

IC-38 Health Insurance Study Material 2026

Detailed Health Insurance Learning, Claims & Revision Guide

Prepared as an original learning and revision resource.

This guide is designed to explain concepts in clear language and support exam preparation. It is not a replacement for the latest official syllabus, regulations, circulars, or insurer instructions.

How to Use This PDF

- Study common IC-38 concepts before Health Insurance topics.
- Understand waiting periods, PED, co-payment and deductibles clearly.
- Practise cashless versus reimbursement claim scenarios.
- Learn how portability and renewal differ.
- Use the official IC-38 Health material for the complete prescribed syllabus.

Chapter 1: Health Insurance Fundamentals

Health insurance is designed to cover specified medical expenses or provide defined benefits according to the policy. Coverage, limits and exclusions differ by product.

Types of health cover

Common structures include individual health insurance, family floater policies and group health insurance. Products may also include specific disease, senior-citizen, top-up or benefit-based structures.

- Individual cover generally applies to the insured person.
- Family floater coverage usually shares a sum insured among covered members.
- Group policies are issued under group arrangements and have their own terms.

Sum insured and premium

The sum insured is the maximum amount or defined coverage limit for covered benefits, subject to policy terms. Premium depends on factors such as age, product, coverage, risk characteristics and insurer pricing.

- A higher sum insured does not mean every expense is payable.
- Premium is not the same as claim amount.
- Sub-limits and deductibles can affect out-of-pocket expenses.

Chapter Practice Questions

1. A family floater generally provides:

- A. separate unrelated policies only
- B. a shared sum insured for covered family members, subject to terms
- C. only life cover
- D. only travel cover

Answer: B — A family floater typically shares a sum insured among covered members.

2. A waiting period is:

- A. a period during which specified coverage may not yet apply
- B. a premium discount
- C. a claim bonus
- D. a policy number

Answer: A — Waiting periods restrict coverage for specified conditions/events for a stated period.

3. Cashless treatment generally involves:

- A. no policy verification
- B. an insurer/TPA arrangement with a network provider subject to approval and policy terms
- C. automatic payment for every treatment
- D. no documents ever

Answer: B — Cashless services operate through network arrangements and are subject to policy conditions and authorisation.

4. Co-payment means:

- A. the insurer pays the entire amount

- B. the insured bears a specified percentage/portion of an admissible claim
- C. the premium is waived
- D. the policy is renewed automatically

Answer: B — Co-payment is the portion of an admissible claim payable by the insured as specified in the policy.

5. Portability generally allows an eligible policyholder to:

- A. transfer a policy to another insurer subject to applicable rules
- B. convert health insurance into life insurance
- C. remove every exclusion
- D. guarantee a claim

Answer: A — Portability is a regulated mechanism for moving health coverage between insurers subject to applicable conditions.

Chapter 2: Waiting Periods, PED and Cost Sharing

Health policies often contain conditions governing when specified illnesses or treatments become payable and how expenses are shared.

Waiting periods and pre-existing disease

A waiting period is a specified time before certain coverage becomes available. A pre-existing disease (PED) is defined by the applicable policy wording and regulations; the exact definition should be checked in the policy.

- Do not promise immediate coverage for every condition.
- Disclose health information accurately during proposal.
- Definitions and waiting periods can differ by product.

Co-payment and deductible

A co-payment is a specified share of an admissible claim borne by the insured. A deductible is an amount/threshold that the insured bears before insurer liability applies, depending on the product structure.

- Both can increase the customer's out-of-pocket cost.
- Explain cost-sharing before purchase.
- Read the policy schedule and wording for exact application.

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Chapter 3: Cashless and Reimbursement Claims

Health claims commonly involve either cashless treatment through a network arrangement or reimbursement after the insured pays eligible expenses, subject to policy terms.

Cashless process

The customer generally visits a network provider, presents policy/identity details, seeks pre-authorisation where required, receives treatment, and the insurer/TPA processes admissible expenses subject to policy terms. Non-covered or excess amounts may remain payable by the customer.

- Network status can change; verify before treatment where possible.
- Cashless does not mean every expense is free.
- Pre-authorisation is not necessarily final claim approval.

Reimbursement process

For eligible reimbursement claims, the insured generally pays the provider and submits the required claim form and supporting documents within the prescribed timelines.

- Keep original bills/receipts where required.
- Discharge summary, prescriptions, reports and payment evidence may be relevant.
- Late submission or missing documents can affect processing subject to applicable rules.

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Chapter 4: Portability, Renewal and Customer Support

Health insurance servicing continues after issuance. Customers should understand renewal, portability and grievance processes.

Renewal and portability

Renewal keeps coverage in force subject to applicable conditions. Portability allows an eligible policyholder to move health insurance coverage from one insurer to another under applicable rules, with continuity benefits handled according to the regulatory framework.

- Renew before the due date where possible.
- Portability is not the same as buying a completely new policy.
- Always verify the current regulatory requirements.

Customer support and grievances

Agents should communicate accurately, assist with documentation and direct complaints through the insurer's prescribed grievance mechanism. Customers may have additional escalation routes under the applicable framework.

- Keep written records of important requests.
- Do not guarantee claim outcomes.
- Use official insurer and regulator channels for escalation.

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Final Revision Checklist

- Can you define the major insurance terms without referring to notes?
- Can you explain the core principles and distinguish them from one another?
- Can you identify the customer-service and ethical responsibilities of an agent?
- Can you explain the relevant policy, underwriting and claim concepts for your branch?
- Have you completed the practice questions and reviewed every incorrect answer?
- Before the examination, confirm the current examination instructions with the official authority or examination body.