Buying insurance is hard. Reading a policy document is even harder. And even if you make an effort to painstakingly go through this thing, you'll most likely draw a blank because you won't know what half those words mean. So in a bid to uncomplicate matters and teach you how to read a policy document, we've created a set of simple case studies to explain what some of the most common terms and features actually mean. We will also tell you how they impact you and why you may or may not need them.

Co-Payment

You're about to buy health insurance. The agent pitches a policy with a cover totaling 5 Lakhs for a bargain price of just ₹7000 a year. But then he sweetens the pot even further. He promises to cut down the premium by 25% (roughly ₹1800/year) if only you agree to a 20% co-payment clause. You think that's amazing and you sign off on the agreement. Wow, you just saved ₹1800.

9 months later, you suffer an accident. You're hospitalized and you need extensive care. Thankfully you make a full recovery 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 since you promised to co-pay 20% of the bill.

You start doing the math. You saved ₹1,800 but you had to pay ₹40,000 because of the co-payment clause. It would take ~22 years worth of premium savings to make up for this fatal mistake. Not something you want in your insurance policy

Co-payments almost never make sense unless they are mandatory or you're buying it for someone who's old with pre-existing diseases. In this case, a co-payment clause can bring down premiums on your health insurance plan drastically.

Insurers might nudge you to consider a co-payment clause, in which case, you'll be forced to foot a part of the bill each time you make a claim. Could be 10%. Could be 20%. Could even be 30% of the bill. So opting to co-pay might not be the best option, unless you have no choice.

Restrictions on room and room rent

Imagine falling sick and finding out your insurer has a limit on room rent. You pick up the policy document begrudgingly and notice that that cap is set at 1% of your sum insured. 1% of ₹5 lakh insured is ₹5,000 each day. That's not a lot. And now you are upset you can't pick the room you wanted — one that costs ₹10,000 a day.

But you're fairly certain you won't be staying here for long. It's only going to be for a couple of days. And even if you pick the nicer room, you'll only have to pay the extra ₹10,000 (2 days*5000). So you choose the plush room anyway. However, 2 days later, you're discharged and the 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 room that's too expensive.

How much will they pay? Well, here's the 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 and the surgeon's fee adds up to ₹50,000. They'll only pay ₹25,000. The rest is on you.

Avoid policies with caps on room rent. It's that simple. If you still want to pursue this policy, make sure you pick a room that's well within the limit.

Some insurers won't let you pick a room you like. Instead, they'll have a limit on room rent. And in the event, you breach this limit, they'll make you pay extra for every little service rendered in the room and not just the rent. At the end of it all, you'll end up paying a good portion of the bill. So opt for a policy that doesn't have too many restrictions on this front.

If you stay in a room whose rent exceeds the limit specified in the policy, then you will have to pay the extra rent on your own including a percentage of the cost of all services rendered in the room. This percentage is calculated by dividing the limit specified in the policy by the actual room rent, subtracting the ratio by 1 and multiplying it by 100.

Disease Wise Sub-limits

10 lakh cover at a premium of just ₹6,000 a year. That's the offer in front of you. But instead of jumping for joy, you're suspecting something already. This guy is offering you a price that nobody else is matching. You are sceptical and you ponder for a while. But you go ahead with his recommendation anyway since he is a family friend of sorts.

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 a clarification.

Eventually, they tell you your policy has disease wise sub-limits. Meaning, they have a cap on the total coverage amount specifically mandated for certain diseases.

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

For knee replacements —₹2,75,000

For other major operations like the one you just had — ₹2,00,000

And finally, you realize how the company could offer you a ₹10 Lakh cover at such a low premium. They probably never end up paying the full cover amount in most cases.

Don’t fall prey to this devious practice. Make sure you always know there are no disease wise sublimits. Because you don’t know what will hit you. It’s always prudent to pick a policy that has no such stipulations, after careful comparison among the best health insurance plans available in the market.

It’s what happens when the insurer offers you a massive cover (say 10 lakhs) for a modest fee, only to include restrictions on how much of this cover will be available for each disease. So, in effect, you’ll likely end up having only a part of the 10 lakhs available in most cases.

You do not want to see Cardiovascular diseases, cataracts, dialysis, chemotherapy in the disease-wise sub-limit list.

Waiting Periods

The scariest thing about insurance is the uncertainty involved in buying a policy - because the moment the sweet-talking concludes, the insurer will want to talk to you about your medical history. Do you have diabetes? Do you have any cardiovascular problems? Do you have thyroid-related illnesses? Or do you have any other pre-existing conditions? The list is endless.

Once they are through with that line of questioning, they might ask you to take a few medical tests. And based off of these reports, they will tell you that they will cover your hospitalization expense so long as it's not related to your pre-existing condition. But what happens if you are hospitalized for a complication arising out of a past condition? Well, in that case, they will ask you to wait for a while - maybe 2 to 4 years. And while it makes sense for the insurer to add this clause, it can be a particularly gruelling exercise for you.

See the problem here is straightforward. Let's say you have problems with your blood pressure. You disclose this condition and then you buy your policy. Unfortunately, the very next year, you have a heart attack and you are desperately hoping your insurer will come through. However, it's quite possible that the insurer can deny your claim if they can connect your blood pressure disorder to the heart attack. So if an insurer makes you wait 4 years, you just have to hope and pray that you don't fall sick because of a pre-existing disease. And trust us, it's not a good place to be at.

Waiting periods are a common feature in most insurance policies. The only thing you can do is make sure you pick a policy that makes you wait the least amount of time.

If you have pre-existing diseases (including diabetes, blood pressure or thyroid-related illnesses), then it’s likely you’ll have to wait a fixed period before your insurer starts covering claims arising out of these complications. Typically anywhere between 2 to 4 years. So it’s always best to pick a policy where you don’t have to wait a lot.

Pre and post-hospitalization care

You wake up one day and you start feeling dizzy. You consult your doctor. She prescribes a blood test. Nothing out of the ordinary, she says. So you go home with an ORS pack. But your condition

deteriorates. You feel dizzy once again next evening. And this time the doctor prescribes an MRI. She checks the results and asks you to admit yourself to the hospital.

The doctor effectively treats your condition over the course of the next 3 days and you are discharged soon after.

The Hospital Bill adds up to ₹10,000

The MRI and the diagnostic tests before hospitalization adds up to ₹15,000

You are hoping your insurance covers both bills. But the company states they don't cover pre-hospitalization expenses. Meaning they won't cover all the costs you had to bear leading up to your hospitalization. Which is ironical because doctors often prescribe a host of diagnostic tests before they admit you to a hospital and sometimes even after they discharge you. And it can get quite expensive.

It's always a good idea to pick a policy that covers both pre and post-hospitalization expenses. 30 days before hospitalization and 90 days post-hospitalization should be the bare minimum expectation. 60 days pre-hospitalization and 180 days post-hospitalization benefits would be ideal.

Nobody falls sick right off the bat. You'll likely have to go through a host of diagnostic tests before you're hospitalized. Once you're discharged you'll have to worry about medication. And these costs can add up. So it's always best to pick a policy that covers pre & post-hospitalization care.

Restoration benefit

It's a Sunday morning and you're sipping coffee on the hospital bed. You are thinking about how a small heart complication forced you into a 3-week stay at the hospital. More importantly, you're thinking about how you racked up a bill totaling ₹4,88,000. Thankfully, your insurance policy is going to take care of the burden. After all, you have a ₹5 Lakh cover. So you don't have to pay anything right now. But you start thinking about other possibilities.

See, you bought a combined policy — For both your wife and yourself. And if she were to fall sick anytime soon, then the insurance won't cover her bills. You've used up the benefits already.

But what if the insurance restored itself to the initial state immediately after you make a claim? What if your insurer offered you a ₹5 lakh cover once again in the event you or your wife have to be hospitalized anytime soon?

Well…Guess what? It's possible with a restoration benefit.

While some policies offer unlimited restoration for any illness, others have some restrictions. For instance, some policies will tell you that you can't claim the restoration benefit if you have the same illness once again. In this case — a heart complication.

It’s always prudent to opt for restoration benefits if you have a combined policy. It also makes sense even if it’s an individual policy. Just make sure you read the fine print on how the cover is restored each time and you’ll be set.

You buy a policy for the family. You are hospitalized. You make a claim. Your cover runs out. And then a few days later, someone else in the family falls sick. But you’ve already used up the cover. The only thing that can help you is a restoration benefit i.e. if your insurer restores your cover each time you make a claim. If not every time, maybe at least once? It’s possible. You need only ask.

Coverage for treatments that last <24 hrs or daycare treatments

You are out playing a game of cards with your friends. Suddenly you feel a sharp twitch in your abdomen. It's odd, but these things keep happening to you all the time. So you don't pay a lot of attention. A few moments pass. and then suddenly the twitch is there again. This time it doesn't go away. Instead, within a moment the pain intensifies. Soon, it becomes unbearable. Your friends take you to the hospital. And after a quick inspection, the doctor breaks the news. It's appendicitis and they have to operate on you immediately.

But it's not that big of a deal. In fact, the doctor assures you that he'll discharge you the same day. And although you require some treatment, you walk out of the hospital within 24 hours. However, it's an expensive procedure. The bill adds up to ₹80,000 and you're gobsmacked. You call your insurer hoping they will cover these costs in full. And suddenly they break the news to you. They won't cover this.

You are incensed and you press for a clarification. The agent calms you down and walks you through the policy document once again - where they explicitly note how they don't cover daycare treatments. Or in other words, treatments that require hospitalization but those that last less than 24 hours. Think - Chemotherapy, Dialysis or in this case appendicitis.

Always prefer policies that cover daycare treatments. Because you never know when your appendix might put you in a soup.

Chemotherapy, dialysis, appendectomies, radiotherapy, Stone Removals - all of these procedures might last less than 24 hours. And even if you’re hospitalized to avail treatment, some insurers might not cover these claims, because they don’t do “daycare treatments”.

Domiciliary Expense

A deadly pandemic starts wreaking havoc. However, your job forces you to step out every day. And then suddenly, one day 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 the emergency services. But they tell you they can’t find a hospital bed. Your

only choice is to obtain treatment at home. Some hospitals provide this facility. But it's going to cost you money. A lot of money!!!

And then a ray of hope. Your insurer tells you they will cover your expenses since you are forced to be treated at home.

It could be because of a specific condition or because the hospital couldn't find you a bed — Like in this case. It's rare to be in such a spot. But you are glad you have this facility nonetheless.

Another good-to-have benefit. But in most cases, you don't have to go out of your way to find a policy that will cover domiciliary expenses.

No Claim Bonus

Insurers will tell you they want you to stay fit and healthy. In fact, they will even incentivize you in a bid to achieve this objective. For instance, how would you feel if somebody told you they'll up your cover (above and beyond the sum insured) by 50% each year in the event you don't claim insurance. That would be amazing, right?

Think about it. You could start with a cover of ₹5 lakhs. And then see it move up to ₹7.5 lakhs and then the next year, another 50% over and the above the sum insured would take your total cover to 10 lakhs. Obviously, they'll stop at some point. Most insurance companies will tell you they'll stop once the cover doubles in value. In fact, they'll also tell you they'll cut the sum insured by the same amount (50%) in the event you claim insurance after receiving the bonus. So technically, next year, you could be back with a cover of just 5 lakhs.

But still, it's a pretty nifty bonus.

No Claim Bonus is pretty useful. All you have to do is make sure that the bonus is actually substantial. For instance, anything below 10% is not really meaningful. So it might just be a marketing tactic.

What if the insurer offers you extra cover every year you go without making a claim? Wouldn't that be nice? Well, guess what? Some insurance policies do offer a lot of bonus cover. So maybe it makes sense to check if your policy extends these benefits too.

Free health checkups

It's a lazy Saturday afternoon. You've been waiting for almost an hour now and you can't help but look at the receptionist intently hoping he will call your name. And then suddenly when you least expect it, you hear your name called out loud. You walk into the doctor's room. She directs you to a certain spot and measures your height. She then checks your weight. She makes you sit straight and then takes your blood pressure. She listens to your heart and lungs and orders a blood test for cholesterol and blood sugar. And just before you leave, she offers some advice on how you can lower risks for diabetes, heart disease, and cancer. You get your reports the next day and everything is perfect. You don't need follow-up care. At least, not until next year.

What you just had was a full body health checkup. And while some people might just ignore it altogether, it gives you a certain peace of mind. Now usually these health checkups can cost you anywhere between ₹1,000 and ₹1,500. And if you're fairly regular with these checkups, it's going to weigh on your pockets consistently.

Once again, we know it's not a lot of money. But it wouldn't hurt if you save on these costs entirely. And that's why some insurers will pay for your health checkups. Okay, maybe they won't do it every year. But even if they do it once in 2 years it's still an added bonus, right?

While it’s not a deal-breaker, it is definitely nice to have a policy that offers you a free health checkup every year.

Some insurance policies pay for your health checkups each year. So if you are looking to make sure you’re always in tip-top shape, these health checkups might come in handy.

Some of the essential tests a free health checkup must include Complete blood count, Lipid Profile, HDL/LDL, and urinalysis.

Cover for Alternative treatments

You’re pushing 50 and you feel drained each day. You go to your physician and he tells you there’s nothing wrong. “It could be stress”, he exclaims. You are unsatisfied but you go home nonetheless. The next day however you bump into your neighbour. You start chatting and he suggests visiting a government certified Ayush Centre.

So you visit the facility and meet with the practitioners. They suggest getting an Ayurvedic Rejuvenation Therapy — Panchakarma. It’s going to last 7–11 days and it’s going to cost you ₹25,000. That’s quite expensive you think. And then suddenly it hits, your health insurance policy covers Ayush treatments. So you sign off on the payment and get started immediately. Good thing, you remembered that little detail eh?

Ayush Coverage is a good-to-have feature. But remember, the policy will only cover these treatments so long as you’re hospitalized in a government certified Ayush facility.

If you’re into alternative medicine — Think Ayurveda, Yunani, Siddha etc, then you might want to check if your insurer covers these treatment options as well.

Maternity Benefits

You are thinking of having kids. But you know you'll have to plan for it in advance. The first order of business is to make arrangements for childbirth - when you will have to visit the hospital and get the baby delivered. You know getting there won't be a problem, but the hospitalization could turn out to be an expensive affair. But what if you could offset this by opting for an insurance policy that covers this cost? It looks like a solid idea. But alas… This plan has some issues.

For starters, the insurer knows for certain that they'll have to bear this expense in the event you decide to have kids. And since most people have at least one kid, the insurer will most likely have to pay up. So, many companies simply don't offer the benefit. The ones that do will make sure they are adequately compensated.

So they'll push the premiums way higher. Or they'll tell you they'll only cover a small part of the expense. Or sometimes, they'll only offer it in a family plan and make sure both you and your spouse are covered - in which case one of you is opting for the benefit even if you won't be hospitalized for a maternity-related matter.

There is no free lunch in this world. And while it's all good if your insurer does cover this expense, make sure you don't end up paying ridiculously high premiums just to avail this benefit. It might not be worth it.

OPD Benefit

Everybody visits the doctor at least once a year. But the doctor you visit — Her consultation fee is off the roof. A routine inspection could set you back thousands. So you come up with a genius plan. You decide to buy insurance and opt for a policy that reimburses all expenses incurred during these visits. You look for options that include outpatient consultation benefits and you find one after a couple of minutes of search.

You exclaim — “Genius.” And you give yourself a pat on the back.

But alas... Nothing in this godforsaken world is as it seems.

For starters, the insurer knows for certain that they’ll have to pay you something each year. Just ask yourself. Have you been to the doctor this year? Have you paid over ₹1,000 in consultation fee? Have you paid more? Do you think this trend is likely to change?

Yeah... It’s not going to change. So it’s quite likely that the insurer will be forced to reimburse you some amount each year. And that’s why many companies simply don’t offer this benefit. The ones that do will make sure they are adequately compensated. So they’ll push the premiums way higher. Or they’ll tell you they’ll only cover a small part of the expense.

There is no free lunch in this world. And while OPD benefits look good on paper, it's possible that you’ll actually end up paying more in premiums. Believe it or not, it might actually be more cost-effective to not opt for this benefit, in most cases.

Essential features for a family floater plan

A good restoration benefit – You don’t want to be running out of your cover because multiple members of the household fell sick at the same time. A good no-claim bonus of 50% will also help boost your cover in the event of a catastrophe. Free health checkups do a lot of good, especially when you have young kids.

Essential features when buying a policy for a married couple

Maternity benefits – When you are getting married, it's likely that you will be planning for childbirth in a year or two. So buying a plan that extends maternity benefits do make sense, if you have the extra money to spare. A good restoration benefit – You don't want to be running out of your cover because multiple members of the household fell sick at the same time.

Essential features for a senior citizen policy

You have to have short pre-existing disease waiting periods, preferably less than 3 years. You shouldn't have a co-payment clause. And the policy must be affordable.