they ever find out if they don't insist you get a blood sugar test done? And in the absence of any declarations, they won't conduct an independent evaluation either, at least not when you're young.

So you could potentially try and get a sweet deal by hoodwinking the insurance company. But alas, this kind of thinking is riddled with flaws. Insurance companies have been in this business for centuries now.

They have a firm understanding of all the devious methods employed by a small subset of people looking to profiteer off this arrangement. Granted, they may not call your bluff at the time of purchase. But they will do so when you make a claim, and I suppose it's best if I illustrate this with another example.

Imagine you come down with a bad case of retinopathy. After treating crippling diabetes for eight years, the blood vessels in the back of your eyes are now shot. You need surgery, and you need it now. Your only saving grace is a health insurance policy you bought recently. But as we already noted, you thought you could outmanoeuvre the insurer by simply making no declaration about your past medical history.

And it's going to bite you back at this point.

Because when you make a claim, insurance companies will be comprehensive with your medical records. They'll sift through the discharge summary and any other documents on paper to evaluate if you have a history of diabetes.

They'll already suspect something is amiss since retinopathy mainly presents itself in patients with uncontrolled diabetes. And once they go through your past medical history, they'll have enough evidence to repudiate your claim. Sure, you could try and fight back by going to the regulator.

Or perhaps take a punt by approaching the courts. But this is a battle that you will not win. You won't have time on your side, and you won't have the patience to fight it out. It'll probably be more expensive than the insurance plan itself. In

all likelihood, you'll be throwing more good money after bad, and it's not a position you'd want to find yourself in.

My point here is this—When you're making those declarations and insurance companies take you at your word, they're not doing so because they're gullible. On the contrary, they are playing this smart.

They know that they can weed out most frivolous claims at the time of hospitalisation; if anything, this arrangement works in their favour. You'll be paying them good money until you make a claim, and they can refuse to compensate you when they find the slightest discrepancy.

A routine complaint from most customers is that insurance companies often go overboard with this kind of thing. That they refuse to pay out a claim even when you're being honest with your declaration. Say you were blissfully unaware of a pre-existing condition, and you only find out about this at the time of hospitalisation; the insurer is obligated to pay out the claim.

But if you make a claim only a few months after buying a policy, the insurer may suspect foul play either way. And if your medical history lends credence to the idea that you may have deliberately withheld information about your pre-existing condition, they can repudiate the claim altogether.

Unfortunately, you can't prevent this sort of thing. Current regulations stipulate that a claim becomes incontestable only after eight years of paying your premium. Until then, there's always scope for debate, and the only thing you can do is try and optimise your outcomes.

How do you do that?

Well, first thing's first. Declare everything—Even if you think it's insignificant. Most customers withhold information not because they harbour malicious intent but because they don't think it qualifies as a pre-existing condition. Somebody with a history of hypertension may think it's insignificant to divulge

this information when it's under control. But if you're keeping it under control using a medication, it qualifies as a pre-existing condition.

It doesn't matter if you think it's benign, so long as you're popping pills. Recent surgeries and genetic conditions also count. If you had a crippling disease a few years back but made a full recovery, that may also be classified as a pre-existing condition depending on the timescale.

Bottom line—It would bode well for you if you were completely transparent about your medical condition. The waiting period and the extra charge may be unsavoury, but it won't be as dreadful as seeing your claim rejected.

A point of interest: Since there is considerable ambiguity surrounding the precise definition of the word pre-existing disease, the regulator has standardised the term to avoid confusion. According to the guidelines, Pre-Existing Disease means any condition, ailment or injury or related condition(s) for which there were signs or symptoms and were diagnosed and for which medical advice/treatment was received within 48 months before the first policy was issued by the insurer and renewed continuously after that.

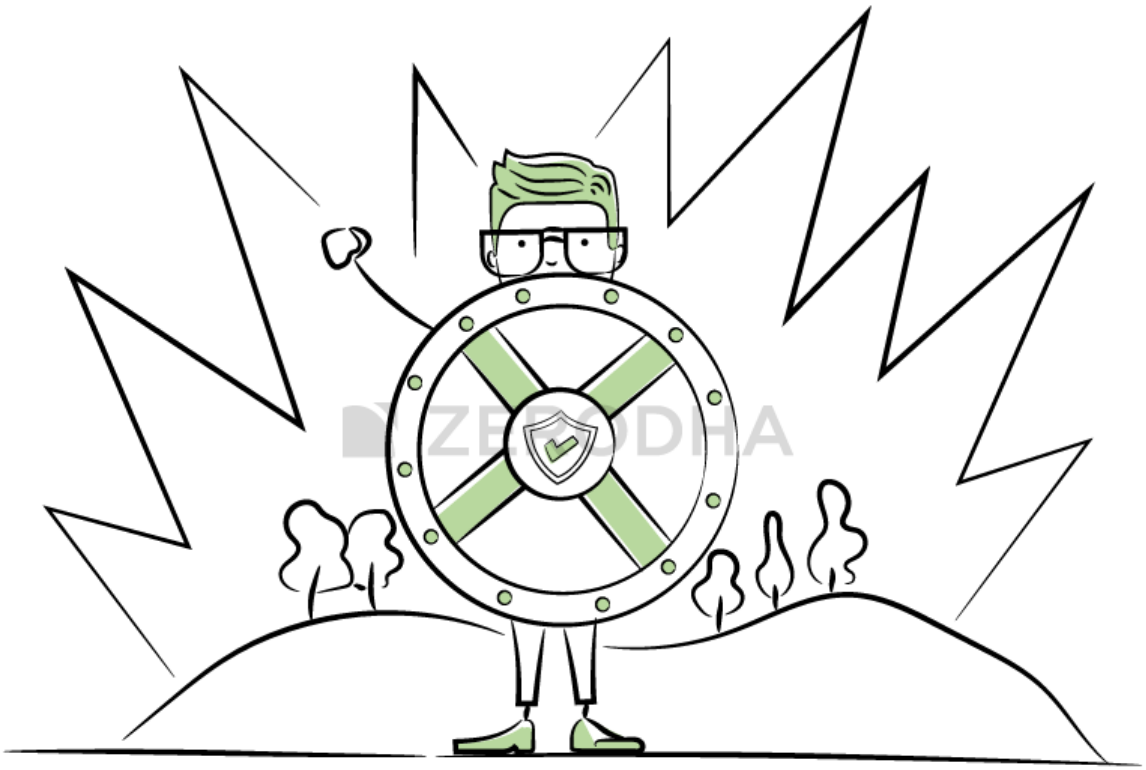
Chapter 6

A mighty defence

6.1 – Understanding specific illnesses, permanent exclusions, disease-wise sub-limits and blacklists

This chapter is authored by Shrehith from Ditto.

While some people have little faith in their insurers, others have an almost unshakable belief in the might of a top insurance company. They are convinced that the insurer will come good during the crisis—That they will pay your bills no matter what. But once again, this is only partly true. And it's not entirely because insurance companies are backstabbing, money-grabbing con artists. Instead, it's because their model is open to abuse.



Consider, for instance, if you're diagnosed with a cataract. It's early days, but your doctor recommends getting surgery in the next year or so. And since you have time on your side, you decide to offset all future medical expenses by getting yourself a health insurance policy.

It seems like a decent plan—To have the insurer pay the bill at the time of hospitalisation. And even though you'll be spending a sizeable premium during this time, you can take comfort in the fact that this sum pales in comparison to the actual cost of surgery, which can often be upwards of Rs. 50,000. So, it's a win-win for you, no matter how you view this.

So how does the insurance company protect themselves from exigencies like these? Can they rely on medical records alone to evaluate whether you've been honest with your declaration?

Well, no. Because they don't have to, health insurance providers have another line of defence. They impose a separate waiting period for a list of illnesses where patients may have the luxury of delaying treatments. Think Cataracts, stones, surgery to fix a deviated nasal septum—that stuff. During this waiting period (2 years on most occasions), you won't be able to claim if you were diagnosed with an illness on this list.

Looking at the sample list of diseases (provided below), you may think that insurers hardly cover anything during the first two years. People routinely complain about the lack of coverage they receive despite paying the premium in total, and it's a pattern we see repeatedly—once we tell them such a list exists.

Organ / Organ System	Illness / diagnoses (irrespective of treatments medical or surgical)	Surgeries / procedure (irrespective of any illness / diagnosis other than cancers)
Ear, Nose & Throat (ENT)	• Sinusitis • Rhinitis • Tonsillitis	• Adenoidectomy • Mastoidectomy • Tonsillectomy • Tympanoplasty • Surgery for Nasal septum deviation • Surgery for Turbinate hypertrophy • Nasal concha resection • Nasal polypectomy
Gynaecological	• Cysts, polyps including breast lumps • Polycystic ovarian diseases • Fibromyoma • Adenomyosis • Endometriosis • Prolapsed Uterus	• Hysterectomy
Orthopaedic	• Non infective arthritis • Gout and Rheumatism • Osteoporosis • Ligament, Tendon and Meniscal tear • Prolapsed inter vertebral disk	• Joint replacement surgeries
Organ / Organ System	**Illness / diagnoses (irrespective of treatments medical or surgical)**	**Surgeries / procedure (irrespective of any illness / diagnosis other than cancers)**
Gastrointestinal	• Cholelithiasis • Cholecystitis • Pancreatitis • Fissure/fistula in anus, Haemorrhoids, Pilonidal sinus • Gastro Esophageal Reflux Disorder (GERD), Ulcer and erosion of stomach and duodenum • Cirrhosis (However Alcoholic cirrhosis is permanently excluded) • Perineal and Perianal Abscess • Rectal Prolapse	• Cholecystectomy • Surgery of hernia
Urogenital	• Calculus diseases of Urogenital system including Kidney, ureter, bladder stones • Benign Hyperplasia of prostate • Varicocele	• Surgery on prostate • Surgery for Hydrocele/ Rectocele
Eye	• Cataract • Retinal detachment • Glaucoma	Nil
Others	Nil	• Surgery of varicose veins and varicose ulcers
General (Applicable to all organ systems/organs whether or not described above)	• Benign tumors of Non infectious etiologye.eg. cysts, nodules, polyps, lump, growth, etc	• NIL

However, this line of reasoning isn't very accurate either. Granted, the list may look prohibitive to somebody who isn't intimately familiar with the medical profession. Still, it only includes a fraction of ailments that you encounter daily.

Dengue, Malaria, a broken bone, cancer (in many cases), and heart conditions are covered after the first 30 days. They're not part of this "specific illness" list.

And so you'll get comprehensive coverage on more occasions than one. You're genuinely vulnerable only after you've bought the policy. For the first 30 days, insurers won't cover anything outside accidental hospitalisations. The precise definition of what constitutes an accident depends on the company. Still, in general, if you needed medical attention after electrocution or a horrible car accident, you could count that as an accident.

Even other insurance companies deploy another more sinister tactic to contain their liability. Alongside the specific illness list, they'll also throw in disease-wise sub-limits.

Imagine an insurer offers you a bargain deal—₹10 lakh cover at a premium of just ₹6,000 a year. It's so good that nobody else can match this price. You are sceptical, and you ponder for a while. But you go ahead with the purchase anyway since he is a family friend.

And then, one day, your worst fears come true. A slipped disk forces you into the operation theatre. You require extensive treatment. The final bill is hefty—₹ 4,36,000—inclusive of all costs. But despite your ₹10 lakh cover, the insurer tells you they can only cover ₹2,00,000. You are outraged, and you press for clarification.

At which point they break the bad news—They have a cap on the total coverage amount specifically mandated for certain diseases, aka disease-wise sub-limits.

For instance, for cardiovascular diseases—They only pay ₹2,50,000

For knee replacements—₹2,75,000

For cataracts—₹50,000

Bottom line—You were suckered into buying a policy that barely pays anything. And while there's no way around mitigating risks associated with specific

illnesses, disease-wise sub-limits are avoidable. You have to pick a policy that doesn't feature such a thing, and you'll be good as gold.

But we're only getting started here since this is just the first line of defence. The second line of defence kicks in soon after to prevent abuse of another kind—a far more severe transgression. Imagine your liver is done for—it's beaten, scarred, and in no working condition.

Your doctor will tell you it's a bad case of liver cirrhosis, and the only alternative right now is to get surgery or a transplant. And if you were hoping your insurance company would come through on the transplant, you'd have to double-check one thing—How'd your liver get so damaged in the first place?

In some rare cases, you could get liver cirrhosis through no fault. But that's only on rare occasions. The likely explanation is that, in your case, cirrhosis is a direct consequence of chronic alcoholism. That your compulsive drinking habits gave way to this tragedy. And here's the kicker—Insurance companies do not cover illnesses that precipitate as a consequence of substance abuse, drugs or even alcoholism.

And this non-coverage isn't just specific to a certain period (as was the case with particular illnesses). Insurance companies never cover this sort of thing, ever. They even have a name for such categorisation—permanent exclusions. So in effect, there is only one way to get the insurer to pay for the transplant—Your doctor has to produce a certificate stating that your condition has nothing to do with alcoholism.

Or you have to bear the costs on your own. And permanent exclusions aren't just limited to substance abuse. It could be extended to a wide array of use cases—ranging from those that seem pretty reasonable and others that are borderline extreme.

For instance, insurance companies are known to exclude all sorts of cosmetic treatments permanently, i.e. They won't reimburse costs associated with fixing

misaligned teeth. Still, if you accidentally broke your jaw and need surgery, they'll pay for it.

They draw the line (in most cases) by asking a straightforward question—"Is the treatment deemed medically necessary, and does it significantly impair your quality of life?" If the answer is no, you'll have a tough time getting the insurance company to pay up. And while this seems like a reasonable exclusion, others may seem a bit extreme. For example, insurance companies are also known to permanently exclude all treatments associated with external congenital diseases—visible conditions present from birth.

Bottom line—You would do well to take your policy document and review all permanent exclusions before you sign off on the agreement. If you want a sample list, here's something to get you going.

But wait, we are not done yet. The third and fourth lines of defence kick in to prevent abuse, not from customers but from hospitals. Some hospitals are notorious for overcharging customers, especially when they know the insurer bears the ultimate liability.

They throw in frivolous expenses—admission charges, administrative charges, extra charge for TV (when there's no TV involved), monitor charge, 100 extra gloves—this sort of stuff. This is why insurers exclude non-medical expenses—often tabulated as consumables. Some companies will cover these expenses if you pay extra, but they are on the exclusion list in most cases.

Then there's the fact that hospitals can also overcharge customers by inflating the cost of treatment itself. Now bear in mind that most hospitals don't do this. They play fair by and large. Sure they may recommend surgery when you have other alternatives, but inflating the actual cost of treatmentis a different ballgame. Because then, they'll have to dabble with some very shady practices.

For starters, they could pursue a line of treatment that may not be appropriate simply because it's more expensive. On other occasions, they may inflate costs associated with intangibles—consultancy charges, surgery costs and other such

things- to extract a king's ransom. But insurers have already accounted for these things.

In both cases, they will have a "get out of jail card" since the policy document states that the insurer is only obligated to pay for treatments deemed "just and reasonable." They're also only expected to settle claims when doctors pursue a line of treatment that is considered acceptable by the medical council of India.

Ultimately, if the hospital tries to con the insurer, they'll walk out of it relatively unscathed, leaving you fully exposed. This is why it's always best to get a second opinion when dealing with expensive medical procedures.

And finally, some hospitals run illegal rackets—plain and simple. They may not have the necessary documentation to run a licensed medical facility, or maybe they're known to have conned insurance companies in the past—by inflating costs or forging records. So most insurance companies will also have a designated blacklist—a list of hospitals they won't work with. And if you seek treatment in such a facility, they can repudiate the claim on most occasions.

You can find this list at the back of your policy document, or you could get an updated list on the insurer's website.

So, if you're expecting the insurance company to come through every single time, you may need to revisit that idea. However, once you're intimately familiar with the nuance surrounding exclusions and waiting periods, you can better navigate hospitalisations and the claims that follow soon after.

Chapter 7

No free lunch

7.1 – Understanding Discounts, Family Floaters, Group Plans, Employee Insurance policies

This chapter is authored by Shrehith from Ditto.

Everybody likes a good discount.

Are you looking for a new pair of jeans? You'll first want to see if you get 10% off.

Are you buying something on an online grocery delivery app? You'll want a coupon code that gives you a discount.

Are they finalising an insurance plan? You'll probably try to get a discount here too. Unfortunately, discounts in the online insurance space don't work the same way discounts work elsewhere. There are strict guidelines on how insurance companies can price their products, so you'll be hard-pressed to see an agent throw an extra 10% off on the premiums because you were nice to them.

Instead, you'll see subtle differences in pricing across different channels. Suppose you're buying insurance through an offline agent. In that case, it's likely that you will have to pay a higher sum considering insurance companies will have to compensate for the extra cost associated with running a brick and mortar facility.

Put another way; you probably will get a small discount if you buy the same product online. Some insurers will also have a different pricing structure within the online sub-domain. They may offer you a small discount if you buy the policy directly from the insurer's website while not extending the same benefit elsewhere.

And this gives people the impression that it would be prudent to buy the policy from the insurer without an intermediary. And that assessment, while reasonably accurate, does have a few issues.

For starters, every channel partner that markets the product will fight back when they see a price disparity. For instance, if an insurer extends a policy at a significant discount to online customers, offline agents will hardly be able to make a sale considering customers often compare prices online. And as such, a substantial discount would effectively dissuade offline agents from ever working with the insurer.

Elsewhere, across online channels, this effect is even more pronounced. People buying a policy through an online intermediary will almost always check prices with the insurer directly. The intermediary is bound to lose when the price disparity becomes evident.

And this is precisely why you rarely see any difference in premiums when comparing prices across the intermediary channels and the insurer's website online. Even when some products boast a difference, the discounts are usually limited to less than 5% of the premium paid during the first year. So, anybody promising you a substantial online value may be duping you.

But what kind of discounts are available to people? How do insurance companies incentivise you to buy their product?

In some cases, you may get a discount on premiums if you prove that you're living healthy. Many insurance companies incentivise people to walk daily and also have an app to track progress. If you meet the quota over the specified period, you'll be entitled to a discount while paying the premium next year. Even others may offer a discount to medical professionals or when you buy a policy for 2 or 3 years as opposed to the standard tenure of 12 months.

But if you're still searching for something big, you'll have to think differently about insurance. Perhaps consider including multiple people in the same plan and purchase what is called a family floater policy.

Think of it this way. A family floater policy covers you and your family under a single umbrella contract. You can include several people in the same plan and pay a single premium for combined coverage. However, most insurance providers have a relatively narrow definition of what dependents mean. And they only let you include your spouse and kids alongside yourself.

But despite this restriction, it is an economical option for people on a budget since you can get these products at a significant discount compared to individual plans. Granted, the flipside is that you will have a combined cover of 10 lakhs instead of having 10 lakh each, but if you can live with that, this could be a decent option for most people.

The only niggling feature is that your kids must move out of the plan after they breach a certain age threshold. And as we already noted, you may not have the

opportunity to include your parents and siblings in the same plan. So if this is an issue, you may have to look at other alternatives.

Alternatives like a group plan.

Group plans aren't like retail plans. You can't find them on the insurer's website. These are customised contracts drafted for a group of people with some association. For instance, you could have a group policy for all of Zerodha's customers. Or you could have a group policy for all employees in a company.

But for illustrative purposes, let's assume we are talking about a group policy floated by a bank. In this case, the group will consist of members who own an account in the said bank.

Once the group has been identified, the insurance company will need to draft a custom contract for the group. However, they won't extend a policy to each individual. Instead, they will offer a quote to the master policyholder. In this case, the bank. The bank will then choose to price each policy, and that's the premium you'll have to cough up.

Also, the features in the group policy will be tailor-made based on the requirements of the master policyholder, and you will have little flexibility on this front. The upside is that you get a better price, and on average, you could expect to see a group policy sell at a slight discount compared to a retail policy with similar specifications.

The downside, however, is that the pricing is subject to change—each year. And the decision is solely at the discretion of the insurance company. Next year, the insurer might reevaluate the pricing structure, and you might be asked to pay extra if the group starts making claims beyond a particular sum.

Also, you will have your policy so long as the master policyholder survives. But if the master policyholder decides to dissolve the group or if they cease to function, then you'll have a tough choice to make. The insurer will let you switch to a personal insurance plan from the suite of products available to the retail

public. But they may assess your risk once again. If you have diabetes, BP or any other disease, you'll be asked to pay a lot more.

Some will argue that this is unlikely to happen with a bank since they rarely ever go bust. And that's an entirely accurate assessment. But not all groups are built this way. Many companies float group plans while having little financial stability themselves. And this could be deeply problematic for their customers, who may not fully understand the implications.

But there are group plans that do make a lot of sense, and those are plans that many of you may already be intimate with—Employee insurance policies. These are group policies specifically floated by your employer to cover you and your dependents. The employer will bear the cost of insuring you as an individual and sometimes may also bear the costs of insuring your family—including your spouse, children or parents.

Unfortunately, despite its popularity, opinions surrounding employee insurance plans are deeply divided. Some consider this the holy grail of health insurance, which are deeply sceptical of its utility. The truth is that both sides have a point. Employee insurance policies are a godsend for people who can't get insured elsewhere. This may be your last resort if you're a cancer survivor or somebody with crippling heart disease. It is indispensable to your cause.

And then some don't want to put up with the waiting periods—2 years, three years, four years. None of that! They want their insurance to cover everything, And they want it to work from day 1. So if you're somebody who desperately needs immediate coverage, you must love your employee health insurance policy.

However, there's also the fact that employee health insurance policies aren't always the most comprehensive products. I mean, I have to look at the incentives here. Employers must extend a health plan to their employees because the state insists on it. They are expected to shoulder a part of the burden because there is a mandate from the top. However, the mandate tells

them precious little about the specifics. They can tailor the policies any which way they want.

They could make it highly robust, i.e. put together a 10 lakh cover, do away with other restrictions, and include outpatient consultations and maternity benefits. Or skimp on the surface, clawback features, and add a couple of “ifs and buts” to save on costs. And many employers do this. Their focus is on the bottom line. And that is precisely why it always makes sense to read the fine print on your employee health insurance policy.

Also, you may still want to buy a personal health plan even if your employer is extending one. People often switch jobs, dabble with entrepreneurship or simply retire when they don’t feel motivated anymore.

There often comes a time in people’s lives when they don’t want to do the same things they’ve been doing all their lives. At this point, they may find themselves at a crossroads if they don’t have adequate protection. Sure, you could buy a personal health insurance policy when you make this choice.

Still, often, that avenue may not be available if you’re already dealing with a debilitating disease. Insurers may refuse to extend a health policy or, in some cases, make it ludicrously expensive. So if you have some money to spare, you should undoubtedly consider beefing up your employee health insurance policy with a personal plan.

Because you never know when you may want to hang up your boots.

Chapter 8

Gimmick or not (Part 1)

8.1 – Understanding the gimmicks of Insurance

This chapter is authored by Shrehith from Ditto.

Insurance is a cutthroat enterprise. Everybody is trying to outcompete each other. It's all-out warfare.

In this domain, companies have to be creative. They have to have an edge. They must convince customers that their products are best suited for the masses. And to entice these people, they'll whip up creations with cows, bells and whistles. On paper, they'll seem like an absolute bargain. And the sales folk will convince

you as much. But under the hood, these product features may not mean much. If anything, they may be detrimental to your cause.

So how do you separate the wheat from the chaff? How do you know if the insurance company is trying to shortchange you?

Over the following two chapters, we will draw up a list of product features and see if they pass the scrutiny test. We will even offer a relatively concise verdict at the end, characterized by two words—"Gimmick or not."

8.2 – Network Hospitals

You've probably seen it already—Insurance companies boldly proclaiming the thousands of network hospitals they've partnered with.

One company's website reads—5000 network hospitals and counting.

Another one reads—9000+ hospitals at your disposal

And you'll see this pattern repeat across websites. Network hospitals, network hospitals, network hospitals.

But if you're hearing this thing for the first time, you'd be thinking: What on earth does a network hospital even mean? And why are insurers stuck up on this little detail?

Well, here's the thing. Despite the "over-the-top" advertising, network hospitals are a big deal. They can quite literally be a lifesaver. For instance, suppose you've had a minor accident, and you're taken to a hospital just 2 miles off the block.

If your insurer has already partnered with the hospital, here's how things may pan out. The hospital will ask you for your health card and note the policy number. They may also seek to verify your identity to make sure it's you. Once they're through, the hospital personnel will inform the insurer that you're

admitted to their facility. They'll furnish details about the hospitalization, costs, and other procedural matters. And then they'll wait.

If they don't get a reply immediately, the hospital may ask you to put up an extra ₹10,000—Rs. ₹20000 just in case the insurer doesn't come through. After all, the last thing they want is to find out that the insurer has refused to pay the claim and that you can't pay the bills on your own. They don't want to be taking that kind of gamble. So it's a safety deposit they'll immediately reimburse once the insurer gives the go-ahead.

Meanwhile, the insurance company will establish the claim's veracity for an hour or two. They'll want to make sure that you're not currently in a hospital being treated for something they don't cover. And if everything checks out, the insurer will pre-authorize a sum. Say ₹ two lakhs. That's them telling the hospital they will pay up to ₹ two lakhs once you're discharged.

And that's the crux of this story—If you're in a network hospital, the insurer may settle the bills without you putting up a single penny. It's called a cashless claim, a godsend for people strapped for "cash."

On the flip side, if you're not in a network hospital, you'll have to pay the bills and prepare for a rather arduous journey. You'll have to collate all the medical records, fill out the claim form, and get the hospital to sign it. Put all the documents in order. Please send them over to the insurer and wait for them to evaluate everything. Answer any additional queries they may have. Furnish other records that they may seek. Wait some more. And finally, after all this time, maybe the insurer will reimburse your bills.

This can be torturous, especially if you have a hefty bill. This explains why customers and insurers put network hospitals at the front and centre of every "insurance-related" discussion.

However, there is something you should know. Insurers aren't obligated to settle claims cashlessly just because you're at a network hospital. They always have recourse. For instance, if they suspect you're hospitalized for a rather

complicated matter that could cost a ton of money, they'll be highly reluctant to pay anything upfront.

So, many insurers simply decline to process the claim by stating on record that they don't have all the information they need just yet. They'll tell you they want to run a more thorough investigation after accessing your medical records. And will consider your application once you're discharged, but on a reimbursement basis.

On other occasions, their pre-authorize can only be described as "modest at best" One customer we've dealt with had a bill totalling ₹ two lakhs with the insurer only pre-authorizing ₹50,000 at first. He did eventually manage to get the remaining ₹1.5 lakh reimbursed. But it was particularly disheartening at the moment, knowing they wouldn't pre-authorize the whole thing.

So what do you do in such a case? How do you assert your rights? You need to get hold of your insurer and press them for specifics. Let them tell you in no uncertain terms why they're refusing to settle the claim on a cashless basis. If they're only pre-authorizing a tiny sum, then seek out their rationale. If it seems dubious, you can continuously loop in the Ombudsman. This may get them to recon
an extensive rider. And most importantly, remember that a vast network doesn't continually optimize. You're optimizing for all outcomes. Your insurer could have 10,000 across India, but only if but only have ten hospitals in your city. So make sure you get a list of all the hospitals in and around your area before jumping in and making a purchase.

Verdict: Not a Gimmick

8.3 – Alternative Medicine or Ayush Treatments

Medical doctors don't usually like the moniker of alternative treatments. They'll tell you that there are only two kinds of medicine—medicines that work and

medicines that don't. However, insurance companies don't quite agree with this assessment.

They make provisions for allopathic treatments and other alternatives that don't qualify as such. Think—Ayurveda, Homeopathy, Unani and Siddha. And while several insurance companies cover these treatments now, you should know a few things about this seeming benefit.

For starters, you'll only be able to claim if you're hospitalized in a government-certified Ayush facility. That means a specialist has to diagnose your condition, recommend hospitalization, and treat it as any other doctor would. And in our experience, insurance companies routinely dismiss these claims because they don't meet the burden of proof.

Often people conflate wellness therapies with legitimate treatments since the line is so blurry in this domain. A few facilities aren't equipped to deal with hospitalizations, and insurance companies rarely pay these claims. So while the feature may not be a gimmick per se, you'd have a tough job convincing insurance companies to pay for these treatments anyhow.

Verdict: Slightly Gimmicky

8.4 – Restoration Benefit

The original use case for the restoration benefit was honestly stellar. People who bought a family floater plan often moaned about the lack of protection they received whilst subscribing to such policies. And you could see why they had a grouse. When you're a family of 4 living together in the same household, the risks are often correlated. If covid affects an individual in the family, it might affect everyone involved. If you're involved in an accident, it's likely to have your family and kids alongside you. When tragic events transpire, you may have to witness multiple hospitalizations simultaneously, and a single cover may not cut it.

So insurance companies extended a restoration benefit, promising to restore the Cover in total if you ever had to make a claim. So if you were working with a sum insured of ₹10 lakh and spent five5 lakhs tending to your child, the insurance company offering an extent of ₹ ten lakhs on top is a bonus. You could use this additional protection if somebody else in the family were hospitalized again. And since the feature had such a great pull, companies across the board began marketing the restoration benefit. It soon caught on like wildfire, and a few insurers began modifying the use to make it even more compelling.

Suppose you were inflicted with cancer and needed surgery. There's no doubt that this is going to be an expensive affair. But the costs pile up as you go through the chemotherapy sessions. This can be particularly taxing on your financials—the same way it's taxing your body. So insurers drew up the restoration benefit to make it more comprehensive. They extended the advantage to individual policyholders to offer a little bit of extra protection.

But at some point, insurers began recognizing the added costs associated with these acts of benevolence. Sure, they still needed to market the feature to compete in a cutthroat industry, but they also needed to mitigate some risks. And that's when they dabbled with wordplay once again. The idea was to market the restoration benefit across all channels and make it harder for people to stake claim to this benefit by adding a few additional conditions.

For instance, some insurers will tell you that they'll restore the Cover so long as you're making claims for two separate illnesses. In the example we quoted earlier, the insurer would restore the body after your surgery but then refuse to let you use the extra ten lakhs if you had to undergo chemotherapy. Their rationale for doing so? You're using the benefit to treat the same illness. And according to the policy document, that's a no-go.

This effectively means the restoration benefit is practically useless for individual policyholders.

Even other insurers deploy a more sinister ploy. They'll tell you that they'll restore your Cover. But only after you've fully exhausted the protection you're accorded at first. For instance, if you claim ₹ eight lakhs after holding a policy with a cover totalling ₹ ten lakhs, the insurer will settle the ₹ eight lakhs and do nothing afterwards. They won't give you the extent of ₹ ten lakhs as promised. And if you were hospitalized once again, god forbid, with a bill totalling ₹ six lakhs, you'll have to pay ₹ four lakhs out of pocket. The restore benefit won't kick in.

However, now that you've exhausted the Cover, the insurer will give you an extra ₹ ten lakhs if you're hospitalized again. But since the likelihood of that happening is relatively remote, you can see how the restoration benefit is extremely limited in scope this time.

This is why it's imperative to read the fine print.

What is the insurance company promising you?

Are they telling you they'll restore the Cover with no caveats, or are they trying to pull a fast one over you? You have to read the fine print.

Verdict: Not a gimmick, but "buyer beware."

8.5 – Pre and Post-Hospitalization Expenses

You seldom visit the hospital out of the blue. Often, there's a sequence of events that precede this eventuality. Doctors will commission various diagnostic tests to see what's wrong. Sometimes it'll be a relatively simple affair. A blood test and a routine checkup will do. In other cases, you may need MRI, heart scans and ultrasounds before they can genuinely hone in on the issue.

Once you're through hospitalization, you may have to contend with similar outlays again. Medication costs can be prohibitively expensive, and you may need follow-up consultations before you're truly out of the woods. And if you're not careful, these costs can add up very quickly. They can run into the thousands

and put a massive dent in your financials. Thankfully, however, insurance companies cover these costs, and while they will market this as a niche offering available only on select products, that is not entirely true.

Almost every policy we've reviewed covers pre- and post-hospitalization expenses. The only thing setting them apart is the quantum of protection. Some policies will cover all costs incurred during the 15 days that precede hospitalization and 30 days afterwards. Other more robust policies will pay off all expenses over more extended periods—for instance, all costs incurred during the two months that precede hospitalization and six months post-hospitalization.

That's the only difference.

So yeah, while it's most certainly an indispensable product feature, it's not exactly unique to your insurer, either.

Verdict: Not a gimmick, but nothing extraordinary either.

8.6 – Day Care Treatments

Here's a case study that we put together a year ago. A young man is out playing a game of cards with his friends. Suddenly he feels a sharp cramp in his abdomen. It's odd, but these things always keep happening to him. So he doesn't pay a lot of attention at first. A few moments pass, and the twitch is suddenly there again. This time it doesn't go away. Instead, within a moment, the pain intensifies. Soon, it becomes unbearable. His friends take him to the hospital. And after a quick inspection, the doctor breaks the news. It's appendicitis, and they have to operate on him immediately.

But it's not that big of a deal. The doctor assures him that he'll be discharged the same day. And although he requires some treatment, he walks out of the hospital within 24 hours. It's a success. But then comes the bombshell. It was a brief stay but an expensive procedure. The bill adds up to ₹80,000, and he's gobsmacked. He calls his insurer, hoping they will cover these costs in full. But

then they break the news. They won't cover it. They tell him they'll pay nothing since their carefully worded policy document states that they don't cover treatments when you're hospitalized for less than 24 hours.
Think—Chemotherapy, Dialysis or, in this case, appendicitis.

And yeah, that's it. The moral of the story here is relatively simple—Ensure the insurer covers daycare treatments. It's okay if they don't have an extensive list of 500 procedures. But make sure they cover the obvious use cases, at least.

Verdict: Not a gimmick

8.7 – No Claim Bonus

Remember how we told you insurers have an added incentive to keep you healthy? Sometimes, they throw in incentives that may not seem obvious initially. For instance, this little feature—No claim bonus. The idea here is simple—If you don't make a claim any given year, then the insurer will tell you that they'll increase your Cover by a certain margin depending on the conditions they lay out in the policy brochure.

Suppose you buy a policy with a sum insured of ₹ ten lakhs and a no-claim bonus of 50%. And you go an entire year without making a claim. At this point, the insurer will increase your Cover by 50%, and you could end up boasting a cover of ₹15 lakhs the following year if you choose to renew the policy. If you go another year without making a claim, your sum insured will jump up by an extra 50% (over the base figure of ₹ ten lakhs), and you'd have total protection worth ₹20 lakhs.

This is, in all honestly, an excellent feature.

However, there are a few things you should be privy to. For starters, the cover expansion won't go on forever. Insurers will cap it at a certain level. We've seen insurers go up to 200%. And we've also seen insurers go up to a measly 50%. It depends on the plan you pick. There's also the fact that some companies claw back your bonus if you do claim in any given year. So if you were to accumulate

all that bonus and end up with a cover totalling ₹20 lakhs, as we noted earlier, you'd be back up to ₹15 lakhs the following year if you do go on to make a claim. And if you were hard-pressed to make a claim the subsequent year again, you'll be down to ₹ ten lakhs. That's the cap. They can't go down any lower.

So, a no-claim bonus is a good thing, so long as the premium is substantial and the clawback doesn't eat away your gains.

Verdict: Not a Gimmick

8.8 – Domiciliary Cover

Imagine a deadly pandemic starts wreaking havoc. But your job forces you to step out every day. And then suddenly, one morning, you wake up with a bad cold. You are coughing incessantly. You hope it'll go away on its own. But then you have trouble breathing. Your condition deteriorates, and you are forced to call emergency services. Only for them to tell you that they can't find a bed right now. Your only choice is to pucker at home and see if somebody will set up a mobile medical facility for you at your domicile, i.e. your home.

And if you're lucky enough to find a service provider, you'll have to worry about the cost. These things can cost a pretty penny and leave you in a deep financial hole unless your insurer extends Cover for domiciliary hospitalizations and pays out the bills on your behalf. People routinely ask us if they can get protection if they are ever hospitalized at home, and while we answer in the affirmative, we also tell them that caveats are involved.

For instance, domiciliary hospitalizations are only covered if the following criteria are met.

1. You must have a condition that prevents you from moving into an actual medical facility, or you could prove that you can't find a hospital bed in town.

2. A medical practitioner must confirm that hospitalization is necessary, with you having been hospitalized for at least 72 hours.
3. All costs must be deemed just and reasonable. Sure, this condition holds for every claim you make. But it's especially pertinent here, considering the service provider can often supplement your care with needless provisions. So you've got to be careful here.

And while there are policies that do cover such treatments without imposing as many restrictions, we always see that insurers aren't particularly proactive when dealing with such claims. They often pull up flimsy excuses and don't always come through. So if you're betting on this feature being prominent, maybe it's time to reconsider.

Verdict: Slightly Gimmicky

Chapter 9

Gimmick or not (Part 2)

9.1 – Consumables

This chapter is authored by Shrehith from Ditto.

Here's the thing—When you parse through a hospital bill, you'll almost always see line items that are a bit dubious. TV monitors, administrative charges, gloves and masks for attendants, telephone bills etc. These are expenses that insurance companies seldom cover since they don't have a handle on how medical practitioners deploy these assets. The hospital could bill an insurance company for 20 PPE kits, and the company would have no way of verifying this detail. This is why such expenses are often excluded. And since insurers don't cover these

costs, consumables can burn a small hole in your pocket as these items could make up as much as 2–10% of the bill.

However, some companies will promise to cover these costs if you pay extra. They will throw it as an add-on and maybe ask you to pay an extra ₹1000 or something. Others will make the proposition more enticing by telling you they'll increase your cover each year by a small margin to compensate for inflation.

All for a bargain price of ₹1000 or so!

So should you take this deal?

Maybe. Paying a nominal annual sum doesn't seem to hurt too much. But it can quickly add up if you go years without making a claim. Even if you are hospitalised eventually, consumables may only make up a fraction of the bill. It may make sense if you get inflation protection alongside this benefit. Otherwise, it's "touch and go."

Verdict: Not a gimmick

9.2 – Critical Illness

It's a no-brainer at this point. People are petrified of things like cancer and will do everything to protect themselves from these difficulties. Insurers routinely prey on this paranoia and push products that may be entirely sub-optimal. Take, for instance, critical insurance policies. Most of these products only pay for medical expenses you incur while being treated for a relatively limited subset of diseases, i.e. acute illnesses. However, the only problem is—Critical illness isn't a well-defined term per se. Is dengue a critical illness? Is a fracture a critical illness? Or is there some other distinction that makes an illness "critical" in nature?

Well, there isn't anything of that sort. Instead, the policy will list down a bunch of diseases they will cover. And if somebody is hurried, you'll only probably

glance at the document. Perhaps you'll see the word cancer mentioned on the advertising brochure and sign off the contract.

However, insurance companies are exact with their language. They'll cover cancer, sure, but they'll only do it if you're inflicted with cancer of specified severity. So you'd be well advised to read the entire list very carefully. The last thing you'd want is to buy one of the policies and then dispute the interpretation of the language. And it's not a pleasant experience even if these policies sell for low dirt prices.

Elsewhere, customers may have completely different expectations from the product itself. Some customers we spoke to believed that these policies would pay out a lump sum if they were diagnosed with a critical illness. They told us they were expecting a payout of ₹ ten or ₹15 lakhs to effectively mitigate the crisis that beckons when one gets diagnosed with a crippling disease.

However, health insurance companies don't often extend such a benefit. The ones that do are often dubious since the pricing is subject to change. You do not want to pay a modest sum for five years and suddenly find out that your premiums have increased by a whopping 50% overnight. It's not a great feeling, so it is to avail of this benefit while buying a good term plan. That should take care of that.

More importantly, Super top up is a more comprehensive alternative than a critical illness policy if you only want to cover health-related expenses. They offer an enormous cover with limited exclusions instead of an essential illness plan that only protects you from a small subset of diseases.

Verdict: Slightly Gimmicky

9.3 – Top-Up Plans

Imagine a health insurance policy with a relatively small cover, and you want to beef it up. You have two options in front of you. You could increase the sum

insured by a few lakhs and pay a hefty additional premium, or you could buy a top-up policy and get the extra protection you need at a relatively lower premium.

By relatively low, I mean down. One top-up policy with a cover of ₹50 lakhs sells for as low as ₹1000 a year.

However, like all things we've discussed before, they come with a few caveats, and to understand them better, we need to understand top-ups better.

A top-up plan offers a sizeable extended cover after the customer pays the deductible during a hospitalisation. Think of this deductible as the minimum sum you can pay out of pocket when you're hospitalised. If the deductible is set at ₹ five lakhs and you're hospitalised with a bill totalling ₹12 lakhs, then you'll be expected to pay the first ₹ five lakhs, and the top-up will be expected to take care of the rest.

There's no rule mandating that you must pay the deductible out of pocket. You could also use another insurance plan to pay it off. But once that's taken care of, the top-up will kick in and settle what's left, so long as the claim is valid.

Here's another example of driving home at this point.

Suppose your employer offers you a health insurance plan with a cover totalling ₹5 Lakhs. It's a decent figure, but there's a possibility that you may want to add a bit of extra protection. So you decide to buy yourself a top-up policy. And when you do so, the insurer will have two questions for you.

1. What kind of cover are you seeking?
2. What kind of deductible do you want to pick?

The cover options are usually quite hefty in the case of top-up policies. They can begin at ₹20 lakhs and go up to a crore in some cases. So you'll have many options to choose from. Deductible options, on the other hand, are pretty

limited. Insurers may offer you the possibility to pick between ₹ five lakhs or ₹ ten lakhs, and you may not have the flexibility to bargain here.

A top-up plan with a deductible of ₹10 lakh is more affordable than a top-up plan with a deductible of 5 lakh, all else equal. It's a simple game of probability. During a hospitalisation, it's more likely that you'll hit the ₹ five lakhs threshold instead of the ₹10 lakh threshold. Once this limit is breached, the insurance company will be expected to pay off the rest. So a ₹10 lakh deductible will give the insurer more breathing room.

However, in the example we quoted above, a deductible of ₹ five lakhs makes more sense to you because that's what your employer already covers. In the event of a hospitalisation, you can use the first ₹ five lakhs from the company-issued insurance plan and then use the top-up policy to protect the rest.

It seems like an absolute bargain in; ain doesn't like it.

So what's the catch?

Well, it's the wording. Top-up plans only pay out the claim after you furnish the deductible. And you'd have to do this "each time you're hospitalised, a scenario where things can go wrong if you fully trust this inexpensive product. Suppose you have a bill totalling ₹ seven lakhs after you are discharged from a medical facility. At this point, you can pay the first ₹ five lakhs using an employee insurance policy and the next ₹ two lakhs using the top-up plan, and everything works just fine. But let's suppose you're hospitalised again after a couple of months. This time you'll have to pay the deductible again if you wish to put the top-up plan to good use.

This means that the product is extremely limited in its scope. Imagine going to the hospital and finding out that your top-up won't kick in because you've only incurred a bill of ₹ three lakhs. It can be particularly distressing to know that you must pay the deductible once again when you've already exhausted the employee insurance policy.

So it doesn't matter if you have a top-up policy with a cover totalling ₹50 lakhs. It will not come in handy when you need it the most.

Verdict: Highly Gimmicky

9.4 – Super Top Up Plans

Super top-up plans were built to alleviate some of the big problems that plagued top-up plans. The idea was to ostracise the recurring deductible feature and make it more usable. They said that paying the deductible once should be good enough, and that's how the product came to be. It's slightly more expensive when compared to top-up plans but infinitely more usable.

Let's go back to the example we quoted earlier. Suppose you have a bill totalling ₹ seven lakhs after you are discharged from a medical facility. And you have a super top-up plan with a deductible of five of ₹ five lakhs. You leverage the employee insurance plan and pay the first ₹ five l, lakhs an awesome super top-up will pay out the next two lakhs.

Great.

But then, imagine you have to go back to the hospital once again, and you're asked to pay up another three3 lakhs after a brief stay at the hospital. The top-up plan would have asked you to pay the deductible once more and, consequently, forced you to put up the ₹ three lakhs yourself. But the super top-up plan will do no such thing. It will settle three,e ₹ three lakhs and won't ask you to pay the deductible once again since you already did it the last time. It doesn't even matter what the bill is. Even if it's a whopping ₹ ten lakhs, the super top will take care of it, so long as you have a hefty cover. It's really.

The only thing to remember is this: Make sure that you buy the super top-up policy right around the time you renew the employee insurance plan. The dates have to line up. If they don't, there's a possibility that things may not work out well for you. Here's an example

January 3rd 2021: You buy a super top-up plan with a ₹5 lakh deductible for some added protection.

March 3rd 2021: Your employee insurance plan is up for renewal. You pay the premium, and a new term begins. The policy will be in force until March 3rd 2022.

December 20th 2022: You're hospitalised and expected to pay ₹ five lakhs. The employee insurance policy takes care of the bill. The deductible is paid out.

January 3rd 2022: You renew the super top-up policy, and the contract will now be in force until January 3rd 2023.

February 20th 2022: You're hospitalised once again, and you must pay up to ₹ three lakhs.

However, you can't use the super top-up policy right now because you haven't paid the deductible during this policy term. Sure, you were only hospitalised a couple of months earlier, and you did pay ₹ five lakhs then. But you renewed your super top-up policy afterwards. A new term has begun, and a new contract is in place. So you're expected to pay the deductible once again if you want to put the super top-up plan to good use.

Also, note that these products are selling at dirt-cheap prices. And if there's anything we've learnt so far, there's no such thing as a free lunch. We don't think the pricing is sustainable, and a correction may be due soon.

Verdict: Not a gimmick, but make sure the stars line up.

9.5 – Claim Settlement Ratio

The industry's most famous figure, the Claim settlement ratio, tells you about the percentage of claims settled by an insurer during a specified period. Put another way, a claim settlement ratio of 90 means that the insurance company paid 90 shares for every 100 claims they book during the year.

This one isn't a gimmick. If anything, you should use this as a metric to gauge if your insurer will come through in your hour of need. However, insurers routinely play fast and loose with this number.

Take, for instance, this egregious case. For 2018–2019, one public insurer reported an obscenely high claim settlement ratio.

This figure was calculated using the formula: Claims settled / (Claims booked + Claims outstanding at the beginning – Claims outstanding at the end). And if you pay close attention here, you can see how you can pull out a high ratio, even without expediting claims.

Let's suppose the insurer has a boatload of pending cases at the beginning of the year. And let's assume most of them were settled over the next 365 days. Then you don't need to pay any claims booked during the year so long as you dispose of cases from last year. You'll still have a comfortably high ratio despite not being customer-centric. Effectively, the extensive CSR is a damning indictment of the company's operational inefficiencies. It tells you precious little about their actual settlement processes and gives you an honest assessment of their ineptitude. So if you're basing your decision solely on this nugget, maybe you should think twice.

There's also the fact that general insurers (insurers that dabble in health, life, motor etc.) report settlement figures for all their businesses together. In contrast, standalone health insurance companies say settlement figures for the health business alone (since they don't dabble in anything else). So a company may boast a high settlement ratio by paying out all the motor insurance claims while skimping on the health claims. In this case, you may want to ask your insurer for more specific numbers before making a decision.

Finally, remember that the claim settlement ratio tells you little about the amount settled. A high number is generally a sign of good things to come. But insurers can easily game the system if they're deceptive in how they do their business. For instance, some insurers will pay out the inconsequential claims

while repudiating the significant money cases. This way, they can settle more claims without paying as much. So you could quickly be misled if you looked at the claim settlement ratio alone.

Instead, it would help if you looked at the claim settlement ratio in conjunction with another figure called the incurred claims ratio.

That is—You take the total claims paid out by an insurer during the year and then divide it by the premiums they collect during the same period, and voila, you get ICR. Most people use this figure to see if their insurer is financially stable, i.e. If there's a company paying out ₹120 in claims while only collecting ₹100 in net premiums, you can safely assume that the insurer is losing money. And if this pattern persists, then there's a genuine risk they may go under.

But this isn't a reason to panic. The regulator won't just let the company die and leave all the policyholders in a lurch. Instead, they will jump in and force a merger. However, it can be an unsavoury experience. So a high ICR is most certainly not a good thing.

However, a low ICR isn't something you should be looking forward to either.

If you have a company that's paying out ₹50 in claims for every ₹100 they collect in premiums, it could indicate the insurer may be penny-pinching while paying out the big claims. This is why looking at the claim settlement ratio alongside ICR is essential. It gives you a more holistic assessment of who's better when looking after your interest.

Finally, insurance companies can easily boast high settlement figures while dealing with a few thousand clients. The real test is to settle claims when dealing with millions of clients. This is why it's imperative to see if you're insurer is dealing with a large customer base. If that isn't the case, the new figures may go for a toss as the company scales and expands.

Verdict: Claim Settlement Ratio is not a gimmick, but you need much more context before making a choice. You can find the most accurate numbers in IRDAI's annual report.

9.6 – Porting

When you figure your insurance is no good, you have two options in front of you. You can ditch it and buy a new plan or port your policy.

To the layperson, this may come as a surprise, but they are, in fact, two very different things. When you're buying a new policy, it's a fresh start for all parties involved, as discussed earlier. Do you have a pre-existing disease? Waitthree3 years before making a claim? Do you want to get your cataracts sorted? Wait two years. You want to claim after 20 days of buying the policy. Sorry, you've got to wait some more.

It cannot be very pleasant. And it can be particularly irritating if you've already done their bidding once. If you've had a policy for three years, you'd likely have fully complied with all the restrictions. When you want to switch and buy a new approach, the insurer wants you to do the same thing again. Preposterous.

This is why most people choose to port their policy. When you port a policy, you can carry over some of the benefits from your erstwhile insurer.

The most obvious benefit is that you won't have to put up with the waiting periods once again. For instance, someone looking to port after having held a policy for five years. The chap has had crippling diabetes for almost a decade now. And the previous insurer imposed a three-year waiting period before covering diabetes, a 2-year waiting period for specific illnesses and a 3030-day waiting period for non-accidental hospitalisations. And so, when he ports to a policy that imposes similar constraints again, he can tell them he's done it already.

That's it. The new insurer will cover all complications from day one unless it's expressly excluded in the contract.

However, you do have to remember a few things. For starters, you can't port a policy anytime you wish. There's a porting window—of 45–60 days before you renew your policy once again. This is when you go to a new insurer and tell them you intend to begin the process. Second, you can't expect the new playtester to waive off all waiting periods just because someone vouches for you.

It's incumbent on you to prove this with material documents on record. If you want the specific illness waiting period waived, you must show them that you've held the old policy for at least two years. Suppose you toh for have had the three years pre-existing disease waiting period waived off. In that case, you've to produce documents showing that you've held the old policy for three years, explicitly mentioning the pre-existing condition. If it's a new condition you only recently discovered, you can't expect the insurer to waive off the waiting periods. A mention of this disease will have to be made on the policy document, and that's the only one that works.

Finally, if you've held a policy with a sum insured of 5 lakhs (no Bonus included) and you're now porting to something with a slightly more extensive cover— say ten lakhs, then the waiting periods will only be waived off for the first five lakhs. Put another way; all complications will be covered from day one so long as the bill tallies up to about five lakhs. If it breaches this threshold, the insurer will pay off the first five lakhs and see if they are obligated to pay the rest instead of the waiting periods imposed on the additional cover.

So, porting is almost always a more prudent alternative, and you should always consider this while buying a new policy.

Verdict: Not a Gimmick