

Health insurance is an essential security. However, often our claims are unexpectedly denied or significantly reduced. Claim denials have been rising steadily, creating uncertainty, frustration, and stress for patients.

It is important to understand the reasons behind claim rejections and the conditions in the fine print, and how to proactively manage them. This will help you in selecting the most suitable insurance policy for your family, as well as in ensuring that your claims are honoured.

Reasons for Claim Rejection

The most common reasons are:

- **Non-disclosure of Pre-Existing Conditions**, such as surgeries, diabetes or hypertension, could lead to insurer rejection-related claims. Many policies cover pre-existing conditions with an additional premium. Check your policy details carefully.
- **Claims Within the Waiting Period**: Health insurance plans may specify an initial waiting period during which claims are not accepted. Even if you have serious issues. These conditions may be waived with additional premiums.
- **Policy Exclusions**: Many insurance policies list treatments, diseases, and procedures that are not covered, such as cosmetic surgeries, dental treatments, maternity expenses, and self-inflicted injuries. Many other conditions in the policy may also lead to rejection of your claim. Normally, our main focus is on the amount covered and the premium payable, but it is important to check your policy for specific exclusions
- **Sub-limits and Co-payment**:
These are hidden clauses in fine print that can significantly reduce the claim amount you receive.
 - **Room Rent Limit**: Policies may have a daily cap on room type and rent. If higher, you may have to pay the difference yourself, and the insurer may also reduce other related charges proportionally, even for the very same test and consultation.
 - **Disease-Specific Sub-limits**: Policies cap the amount claimable for certain treatments. Procedures may have a fixed package rate, such as cataract surgery.
 - **Co-payment**: This means you pay a fixed percentage of the claim amount yourself, common in senior citizen policies.
- **Delay in Informing Insurer**: Tell your insurer or Third-Party Administrator (TPA) immediately upon hospital admission, and submit all claim documents as per policy and within timelines. They may time-bar the claim.

Pre and Post-Hospitalisation Expense

Most policies cover related expenses for medication, consultation, and tests, etc before admission and also post-discharge. Ensure your policy has this clause and check the time limit. Keep the bill.

If Your Claim Is Denied

Start by carefully reviewing the insurer's reason for denial. If claims were rejected due to missing or incorrect documents, correct the errors and resubmit. You can also appeal by submitting a formal letter with all supporting documents if you believe the rejection was unfair.

If your appeal is unsuccessful, you may escalate the matter to the Insurance [Ombudsman](#) or complain to the Insurance Regulatory and Development Authority of India ([IRDAI](#)). These are formal and effective dispute resolution mechanisms.

New Guidelines You Must Know

The IRDAI closely monitors patients' complaints and unfair denials and gives guidelines to reduce claim rejections and denials of claims

Pre-existing Conditions: Insurers can no longer reject claims for non-disclosure of pre-existing conditions after five years of continuous policy coverage, unless there is evidence of fraud.

- **Waiting Period Reduced:** The waiting period for coverage of pre-existing diseases has been reduced to three years from four years for new policies. Waiting periods for certain specific conditions have also decreased.
- **No Age Limit for Policy Purchase:** Insurers cannot deny health insurance based on age, ensuring senior citizens have access to coverage.
- **Mandatory Coverage of Severe Diseases:** Policies must now include life-threatening conditions such as cancer, stroke, renal failure, and AIDS. Denials based solely on "severe illness" are prohibited.
- **AYUSH Coverage Without Sub-limits:** IRDAI mandates full coverage for Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homoeopathy treatments up to the sum insured.
- **Claim Decision Deadlines:** Insurers are required to either pay or reject claims within a specific time (usually 30–45 days); failing which, interest must be paid to policyholders.

Choosing the Right Policy

Being an informed consumer helps you select the best policy for your needs:

- **Use Online Aggregators and Trusted Agents:** Compare policies to find options suitable for your family's health and budget.
- **Look Beyond Price:** The cheapest premiums may come with higher co-payments, sub-limits, and exclusions. Always choose plans offering adequate coverage.
- **Customise Your Policy:** Insurers often offer riders for critical illness cover, maternity benefits, or co-payment waivers. Tailor your policy accordingly.
- **Check Hospital Network:** Ensure your insurer's TPA has a wide network of cashless hospitals in your city or frequent travel destinations.

Choose your policy carefully. Read and understand your policy's conditions often in fine print. This will help avoid claim rejections and ensure you get medical expenses covered when you need.

Ensure you pay the premium on time, avoid any break in the policy, and always submit all documents.