1. Health: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

2. Institute: “Institution” means a HEI, like a university, a college, an institute, etc. imparting higher education beyond 12 years of schooling leading to a degree (graduate, postgraduate and/or higher level).

3. Health Insurance (HI): Pre-payment of small amount as premium by students into a common fund pool of insurance company that can finance healthcare costs of enrolled students later if required. It minimizes the uncertainty of both the timing of treatment and the cost of treatment. This term applying to all types of acute losses caused by bodily accident or sickness or for expenses of medical treatment necessitated by sickness or accidental bodily injury.

4. Accident: Unplanned injurious or damaging event which interrupts the normal progress of an activity.

5. Actuary: One who computes and analyses statistics and uses them to calculate insurance risks and premiums.

6. Actuarial Analysis: The examination of risk by a highly educated and certified professional statistician. Actuarial analysis uses statistical models to manage financial uncertainty by making educated predictions about future events. Insurance companies use actuarial analysis to design optimal insurance policies and to analyze insurance risks & premium.

7. Beneficiary: An Individual, institution, trustee, or estate which receives benefits under an insurance policy, for example.

8. Benefits: Benefits are the sum of money received by an insured or an assignee (e.g. a hospital) as reimbursement for medical costs incurred due to illness. Benefits may also be in the form of health services received. These benefits are in lieu of a premium paid to an insurance provider.
9. Cashless claim: Process by which the insured can obtain treatment or medicine without being required to pay up front. The insurance company pays the hospital – often via a third party administrator (TPA).

10. Claim: A request to an insurer by an insured person (or by the provider of a good or service on behalf of the insured individual) for payment of benefits according to the terms of an insurance policy.

11. Claim Amount: It is the amount/benefit payable by the insurer under a policy on a claim occurrence.

12. Coinsurance: A provision in an insurance policy requiring the insured to contribute a certain percentage of any claims. For example, that 10% of any claim will be borne by the insured.

13. Compulsory insurance: An insurance programme in which legislation defines the population covered benefits, the conditions of eligibility, and the sources of funds. An insurance plan may be compulsory only for an employer or for individuals as well. Any universal public plan is necessarily compulsory regarding the payment of taxes (which support the plan), and thus not optional for the individual.

14. Commencement date: This is the date that the policy-and therefore cover-starts.

15. Co-payment: Where the insured pays a specified amount at the time the service is accessed, with the insurer paying the remaining costs. However, unlike coinsurance, where the insured is required to pay a certain percentage of the covered costs, co-payment plans require the insured to pay a specified monetary amount. It is paid in addition to the excess/deductible.

16. Coverage: The protection offered to the insured under an insurance policy.

17. Critical illness insurance: Critical illness cover pays out a predetermined lump sum on the occurrence of the diagnosis of one of a specified range of illnesses, as set as outset, undergoing one of a specified range of operations.

18. Death benefit: The amount stated in an insurance policy to be paid upon the death of the insured.

19. Deductible: The amount of money an insured person must pay “at the front end” before the insurer will pay. In health insurance with a INR 1,000 deductible, the insured must pay any medical bill under INR 1,000 in its entirety, and the first
INR 1,000 when the total is over that amount. The reason for introducing this concept into healthcare coverage is primarily to discourage ‘unnecessary’ use of services, and also to reduce insurance premiums, since all claims have a minimum amount, which the insurer will be spared on every claim. (See also co-insurance, cost sharing and co-payments.)

20. Endorsement: An endorsement is a written document attached to an insurance policy that modifies the policy by changing the coverage it affords. An endorsement can provide additional coverage and can be added at the inception of the policy or later during the term of the policy.

21. Exclusion: This states that the insurer shall not be liable to pay any benefit to the insured for healthcare treatment caused by certain conditions or diseases.

22. Group insurance: Insurance covering the members of a group, such as the employees of a single employer. The benefits are not tailor-made to the needs of each member but if the group is acceptable to the insurer, all members are covered.

23. Health insurance: A financial instrument that, in return for payment of a contribution (or premium), provides members with a guarantee of financial compensation or service on the occurrence of specified events. The members renounce ownership of their contributions. These are primarily used to meet the costs of the benefits.

24. Health sector: The part of the economy that is involved in activities intended to improve health. The term may be used to mean health services but it is often used synonymously with the term health system, to cover both health services and health-related activities.

25. Hospitalization expense insurance: This is the main individual healthcare insurance policy available in India. It essentially reimburses hospitalization expenses (not outpatient treatment) to the policyholder.

26. In-patient: An individual who is admitted to hospital and stays for a minimum period of 24 hours for the sole purpose of receiving medical treatment.

27. Insurance: The contractual relationship that exists when one party (the insurer) agrees to reimburse another (the insured) for loss caused by designated
contingencies. The contract refers to insurance policy, the consideration is a premium, the loss is the risk, and the contingency is a hazard or peril. Insurance is a formal social device for reducing the risk of losses to individuals by spreading the risk among groups.

28. Limitations (or Limited Benefits): Statements in a brochure showing services or supplies that are not fully covered, only partially paid by a plan, or covered only if the service or supply provided meets certain specified criteria, e.g. pre-authorization for surgery.

29. Limited Policy: A contract that covers only certain specified diseases or accidents.

30. Managed Care: Healthcare systems that integrate the financing and delivery of appropriate healthcare services to covered individuals by arrangements with selected providers to furnish a comprehensive set of healthcare services, explicit standards for selection of healthcare providers, formal programme for ongoing

31. Quality assurance and utilization review and significant financial incentives for members to use providers and procedures associated with the plan.

32. Medical practitioner: An individual who holds a degree/diploma of a recognized institution and is registered by Medical Council of the respective State of India.

33. Network Hospital: Hospitals and nursing homes which have been approved by insurer to operate the cashless facility.

34. Out-of-pocket payments or costs: Costs borne directly by a patient who lacks insurance benefits; sometimes called direct costs. Unless covered by insurance, they include patient payments under cost sharing provisions.

35. Outpatient Services: The care provided to you in the outpatient department of a hospital, in a clinic or other medical facility, or in a doctor’s office.

36. Period of insurance: This is the amount of elapsed time for which insurance cover is provided in return for the premium paid.

37. Policy: The legal document issued to the policyholder that outlines the conditions and terms of the insurance; also called the ‘policy contract’ or the ‘contract’.

38. Post-hospitalization expenses: Medical expenses for treatment generally up to 60 days after the hospitalization, for which reimbursement may be sought.
39. Premium: The amount of money or consideration paid by an insured person or policyholder (or on his or her behalf) to an insurer or third party for coverage under an insurance policy. Premiums are related to the actuarial value of the benefits provided by the policy, plus a loading fee to cover administrative costs, profit, etc. Premiums are paid for coverage whether or not benefits are actually used. They should not be confused with cost-sharing mechanisms, such as co-payments and deductibles, which are paid only if benefits are actually used.

40. Pre-existing condition: Any condition or disease which an individual suffers from at the time of purchasing health insurance is known as pre-existing condition.

41. Pre-hospitalization expenses: Medical expenses for treatment generally up to 30 days before the hospitalization, for which reimbursement may be sought.

42. Private health insurance: Health insurance that is sold by either by commercial firms or non-profit-making organizations to individuals or groups. Such insurance is voluntary for the individual or group as a whole (though it may be compulsory for members of the group).

43. Renewal: Most general insurance policies are written as annual contracts and need to be renewed at the end of the year if ongoing cover is required.

44. Reimbursement: Payment by an insurance scheme to a healthcare provider, or to insured persons, as a refund for all or part of fees for services.


46. Social health insurance: An insurance scheme set up and controlled by government or public agencies to provide protection against sickness. Social insurance is usually compulsory for the whole population or for certain group. The contributions are usually from payroll deductions of employed citizens, but the benefits are usually for the entire population.

47. Third party administrator (TPA): Licensed by the IRDA for the provision of healthcare services, their role is to act as an intermediary between the insurer and the insured and facilitate a cashless service at the time of hospitalization. Paid by the insurer, they typically maintain the insurer’s policy records, issue identify cards, receive claims notifications from insured, manage claims and provide customer support.
48. Waiting period: The period of time that an individual must wait either to become eligible for insurance coverage or to become eligible for a given benefit after overall coverage has commenced.

References of Glossary§,**