TCS India Policy – Health Insurance

VERSION 25.0

Document Release Notice

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Approved By: Sathya Narayana Mehta (Head - Policy and Talent Transformation)

Authorised By: Milind Lakkad (Global Head – Human Resources)

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Introduction

For TCS, the health and wellbeing of employees and their families is paramount. Hence, TCS has tied up with an external Insurance service provider to provide all TCS India employees with easy access to best-in-class medical facilities through a comprehensive Health Insurance Scheme (HIS). The Health Insurance Scheme and its provisions are reviewed and updated from time to time.

Applicability

This policy is applicable to:

- Full Time Employees of TCS India and TCS eServe International (HIS coverage will continue till the time of employment).

  Note: *This would also include employees who are currently localised in countries outside India, post their long term deputation, and are having continued coverage for their eligible dependents in India, in the ongoing financial year.*

- ACE Interns, Global Interns & BPOS Trainees

This policy is not applicable to:

- Business Associates, Academic Interns & Contract Consultants

Provisions

1. Definition of key terms

Insurance Service Provider- External Insurance Service Provider with which TCS has tied up for providing Health Insurance services to employees.

Third Party Administrator- Appointed by the Insurance Service Provider and is responsible for processing of claims, settlements with respect to the Health Insurance Scheme and hospitalisation process for the employees and their beneficiaries.

Family/Beneficiaries- 'Family' in this context implies spouse, partner (LGBTQ+ community), children below the age of 25 yrs, parents and/or parents-in-law only who can be enrolled as beneficiaries for coverage under Health Insurance Scheme by the employee.
Kindly refer to Enrolments section for details.

Policy Period - The period to be considered for coverage under HIS and for payment of premium amount which is every financial year starting with April and ending with March of the subsequent calendar year.

Enrollment Period/Window – A window that is made available to associates at the beginning of every policy period in order to modify their Health Plan and enroll/delete beneficiaries from the Health Insurance Scheme.

Sum Insured Limit- The sum insured (SI) is the maximum amount that the insurance company pays to the insured person in a policy year in case a claim is made towards a medical emergency, treatment of illness, etc. The amount paid is usually a reimbursement for the costs incurred by the insured person.

GIPSA- GIPSA (General Insurers' Public Sector Association) is an association of Insurance companies that has negotiated rates and packages at GIPSA specific hospitals (Refer Health Insurance portal to get details of hospitals governed under GIPSA). These negotiated/package rates are known as PPN (Preferred Partner Network) rates.

2. Health Plans under HIS:

- There are various Health Plans under HIS. These plans differ from each other in terms of the coverage as well as the premium amounts payable
- All employees and their enrolled beneficiaries are covered by a default plan based on the employee's grade. Employees can view their plan details (coverage and premium payable) via the path below:

  Ultimatix → Employee Services → Employee Self Service → Global ESS → Benefits and Taxes → Health Insurance Scheme → Beneficiary Details

- At the beginning of the enrollment period, employees will continue to be tagged to their default plan or their previously upgraded plan.
- Employees will have the option to upgrade to two consecutive higher plans from their default plan upto a maximum of the Platinum plan.
- Upgrading plans can be done only during the enrolment period. Once the enrolment period is over, no change to the enrolled plan is permissible during the course of the financial year.
- New joiners will be tagged to a default plan as per their grade. They can upgrade their plan only in the subsequent enrolment period.
- Employees will not be allowed to opt for a plan lower than their default plan/any higher plan they have earlier upgraded to, under any circumstances.

Health Plan details and upgrades permitted

HIS Health Plan	Upgrade Permitted				
	ESIC Plan	Gold Plan	Gold Plus Plan	Platinum Plan	Platinum Plus Plan
ESIC Plan	Default Plan	Yes	Yes	-	-
Gold Plan	-	Default Plan	Yes	Yes	-
Gold Plus Plan	-	-	Default Plan	Yes	-
Platinum Plan	-	-	-	-	-
Platinum Plus Plan	-	-	-	-	Default Plan

Example
Employees with default 'Gold' Plan can upgrade to either 'Gold Plus' or 'Platinum Plan'.
Employees with default 'Gold Plus' Plan can upgrade to maximum of Platinum Plan.

Employees in the 'Platinum Plus' plan have no upgrade options, since this is the highest plan offered.

3. Types of cover under HIS

Below are the types of cover under the above explained HIS Plans. The coverage amount for various types of cover varies as per the HIS Plan.

Type of Cover	When does it apply?	How is it defined?
Domiciliary Cover	Covers the cost of any domiciliary treatment (including dental treatments) of employees and their beneficiaries. It includes pharmacy cost, consulting fees of the doctor, investigatory tests, etc It is applicable only when the insured person undergoes treatment at a dispensary or in a hospital, as an outpatient	Defined for each insured person per policy year Hence, unused sum of one beneficiary cannot be used towards treatment of other beneficiaries.
Base Cover	Covers the cost incurred on treatments that require hospitalization up to a specified limit. Hospitalization means admission in a Hospital/Nursing Home for a minimum period of 24 consecutive hours for in-patient care except for specified procedures/ treatments as mentioned in the Day Care Treatment List (***Refer Appendix - C***), where such admission could be for a period of less than 24 consecutive hours	Defined for each insured person per policy year Hence, unused sum of one beneficiary cannot be used towards treatment of other beneficiaries.
Floater Cover	Covers the hospitalisation expenses incurred over and above the basic hospitalisation cover limit.	Defined per family per policy year In case a part of the Floater Cover is utilised by any beneficiary, the remaining balance can be utilised by the same/other beneficiary, if there is a need

***Note**: Employees who are covered under ESIC (Employees' State Insurance Corporation) are eligible for a floater cover of Rs 5 lacs per family per annum under TCS HIS plan. Such employees may additionally avail the benefits under TCS HIS. For more details, you may connect with your respective HR Business Partner (HR BP).*

Personal Accident Insurance Cover:

- This cover is over & above the domiciliary and hospitalisation cover and is applicable to all employees at no additional cost. This cover is not applicable for other beneficiaries enrolled.

  Note: *This cover is applicable only during the employment tenure of an employee and ceases to exist post retirement/separation.*

- Benefits are applicable in case of Accidental injury leading to Permanent Total Disablement (PTD) or Permanent Partial Disablement (PPD). Benefits are also applicable in case of Permanent Total Disablement (PTD) arising out of any natural causes such as disease / ailment / illness.

Event	Amount Limit (In Rs.)
Permanent Total Disablement	Minimum of Rs. 21 lakhs or 6 times of employee's annual compensation* whichever is higher subject to maximum of Rs. 20 Crore
Permanent Partial Disablement	6 times employee's annual compensation subject to a maximum of Rs. 20 Crore (This is based on a percentage defined under ***Appendix A: Schedule of Indemnities and % of Sum Insured)***

Note: *Annual CTC for calculation of disability claims will be basis the latest TCS India compensation letter of the employee at the time of occurrence of the accident/event.*

4. Beneficiaries under HIS

- All employees are covered under their grade specific default Health Plan from their date of joining.
- Employees may enrol the below family members as beneficiaries for coverage under the HIS:
  - Spouse
  - Children (up to 5 children may be enrolled)
  - Parents/Parents-in-law (a maximum of 2 elders can be enrolled, either parents or parents-in-law or a combination of each)

  Note*: Any other relative (such as brothers, sisters of the employee/Spouse, grandparents, sister/brother-in-law, etc.) whether beneficiaries or otherwise cannot be covered by the HIS under any situation*.

- **Applicable Health Plan**- The enrolled beneficiaries will be covered under the same Health Plan as the employee.

- **<u>Timeline for enrolment</u>**-

  - For existing employees, beneficiaries can be enrolled only during the enrolment period.
  - New joiners can enrol their beneficiaries within 90 days from their date of joining.
  - Beneficiaries may also be enrolled within 90 days from the date of any life changing event like marriage, birth of a child as appropriate. If this window is missed, the beneficiaries may be enrolled only during the subsequent enrolment period in the next financial year.

  ***<u>Note</u>**: The 90-days timeframe to add beneficiaries in case of new joiners and in case of life changing events may not be applicable during the last quarter of the financial year as the HIS beneficiary addition link will remain closed post March payroll freeze. Hence, all employees who join TCS in the last quarter of the financial year or have new additions on account of life changing events are advised to enroll their beneficiaries immediately after joining/after the life changing event, in order to avail the HIS coverage effective from the date of joining/birth/marriage.*

- Beneficiaries may be enrolled using the path: ***Ultimatix → Employee Services → Employee Self Service → Global ESS → Benefits and Taxes → Health Insurance Scheme → Beneficiary Details***
- Beneficiaries added under GESS in Ultimatix in the 'HIS Beneficiary Details' link will reflect in the TCS Health Insurance Portal within a maximum duration of 24 to 48 hours.

  ***<u>Note</u>**: Addition of family details in Ultimatix → Employee Services → Employee Self Services → Global ESS → My Profile → Family Details or any other link apart from HIS Beneficiary link is not adequate for coverage of beneficiaries under HIS. Employees must explicitly enrol their beneficiaries in the above mentioned link.*
- The below criteria apply when enrolling beneficiaris under HIS :

Family Member	Criteria for coverage under HIS
Spouse	- Should be legally married to the employee. - This also includes same sex partners irrespective of their marital status. - Spouse can be added as beneficiaries only after an employee updates one's marital status in company records. Kindly follow the below steps: • Marital status can be updated under My Profile via ***Ultimatix → Employee Services → Employee Self Services → Global ESS → My Profile → About → Basic Details***. • Spouse's contact details should be updated and the dependent flag should be marked as "Y" under ***Ultimatix → Employee Services → Employee Self Services → Global ESS → My Profile → My Contacts*** - Spouse enrolled post 90 days of marriage, will not have insurance coverage for treatment of any pre-existing ailments/diseases/conditions other than those defined under 'List of Tertiary/ Critical illness' in the first year of enrolment. - In case the spouse/partner is employed in another organisation, the employee may claim HIS benefits subject to the following: • In case the Spouse does not get medical benefits/insurance cover from that organisation, they may claim benefits under this scheme. • In case medical benefits/insurance cover is provided by the spouse/partner's organisation, they must first recover the expenses from that organisation to every extent possible. After the sum insured is exhausted from Health Insurance of the other organisation, the employee may claim for the remaining amount under TCS HIS.
Children	- Includes Legally adopted Children - Includes Children of the Spouse from previous marriage - Children should be unmarried. Married Children or those who get married subsequently cease to be eligible for coverage from the date of marriage. - Children should be less than 25 years of age. - Children should not be gainfully employed for wages or profit in any service, business or profession.

Family Member	Criteria for coverage under HIS
	- Employees should remove their children from the beneficiary list when their children get employed/married or reach 25 yrs of age, else these records will be purged at the start of the next policy year. - Children are covered on an "ALL OR NONE" basis. 'ALL OR NONE" means that in case the employee has more than three children, TCS will pay the entire premium for the first three children provided the employee covers the remaining children and bears the cost of premium for the remaining children. In case the employee does not cover the remaining children, TCS will also not cover the first three children. - In case of child-birth/adoption, employee will have the option to enrol the child within 90 days from date of birth/adoption. An unnamed child can be enrolled as 'baby of <mother's / father's name>'. After the baby is named, the employee can edit/update the child's actual name within the 90-day window from date of birth/adoption ***Note:*** *In case of adoption, employees can reach out to Corporate HIS team at corporate.his@tcs.com for addition of the adopted child as a beneficiary.* - In case of cashless hospitalisation of a new born child soon after birth, benefits of HIS may be availed prior to enrolling the child under HIS. However, the employee should ensure that the child is enrolled within 90 days from date of birth, failing which, the cashless expenses can be recovered from the employee.
Parents/Parents-in-law	- All employees have the option to cover Parents OR Parents-in-law OR a combination of each upto a maximum of two beneficiaries - Parents-in-law can be added as beneficiaries only after an employee updates one's marital status in company records. Kindly follow the below steps: • Marital status can be updated under My Profile via ***Ultimatix → Employee Services → Employee Self Services → Global ESS → My Profile → About → Basic Details***. • Spouse's contact details should be updated and the dependent flag should be marked as "Y" under ***Ultimatix → Employee Services → Employee Self Services → Global ESS → My Profile → My Contacts*** - Parents enrolled as beneficiaries post 90 days of joining and parents-in-law enrolled post 90 days of marriage, will not have insurance coverage for treatment of any pre-existing ailments/diseases/conditions other than those defined under 'List of Tertiary/ Critical illness' in the first year of enrolment.

- Kindly note the below while enrolling beneficiaries:

  - An employee whose spouse is also a TCSer should ensure that they do not enrol each other and the same beneficiaries (parents/children) for HIS coverage. Such dual coverage is not permitted under any circumstances

  - If the employee's spouse or any other family member is a TCSer, the said employee/s must complete the declaration of the same under the path ***Ultimatix → Employee Services → Employee Self Services → Global ESS → My Profile → Basic Details → Family Details,*** prior to enrolling beneficiaries.

  - In case of a life changing event (marriage / death of insured beneficiary) if an employee wants to replace the insured beneficiaries (parents / parents-in-law), it can be done only in during the next enrolment window.

  - Expiry of personal/official insurance coverage of parents/parents-in-law who are retiring or exiting their own business will not be considered as an acceptable situation warranting an addition of parents/parents-in-law in the scheme outside the enrolment period.

Deletion of Beneficiaries

- Employees may delete any of their beneficiaries by following the path: ***Ultimatix → Employee Services → Employee Self Service → Global ESS → Benefits and Taxes → Health Insurance Scheme → Beneficiary Details*** and selecting the appropriate reason for deletion.

- Parents / parents-in-law deleted from beneficiary list cannot be re-enrolled for the next 3 years from the year of deletion. If re-enrolled after 3 years, they cannot be deleted again for the next 3 years, except in case of their unfortunate demise.

5. HIS Coverage for employees deputed on International Assignments

Employees deputed on international assignments outside India have to specifically enrol their beneficiaries under TCS India Health Insurance Scheme. New beneficiaries enrolled under overseas health insurance policy would not be automatically rolled over to India Insurance on return to India/end of deputation. There is no restriction on maintaining dual coverage for spouse and beneficiaries under India HIS and overseas Insurance.

6. HIS Coverage for retiring employees

- Post retirement employees can continue to renew the policy by paying premium and completing the renewal process which will be shared at the start of the financial year (during enrolment window period) from corporate.his@tcs.com.

- Login credentials and link to raise claims will be shared by an email at the time of retirement, which needs to be used to raise claims and also to complete the renewal process.

- The policy terms & conditions remains same for the retired employees. Premium needs to be borne in full post retirement as there would be no company contribution. No changes in plan (upgrade/downgrade) will be permitted.

7. HIS Coverage for employees separating from TCS

- As this is a corporate policy, the HIS coverage ceases as and when an employee resigns from the organization. HIS coverage for employee and their enrolled beneficiaries will be valid only till the last working day in TCS.

- If a separated employee wishes to port out of the Group policy and buy a retail policy, they may download the policy continuation letter from the HIS portal and connect with the insurer (www.newindia.co.in/) to buy a retail policy while maintaining the continuity. In such a scenario, term & conditions of the policy and premium needs to be discussed with the insurer separately as this would not be part of the Group policy.

8. HIS Premium:

- The premium amount payable for HIS coverage will vary depending on the type of HIS Health Plan, number of beneficiaries enrolled and age of beneficiaries (for parents/parents-in-law only)

- The total premium amount payable is split between Base Cover and Floater Cover Premium as per the applicable plan.

  - **Base Cover Premium** towards basic hospitalisation and domiciliary cover for employee, spouse and up to 3 children is borne by TCS. Premium for parents / parents-in-law / remaining children, if enrolled, will be borne by employee, as applicable. Such premium for parents' category will be based on the age of the beneficiary.

  - **Floater Cover Premium** is partially borne by the employee and partially by TCS.

- In case the employee upgrades to a higher plan, the additional premium between the existing default plan and the new plan will be borne solely by the employee.

  Note: *TCS and the Insurer reserve the right to review and revise the premium and/or coverage for insured beneficiaries, who are not vaccinated against COVID-19.*

- For complete details on benefits and premium amount payable, refer to GESS via the path: ***Ultimatix → Applications → Employee Services → Employee Self Service → Global ESS → Benefits & Taxes → Health Insurance Scheme → Beneficiary Details***

- Base Cover Premium amount payable for Parents/Parents-in-law will be prorated for new joinees and for employees getting married during the financial year basis their date of joining/date of marriage.

- Premium that is paid for employee and beneficiaries is for the entire financial year as per the terms and conditions negotiated with the Insurance Service Provider. There will be no refund / stoppage of premium recovery in any scenario including the following:

  - Employee separates anytime during the financial year

- Death of an insured person
- Marriage/Divorce
- Deletion on account of dual enrollment
- Children no longer eligible for coverage
- Birth of a child
- Beginning of employment of any of the insured beneficiaries

Note:

i. The premium, as applicable and payable by the employee, is deducted through the employee's payroll. GST is applicable to all the premium amounts.

ii. Premium paid by the employee qualifies for tax benefits as per relevant applicable taxation laws in the country.

- **Special Scenario** - Employees proceeding on Leave Without Pay (LWP):
  - The employee and beneficiaries who are covered (as of LWP start date) will continue to be covered for the entire duration of the LWP. The applicable premium for LWP period will be deducted after the employee reports back to work and the payroll processing starts. In case, the employee fails to report back to work then the applicable premium will be recovered through their FFS.
  - In case the employee resigns while on LWP and prior to reporting back, HIS coverage will continue till the date of resignation. Outstanding premium if any, will be recovered through their full and final settlement.

9. Benefits of being covered under Health Insurance Scheme (HIS)

Refer to the contact matrix for any queries on HIS Benefits.
Ultimatix → Employee Services → Health → Health Insurance Portal → HIS Contact Matrix

Domiciliary Benefit

Domiciliary Benefit covers expenses that an employee will incur on treatments undergone by the beneficiary as an outpaient (OPD). Such treatments also include dental treatments which are non cosmetic in nature (Refer section on Dental procedures). This benefit includes cost of investigative tests, doctor consultations and pharmacy bills. This benefit is defined per insured beneficiary per policy period.

Cashless Hospitalization Facility

- The Insurance Service Provider/TPA has empanelled specific hospitals (known as network hospitals) through which a cashless hospitalization facility can be provided to the employee and the enrolled beneficiaries. i.e. the patient can undergo treatment at the hospital without making

a direct payment to the hospital. The payment (up to the entitlement limit) is made from the Insurance Company directly to the Hospital through the TPA.

- **Types of Cashless Hospitalization:**

  - Planned Cashless Hospitalisation- The insured person seeks cashless hospitalisation through planned admission (that is, with prior intimation to the insurance company and approval). In such cases, it is mandatory to intimate the TPA about the details of the hospitalization at least 72 hours in advance. This will enable the TPA to ensure a smooth and hassle-free admission process for the patient.

  - Emergency Cashless Hospitalisation- The insured person is admitted due to a medical emergency within a very short notice and requires urgent treatment (i.e. requests needs to be given highest priority and approvals need to be obtained immediately).

- For more details, please refer to the cashless hospitalization procedure available on TCS Health Insurance Portal: ***Ultimatix → Employee Services → Health → Health Insurance Portal → Claims → Cashless Pre intimation***

  Note:

  i. Cashless hospitalization is available only with network hospitals. For hospitalization in hospitals outside the network, employees will need to bear the expenses on their own and later claim a reimbursement under HIS.

  ii. While availing cashless facility, employees may need to pay the deposit amount as per the hospital regulations. The same can later be claimed for reimbursement on submission of the original deposit receipt. Alternatively, employees may request the hospital to refund the deposit amount once the bill towards all treatments is settled with the hospital by the TPA.

- **Room Category:**

- Room eligibility for employees and enrolled beneficiaries is defined based on the Health Plan as illustrated in the table below:

<table>
<tr><th rowspan="2">Beneficiaries Type</th><th colspan="5">HIS Benefits</th></tr>
<tr><th>ESIC</th><th>Gold</th><th>Gold Plus</th><th>Platinum</th><th>Platinum Plus</th></tr>
<tr><td>Employee, Spouse & Children</td><td colspan="2">Double occpancy/Twin Sharing</td><td>Single Private A/C</td><td colspan="2" rowspan="2">Single Private A/C</td></tr>
<tr><td>Parents/Parents- in-law</td><td colspan="3">Double occpancy/Twin Sharing</td></tr>
</table>

- In case the employee chooses a room which is higher than their eligibility, the additional charges for the room and other related items will have to be borne by the employee.

- Hospital charges differ (for the same services) depending on the room type chosen (General, Shared, Private, Deluxe, Super Deluxe etc.). Incase a room higher than eligibility is availed,

then the proportionate amount will be deducted not only for the additional room charges but also for all other hospital charges that are linked to the room chosen i.e Doctor consultation/visit, Nursing charges, Medical tests, Surgery costs etc.

- Hospitals where the room categories are termed differently, room tariffs based on the default plan or opted plan in case of an upgrade will be taken into consideration for cashless approvals/reimbursement.

Domiciliary Hospitalization Facility

- In cases where medical condition of the employee/an enrolled beneficiary legitimately requires hospitalization but the condition of the patient is so serious that they cannot be moved to the hospital or there is no accommodation available in the hospital, then treatment may be carried out at home.

  ***Example**: The condition of a patient with a heart problem may, in the opinion of the attending physician be such that, the patient could not be moved to a hospital without causing harm to his/her health.*

- Reimbursement requests made in respect of such medical conditions will be considered under the 'Hospitalisation' category of HIS, provided the period of treatment is for 3 consecutive days or more.

  Note:

  iii. Any claim under this head should always be accompanied by a certificate from the attending specialist or physician which certifies that the treatment given is tantamount to hospitalisation treatment (and not domiciliary treatment).

  iv. The following ailments shall not be covered under the Domiciliary Hospitalisation benefits: Asthma, Bronchitis, Chronic Nephritis & Nephrotic Syndrome, Diarrhoea & all types of dysenteries including gastro-enteritis, Diabetes Mellitus & Insipidus, Epilepsy, Hypertension, Influenza, Cough & Cold, All Psychiatric & Psychosomatic Disorders, Pyrexia of Unknown Origin, Tonsillitis & Upper Respiratory Tract Infection including laryngitis & Pharyngitis, Arthritis, Gout & Rheumatism and Peritoneal Dialysis

Hospitalisation Cash Benefit (applicable only for employees and not for other beneficiaries):

- This benefit provides financial support to employees when they are hospitalised for more than 5 consecutive days.
- Employees are eligible for Hospital Cash @ Rs.1,000/- per day starting from the 6th day until the time they get discharged.
- This benefit is over and above the Base and Floater cover insured limits.
- This benefit is applicable only if a hospitalization claim is processed under TCS HIS (as per policy conditions) and length of the stay is justified with necessary documentary evidences.

***Note**: Employees need not apply for this benefit separately. This will be payable by default post the verification of necessary documents and is credited to the employee's account updated in the HIS Portal.*

Critical Illness – Leave Without Pay (LWP) Benefit (applicable only for employees and not for other beneficiaries):

- Employees who are suffering from tertiary/critical illness or any bodily injury caused due to accidents/occupational hazards arising out of and in course of employment, are hospitalized due to the same for a prolonged period and have exhausted their available leave balance and are on Leave Without Pay may avail the Critical Illness – LWP Benefit.
- Employees are given a weekly financial support equivalent to 66% of their monthly compensation/number of weeks in a month (OR) Rs. 40,000/- per week, whichever is lower.
- This benefit is over and above the base and floater cover insured limits and is available for a maximum period of 52 weeks. It can be availed only once by the employee during their tenure with the organization.
- The amount is credited in the salary account of the employee by the end of every month and will be calculated on a prorata basis.

  ***Note**: Employees need not apply for this benefit separately. This will be payable by default post the verification of the HIS claim raised and Leave Without Pay (LWP) application in Ultimatix.*
- List of Tertiary/ Critical illness for which this benefit may be availed:

  1. Cancer Nephritis of any etiology plus bacterial renal failure requiring kidney transplantation and dialysis,
  2. Cerebral or vascular strokes
  3. Open and closed heart surgery
  4. Malignant diseases confirmed by histopathological reports
  5. Viral encephalitis
  6. Brain surgery
  7. Liver cirrhosis associated with hepatitis B\C
  8. Compound\multiple fracture of femur
  9. Intra cranial injury
  10. Coma
  11. Spinal injury resulting in Paraplegia
  12. Cerebral haemorrhage

13. Third degree burns
14. Major organ transplant
15. Multiple Sclerosis

Trauma Care Support (applicable only for employees and not for other beneficiaries):

- Employees who are hospitalised owing to an accident and post discharge from the hospital continue to be on leave for recuperation are eligible for trauma care support
- Expenses towards trauma care of Rs.5,000 per week and up to a max of Rs.60,000 will be paid to the employee.
- This is over and above the sum insured limits.
- These expenses will be payable from the day the employee exhausts all the available paid leaves and proceeds on LWP.
- This benefit is applicable only if a hospitalization claim is processed under TCS HIS.

Note:

i. *Employees need not apply for this benefit separately. This will be payable by default post the verification of necessary documents raised as part of hospitalization claim and is credited to the employee's account updated in the HIS Portal.*
ii. *Wherever, both Trauma Care and LWP Financial Assistance is applicable, only one benefit will be extended (whichever is more beneficial to the employee)*

Ambulance Expenses:

- In an event when employees or any of their enrolled beneficiaries require ambulance services to shift the insured person to the nearest healthcare facility and/or from one healthcare facility to another for better treatment/diagnosis, this benefit may be utilized.
- Road Ambulance expenses are reimbursable up to a limit of Rs. 2500 per family during the policy period. This benefit is under your hospitalisation sum insured limit.
- In extremely critical situations where medical condition of the patient is very critical and requires emergency hospitalization for survival or when the patient is based out of a remote location and/or other modes of transport are inadvisable as per the treating doctor, then Air Ambulance services may be availed.
- Air Ambulance expenses are reimbursable up to a limit of Rs. 1,00,000 per event. This limit is over and above sum insured limit.

Note:

i. *Air Ambulance referes to the use of air transportation, aeroplane or helicopter, to move patients to and from healthcare facilities and accident scenes*

ii. *Transportation by Air Ambulance is only to the nearest healthcare facility where patient can be treated.*

Cancer Care Benefit:

- This benefit provides monetary support to employees in caring for the beneficiaries undergoing treatment for cancer.
- Employees and enrolled beneficiaries undergoing treatment for cancer will be eligible for a monetary benefit of Rs 25,000/- as a one time benefit per beneficiary.
- This benefit is over and above the base and floater cover insured limits.
- It can be availed only once during an employee's tenure with the organization.
- This amount is paid directly to the employee's account updated in the HIS portal post validation of any hospitalisation claim regarding the same.

Periodic Health Screening (PHS)

- Employee/s and their spouse (enrolled under HIS) aged 40 years and above are eligible for a Periodic Health Check as a part of their Health Insurance Coverage.
- This can be availed annually for employees and their spouse aged 50 years and above; and bi-annually (once in a block of two financial years) for employees and their spouse aged 40 years and above.

  Refer to: Ultimatix > MyHR > India > Heath, Safety & Wellness > Health & Insurance > Periodic Health Screening > TCS India Policy - Periodic Health Screening for more details.
- Employees can book an appointment for PHS under ***Ultimatix → Employee Services → Health → Health Insurance Portal → Wellness → Periodic Health Checkup.***

Vaccination towards COVID-19:

- Expenses on vaccination towards COVID-19 are reimbursable on actuals per insured beneficiary up to the recommended dosage to be fully vaccinated as declared by the Government of India (Two doses for Covishield/Covaxin/Sputnik V).
- Employees and their enrolled beneficiaries eligible for vaccination as per government notification which may be updated from time to time can avail this benefit.
- This benefit is over and above the domiciliary cover.

  Note:

  i. *Expenses towards booster vaccination dose is covered under this benefit.*

ii. *TCS and the Insurer reserve the right to review and revise the premium and/or coverage for enrolled beneficiaries, who are not fully vaccinated against COVID-19.*

iii. *TCS will review any exceptions for associates under the reasonable accommodation before such revisions are imposed.*

10. Criteria for HIS coverage for some specific conditions/ailments/treatments

- All the limits specified below are limits for various conditions/ailments defined under the total insured amount for the beneficiaries and are within the limits of the domiciliary, base and floater cover for the policy period. This is not over and above the defined coverage.
- The below specified limits are applicable to all employees including employees deputed on international assignments outside India
- While considering any reimbursement request with regards to the below ailments/treatments, the below specified limits or base and floater insured limit or GIPSA limit whichever is lesser would be considered.
- These limits are inclusive of any related complications due to the health condition/ailment and all expenses incurred on the same one month prior & post the hospitalisation.
- The limits defined below are per beneficiary per policy period unless specified otherwise.

Maternity Benefits

- Maternity benefits shall include the following:
  - Expenses on delivery (including complicated deliveries and caesarean sections)
  - Expenses on surgical intervention for treatment of infertility and / or In vitro fertilization (IVF)
  - Expenses on lawful medical termination of pregnancy necessitated due to medical conditions
  - Pre-natal and post-natal medical expenses for delivery or medical termination of pregnancy.
  - Expenses on treatment of any complications arising during the course of pregnancy and prior / post delivery
- The total amount payable for surgical intervention for treatment of Infertility and / or IVF is limited to INR 1,00,000/-

Note:

i. *The benefit for treatment of infertility and/or IVF may be availed by employees or insured beneficiaries irrespective of the gender*

ii. *The benefit can be availed as a reimbursement claim only.*

iii. *An employee can submit reimbursement claims post completion of the IVF event (completion of both stages comprising of ovum pick-up and transfer), irrespective of whether it was successful or not.*

iv. *Only 1 episode of treatment towards Infertility / IVF procedures may be claimed in a financial year. A maximum of 2 episodes of such treatments towards Infertility / IVF may be claimed throughout the employee's tenure*

v. *Non-surgical intervention (Intra Uterine Insemination) or medical management for treatment for infertility is admissible under Domiciliary cover only.*

vi. *Expenses on sterility/ family planning treatments are not admissible under HIS.*

- The total amount payable for any maternity related hospitalisation resulting in normal delivery/ instrumental delivery (forceps/ vacuum/etc.) is limited to INR 75,000/- for the entire maternity related hospitalization episode.

- The total amount payable for the maternity related hospitalisation resulting in C-section delivery is limited to INR 1,00,000/- for the entire maternity related hospitalisation episode.

Note:

i. *The overall limit as mentioned against each of the delivery types is inclusive of pre-hospitalization and post hospitalisation expenses, pertaining to one month prior and post-delivery.*

ii. *The overall limit for maternity benefits remains the same in case of multiple child births (twins/triplets) or complications related to the same.*

iii. *The benefits are limited to three deliveries or medical termination of pregnancies or either during the lifetime of an insured person. The benefits cannot be availed for any subsequent deliveries irrespective of whether maternity benefits for the earlier deliveries were claimed through this policy.*

iv. *Maternity related expenses like expenses on medicines if any, doctor's consultation fees, routine check-ups and diagnostic tests conducted during the maternity period are not covered under the domiciliary cover.*

- Maternity benefits shall exclude any expenses on the new-born baby. A new-born baby is a new insured beneficiary after being enrolled under HIS.

- New born baby expenses – Well Baby Care expenses (expenses related to wellbeing of the baby immediately post delivery, subject to review) may be considered only within the Maternity limit of Rs. 75,000/- or Rs. 1,00,000/- depending upon the mode of delivery and subject to the Insurance company's review and decision.

- Other expenses related to new born baby which re not covered under Maternity Benefit but are covered under sum insured limit of the new born baby.

- The Hospitalisation expenses of the new born child only if the child is suffering from any ailment/illness/disease/condition which requires in-patient treatment in the Hospital. This is subject to addition of child under HIS within the stipulated period.
- Hospitalisation expenses for routine check-up/tests/screening and vaccination charges, etc. of the baby are not admissible.

Cataract Treatment

- Expenses up to Rs 30,000 towards correction of cataract in a single eye are covered under HIS. This limit is per procedure and may be availed multiple times during the policy year.
- The limits are inclusive of all the expenses incurred towards correction of cataract including the lens charges and pre and post hospitalisation expenses (if any) incurred one month prior to and post hospitalization.

Joint Replacement

- Expenses up to Rs 2,50,00 for Single Joint Replacement and Rs. 4,00,000 for Bilateral Joint Replacement are covered under HIS.
- The limits are inclusive of pre and post hospitalisation expenses (if any) incurred one month prior to and post hospitalization.
- Beneficiaries must ensure a minimum gap of one month between two single joint replacement procedures in order to avail the benefits of HIS.

Treatment for Hysterectomy

- Hysterectomy includes Hysterectomy with or without Salpingo-oopherectomy.
- Expenses up to Rs 70,000 per beneficiary per policy period are covered under HIS.
- The limits are inclusive of all the expenses incurred towards correction of cataract including the lens charges and pre and post hospitalisation expenses (if any) incurred one month prior to and post hospitalization.

Cancer Care

- Expenses incurred on Conventional/Parenteral chemotherapy or radiotherapy are covered under HIS.
- Other therapies including Oral/Targeted/Hormonal Chemotherapy are also covered subject to a maximum limit of the base cover insured per beneficiary for the policy year. (For ESIC plan the limit will be up to Rs.1 lac).

Treatment of Multiple Sclerosis (applicable only for employees and not for other beneficiaries):

- OPD/Daycare medical expenses incurred for the treatment of Multiple Sclerosis for the employee are covered subject to maximum limit of Rs 2,50,000 per policy period.

Cochlear Implants

- Expenses for Cochlear implantation including hospitalization (if required) are covered up to 50% of the actual expenses or 50% of the sum of base cover per insured beneficiary and floater cover for the family, whichever is less.

Treatment for Obstructive Sleep Apnea

- Expenses incurred on treatment for obstructive sleep Apnea are covered up to 50% of the actual expenses. However, this medical condition has to be confirmed by Polysomnography test and should be certified by the treating doctor that the employee needs to use CPAP or BiPAP machine.
- Repair, replacement and maintenance charges for the instruments are not admissible under the policy.
- These expenses will be payable only if the employee is using a CPAP or BiPAP machine and only once during his / her tenure with the organisation.

Treatment of obesity or conditions arising thereof (including morbid obesity) (applicable only for employees and not for other beneficiaries):

- Bariatric surgery for treatment for Morbid Obesity where BMI is more than 35 with severe medical conditions or BMI of more than 40 are admitted.

DIVYAANG Benefit

- Employees with differently abled children will need to raise a hospitalization claim with necessary supporting documents to validate the condition of their child. This benefit will be automatically payable post validation of the claim request and the documents.
- An amount of Rs 10,000 per policy period is payable to employees for treatment and therapies of a differently abled child. The amount is credited to the employee's account updated in the HIS Portal.

Sex/Gender Reassignment Surgery (SRS) (applicable only for employees and not for other beneficiaries):

- Expenses towards surgical procedures for sex/gender reassignment are covered up to Rs 5 lakhs per employee per policy period.
- Expenses towards Hormonal Replacement Therapy, psychiatric visits and counselling services related to SRS if any are payable under domiciliary cover.

Treatment for Insanity/ Anxiety / Mental Illness

- Expenses towards treatment for insanity / anxiety / mental Illness is payable under domiciliary cover.
- In case of hospitalization with an 'Active line of treatment', medical expenses for treatment of certain psychiatric and Psychosomatic Disorders or Mental Illness are covered up to Rs. 2,00,000 per family.

- Expenses on hospitalization purely for rehabilitation/observation/diagnostic purposes are not payable.

Treatment for Genetic disease or disorders

- Expenses incurred on treatment for genetic diseases or disorders are covered up to 50% of the sum insured limit (base plus floater) per beneficiary.

Treatment for Puberty and Menopause related disorders

- Expenses incurred on treatment for Puberty and Menopause related disorders are covered up to 25% of sum insured limit (base plus floater) per beneficiary.
- Expenses on treatment for any symptoms, Illness, complications arising due to physiological conditions associated with puberty, menopause such as menopausal bleeding or flushing are covered only in cases that require hospitalisation.

Transurethral Electro-Vaporization of the Prostate (TUEVAP) / Green laser treatment or holmium laser treatment

- Expenses incurred on treatment for the same are covered up to 50% of the sum Insured limit (base plus floater) per beneficiary, subject to a maximum limit of Rs. 2.5 lakhs per beneficiary.

Treatment for age related Macular Degeneration

- Expenses incurred on treatment for the same are covered up to 10% of Sum Insured limit (base plus floater) per beneficiary, up to a maximum limit of Rs. 75,000.

Modern Treatment methods

Use of modern treatment methods and advanced technologies for medical treatments explicitly listed below only are covered under HIS up to the limits specified:

- **Uterine Artery Embolization and HIFU (High intensity focused ultrasound)** – Covered up to 20% of the sum insured limit (base plus floater) per beneficiary, subject to a maximum limit of Rs. 2 lakhs.
- **Balloon Sinuplasty** – Covered up to 20% of the sum insured limit (base plus floater) per beneficiary subject to a maximum limit of Rs. 2 lakhs
- **Deep Brain stimulation** - Covered up to 50% of the sum insured limit (base plus floater) per beneficiary subject to a maximum limit of Rs. 5 Lakhs.
- **Immunotherapy** – Monoclonal Antibody to injections – Covered up to 25% of the sum insured limit (base plus floater) per beneficiary subject to a maximum limit of Rs 2 Lakhs; Intra Vitreal injections – Covered up to 10% of the sum insured limit (base plus floater) per beneficiary subject to a maximum limit of Rs.75,000.
- **Robotic Surgeries** - Covered up to 50% of the sum insured limit (base plus floater) per beneficiary subject to a maximum limit of Rs. 5 Lakhs.
- **Stereotactic Radio Surgeries** - Covered up to 50% of the sum insured limit (base plus floater) per beneficiary subject to a maximum limit of Rs. 3 Lakhs.

- **Bronchial Thermoplasty** - Covered up to 50% of the sum insured limit (base plus floater) per beneficiary subject to a maximum limit of Rs. 2.5 Lakhs.
- **Intra Operative Neuro Monitoring (IONM)** - Covered up to 10% of the sum insured limit (base plus floater) per beneficiary subject to a maximum limit of Rs. 50,000.
- **Stem cell therapy** - Hematopoietic stem cells for bone marrow transplant for haematological conditions – Covered up to 50% of the sum insured limit (base plus floater) per beneficiary subject to a maximum limit of Rs. 2.5 Lakhs.

Modern treatment methods and advanced technologies not explicitly listed in this policy will only be covered up to the conventional cost of treatment of the ailment.

Note:

i. *Sum Insured limit per beneficiary refers to the basic plus floater cover limits applicable under the applicable health plan of the beneficiary in a policy period.*

ii. *Claims raised under HIS for any other advanced procedures not explicitly listed above will be reviewed by the Insurer/TPA in line with such treatments being qualified as advanced treatments by the Medical Council of India, or, in general medical practice. Such treatments can be claimed at the rate of *conventional cost of the treatment and up to a maximum of the Sum Insured limit.*

**Conventional cost is the reasonable and customary charges applicable for a treatment. Reasonable and customary charges mean the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.*

Acquired Immunodeficiency Syndrome (AIDS)

- Expenses on hospitalization for treatment of HIV AIDS is covered under HIS up to a maximum of the sum insured limit (base plus floater) per beneficiary.
- Expenses on medication taken towards the treatment of HIV AIDS can be claimed under domiciliary cover.

Treatment outside India (applicable only for TCS India employees on official travel/assignment outside India where they don't have a local insurance coverage):

- Expenses incurred on domiciliary treatment incurred outside India will not be covered under the HIS scheme.
- Expenses incurred on treatments that require hospitalization while an employee is on official travel/assignment to another country are covered under India HIS up to the sum insured limit (base cover only) per employee.

- For employees covered under overseas insurance cover, benefits should be first availed against the overseas insurance cover first and post exhaustion of the same, claims can be raised under India HIS.

- Cases where the settlement under overseas insurance cover is pending, employees are encouraged raise claims under India HIS within 90 days from the date of discharge/before the year-end deadline. Employees will be required to submit the documents (settlement letter from overseas insurance company and scanned copies of other supporting medical documents) within 60 days of raising the claim in the India HIS portal, once they have the settlement letter from overseas. Post this, the claim raised under India HIS will be reviewed and settled as per policy terms.

- The process for raising claims for treatment taken outside India will be the same as followed for hospitalisations in India. The claim amount should be in equivalent Indian Rupees only and a settlement will be done in equivalent Indian Rupees only. It is recommended to have the claim documents and bills in English language.

- The expenses on test/samples sent outside India for investigation of treatment taking place in India will not be covered under the HIS scheme.

Alternative System of Medicines

- Expenses incurred for Ayurvedic/Homeopathic/Unani treatment are payable up to a maximum limit of 25% of the sum insured limit (base plus floater) per beneficiary provided the treatment for illness/disease/injury, is administered by a Registered practioner and taken in a Government recognized hospital/institute and /or accredited by Quality Council Of India / National Accreditation Board on Health. Only the cost of medicines is reimbursed & not the expenses incurred on special diets, such as fruit juices, milk, ghee, etc.

- Siddha, Panchakarma, Patanjali, Acupuncture, Hypnosis, Health Spa, Naturopathy, Herbal / rehabilitation treatments, health rejuvenation procedures & related expenses are not covered under HIS.

- Expenses payable for each family for the above methods of treatment will be limited to 10% of the floater sum insured for the family.

Dental Treatment

- Expenses incurred on extraction, fillings, medicines, consultation fees, root canal expenses and x-ray charges may be reimbursed under domiciliary cover. The case summary (date wise treatment details) or x-ray films are mandatory to process any claim related to dental treatments.

- Expenses incurred on major dental surgeries such as maxillo facial surgery or any life threatening surgeries are covered under hospitalization and up to the sum insured limit (base plus floater) per beneficiary. Such expenses are covered only if necessitated due to an accident.

- The expenses incurred towards the below will not be covered under HIS - Cosmetic surgeries including crowns, tooth implants, dental implants, artificial dentures, braces, bridges, orthodontics, prognathism, retrognathism, etc.

11. Exclusions under Hospitalization and Domiciliary

The below forms/types of treatment/procedures under specified scenarios are not covered under HIS:

- Expenses towards Health Check-ups
- Expenses towards correction of eyesight, cost of spectacles, contact lens
- Expenses towards cost of braces, cost of scaling of teeth
- Expenses towards hearing aid
- Expenses on beauty treatment- Change of Life (beauty treatment of any description), cosmetic or aesthetic treatment, Hair Loss/Alopecia and its treatment, Weight Loss/ Height Gain treatment, Acne/ Pimples Treatment, Plastic Surgery other than as may be necessitated due to accidental injuries.
- Expenses incurred on treatment of external congenital defects/diseases/anomalies i.e. the defects/conditions/anomalies which are visible at the time of birth
- Expenses incurred on treatment of anaemia, and towards buying a nebulizer
- Expenses incurred on Lasik/Laser surgery and advanced surface ablation surgery
- Expenses towards Vaccination (MMR/BCG/Polio/Anti Typhoid), Inoculation, general heath check-up of a baby
- Expenses on Circumcision (other than on medical grounds), Strictures
- Expenses incurred on Convalescence (which expression shall also cover general debility “run down” condition and general “over haul”) or Rest Cure, Rehabilitation
- Expenses incurred on treatment of Venereal Disease
- Expenses incurred on treating Intentional self-injury. This includes treatment of bodily injury / sickness / disablement due to wilful or deliberate exposure to danger (except to save a human life), intentional self-inflicted injuries, attempted suicide and arising out of non-adherence to any medical advice
- Expenses incurred on treatment of diseases or condition or accidents arising out of intemperance or the use of intoxicating drugs or tobacco or liquor or alcohol or treatment of any disease directly or indirectly due to any one or more of them.
- Expenses incurred on health routine check-up examination / Master Check-up unless necessary positive existence for treatment of any medical condition.

- Expenses incurred at Hospital or Nursing Home primarily for evaluation / diagnostic purposes which is not followed by 'Active line of treatment' for the ailment during the hospitalised period.

  Refer to the definition of 'Active line of treatment' in the section on Hospitalization under Appendix C.

- Expenses incurred on treatment of general weakness not caused by an underlying medical condition.

- Expenses incurred on treatment of injury, disease or illness directly or indirectly due to or arising from ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel (solely for the purpose of this exclusion, combustion shall include any self-sustaining process of nuclear fission) in the event of War, Invasion, Act of Foreign Enemy, Hostilities or Warlike Operation (whether war be declared or not), Riot or Civil Commotion or Breach of Law.

- Expenses incurred on treating bodily injury sustained as a result of participating in any criminal act, Breach of Law, any hazardous sport or hunting. This includes but is not limited to Steeple chasing, Polo or winter sports or riding or driving in races, employment in Military, Naval or Air Services or engaging in Aviation or Ballooning or entering into, travelling in or leaving any aircraft or balloon, unless specifically included in any other policy of the company.

- Expenses incurred on nutritional supplements, vitamins and tonics, etc. unless forming a part of the treatment for an injury or disease as certified by the attending physician.

- Expenses incurred on treatment of obesity or conditions arising thereof (excluding morbid obesity) and any other weight control program services or supplies etc. even if associated with thyroid problem.

- Expenses incurred on instruments, Continuous Ambulatory Peritoneal Dialysis (CAPD) procedure and all related expenses for Dialysis, external equipment or prosthetic devices, ambulatory devices like walker, crutches, belts, collars, caps, splints, slings, stockings, diabetic footwear etc.

- Expenses incurred on experimental and unproven treatment, not recognized by the Indian Medical Council.

- Expenses incurred on Rotational Frequency Quantum Magnetic Resonance therapy (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy

- Expenses incurred on Robotic surgeries, Cyberknife surgeries unless there is no other alternative available for treatment

- Expenses incurred on procedures and treatments usually done in outpatient department but being claimed under hospitalization are not payable under base and floater covers even if converted to day-care surgery/procedure or as in- patient in the Hospital for more than 24 hours. Example: administration of Intravitreal/intravenous injections, Remicade, Herceptin, Zoledronic, Rituximab, Avastin Injections and any other preventive injections or vaccinations, etc.

- Expenses incurred towards abortion, voluntary termination of pregnancy and related complications are not payable.

- Diagnostic, X-ray or Laboratory examination not consistent with, or, incidental to the diagnosis of positive existence and treatment of any ailment, sickness or injury

- Extra amount paid directly by the associate to consultant / surgeon etc. over and above hospitalisation expenses (wherein consultant / surgeon charges are already included in the hospital bill) will not be reimbursed.

- Non-Medical expenses as listed in IRDA guidelines including but not limited to- expenses incurred on Registration/Admission Fees, telephone, television, ayah, private nursing, Visitor's charges, attendant's charges, diet charges (which are not part of the administered treatment), baby food, cosmetics, tissue paper, diapers, sanitary pads, toiletry items, Service charges, surcharge and/or any other Charges like Medico Legal Charges (MLC), Medical Record Charges and similar expenses.

  ***Note**: This list of non-medical items (enumerated above) is only indicative and not exhaustive.*

Terms & Conditions

- TCS and the Insurance Company solely act as facilitators for the disbursement/administration of the insurance benefits. TCS and the Insurance Company are not responsibile in the respect of any eventuality/mishap during the course of the treatment of insured person at any of the hospitals empanelled by the Insurance Company.

- TCS understands the sensitivity of personal information and medical records. TCS and the Insurance Company undertake to secure the confidentiality of all medical records, conditions and treatment of an insured person from unauthorised disclosure & misuse.

- The Insurance Company shall not be liable to make any payment under the HIS in respect of any claim, if such a claim is found to be in any manner fraudulent and supported by any fraudulent statement or device whether by the insured or by any other person on their behalf. TCS/The Insurance Company views such cases very seriously and stern action will be taken against the employee, which may also lead to termination of employment with TCS Or debarment from applying for any claims under the policy for a period of not less than 5 years.

- The Insurance Company shall not be liable for settlement of claims for any treatment taken from the de-listed/black-listed Hospitals/Clinic/Medical Professionals. The list of such hospitals is available under the Health Insurance Portal. ***Go to: Ultimatix → Employee Services → Health → Health Insurance Portal → Hospitals → Blacklisted Hospitals***

- TCS at its dicretion will revise this policy on Health Insurance Scheme from time to time, which may result in a corresponding change in the entitlements, provisions, the extent of coverage, the premium amount payable, beneficiaries who can be covered, etc.

Procedure

Hospitalization Procedure

- Employees must opt for hospitals which are part of the network list and avail the cashless facility. The list of network hospitals can be accessed through the Health Insurance Portal or through MediBuddy Mobile App. ***Refer: Ultimatix → Employee Services→ Health →Health Insurance Portal → Hospitals → Network Hospitals***

- With a view to ensure a hassle-free experience, employees are required to provide prior intimation to the TPA (at least 72 hours in advance), in case of a planned hospitalization. This is applicable for both cashless and reimbursement mode.

  Note: *In case of an emergency hospitalization, prior intimation is not required*

- Intimation of hospitalization must be provided through Health Insurance portal accessible via the below path

  Ultimatix → Employee Services →Health & Wellness → TCS Health Insurance Portal → Claims → Cashless Preintimation (OR) through the MediBuddy Mobile App which can be downloaded on Android and iOS devices.

- A 10% deduction on the admissible amount will apply for both cashless and reimbursement mode if a prior intimation (at least 72 hours in advance) has not been provided by the employee. This excludes situations that require emergency hospitalization.

- An additional 10% deduction on the admissible amount will apply if an employee opts for a reimbursement mode in a network hospital instead of availing cashless facility.

Claim Procedure:

- Employees can register their Domiciliary or Hospitalization claims through the TCS Health Insurance Portal. To access the TCS Health Insurance Portal, employees can follow the below path:

  Ultimatix → Employee Services → Health & Wellness → TCS Health Insurance Portal

- Claim guidelines updated on the TCS Health Insurance portal should be referred to before submission of a claim.

- All reimbursement claims should be raised against the appropriate heads of Domiciliary or Hospitalization in the portal within 90 days from the date of incurring the expense (in case of domiciliary claims) or within 90 days from the date of discharge (in case of hospitalization claims).

  Note:

  i. *The 90 days' timeframe to raise claims may not be applicable during the last quarter of the financial year as the HIS claim reimbursement link will be closed on* ***30th April*** *every year. All employees who have claims in the last quarter of the financial year are advised*

*to raise claims before **30th April.** This includes pre/post hospitalization claims if any and claims of expenses incurred at overseas.*

ii. *For hospitalization spanning across policy years, the sum insured limit under HIS cover for the year in which the beneficiary got admitted to hospital will be considered for processing claims. Example: For hospitalization beginning in February 2021 and ending in May 2022, an employee can raise claims which will be reimbursed against the sum insured limits for Policy Year 2021-22 only. For all such hospitalisation claims, in the absence of actual bills (As the hospitalization still continues) employees may raise a claim with an approximate amount (as per the estimation given by the concerned doctor/hospital).*

- For employees serving notice period, hospitalisation or domiciliary claims, if any, need to be raised in the system on or before the last working day in the company. No claims will be accepted after release from the company.
- All claims must be entered through TCS Health Insurance Portal only.
- Employees should upload and retain scanned or photocopies of all the documents, so that the same can be produced if/ when required.
- The Insurer reserves the right to reject any claims raised with modified dates after the mentioned timeline.
- Any concerns related to claims processing should be raised within 30 days from date of approval/rejection of the claim. ***Refer Contact Matrix at: Ultimatix → Employee Services → Health & Wellness → TCS Health Insurance Portal > Contact Matrix***
- Insurance company or TPA is not liable to return the submitted claim documents under any circumstances. This is applicable even for the claims, which are rejected by the Insurance Company.
- Treatments availed at GIPSA governed hospitals will be covered up to the GIPSA rates or rates defined in this policy, whichever is lesser. In any given scenario, the GIPSA hospitals should not charge an amount higher than the GIPSA defined rates for hospitalization. This is irrespective of the Sum Insured / room eligibility of the employee as per TCS Health Insurance policy. In case, an employee notices any discrepancy, the same can be highlighted to ***corporate.his@tcs.com***.
- To avail/claim hospitalisation benefits (for self) employee should apply for necessary leave for the hospitalisation period. Employees should first exhaust their Sick leave and in case of insufficient leave balance, Casual leave and Earned vacation followed by LWP may be availed. Claim processing team may request for the leave records of an employee to conclude the hospitalisation claims.
- If hospitalisation start date (i.e. date of admission) is prior to coverage start date, then entire hospitalisation episode is not covered under the policy. (Pre/post expenses are also not covered).

Procedure to initiate claim under Personal Accident Insurance (PAI) Cover:

Employees who want to initiate a claim request under PAI are required to notify their HRBP and Corporate HIS team (corporate.his@tcs.com) within 12 months of occurrence of such disability and submit the below supporting documents, towards such claims. The Corporate HIS Team will connect with the employee to further process the claim request.

- Disability certificate clearly assessing the medical condition and percentage of disability, from the Municipal Corporation.
- Medical treatment documents clearly specifying the line of treatment and the current medical condition, at the time of submission of the said claims.
- The other standard documents which are required to be submitted for the same are as provided below:

- Claim Form shared by Corporate HIS team (It should be duly filled, signed and authorised by the Corporate HR Employee Welfare team).
- Medical certificate (the medical certificate which is attached along with the claim form should be duly filled, stamped and signed by the attending doctor or any other registered doctor)
- TCS India Annual compensation with respect to the year of accident.
- Aadhaar Card / any other Govt ID card of the employee.
- MRI/X-Ray copies, wherever applicable (in cases of amputation and/or whenever it is available/applicable).
- Date of joining and designation of the employee on company letter head duly stamped & signed by a TCS Official.
- All medical documents/discharge summaries towards the treatment of the disability from the time of initiation of disability to the final discharge date.
- Documents which are translated into English, if any documents are in local/vernacular language.
- FIR/ Police complaint/ Panchnama, if applicable.
- Any other document that may be necessary for the insurer to verify the claims.

Appendix A

Schedule of Indemnities and % of Sum Insured

1. **Sum assured in case of Permanent Total Disablement**

Event	Compensation as percentage of Sum Insured
1. Permanent Total Disability- Loss of two limbs, two eyes or one limb and one eye	100
2. Permanent Partial Disability- Loss of one limb or one eye	50
3. Permanent Total Disability from injuries other than those named above (PTD)	100

2. **Sum assured in case of Permanent Partial Disablement**

Parts Lost	Compensation as percentage of Sum Insured
1. Loss of toes all	20
i. great both phalanges	5
ii. great one phalanx	2
iii. other than great, if more than one toe-lost, each	1
2. Loss of hearing both ears	75

Parts Lost	Compensation as percentage of Sum Insured
3. Loss of hearing one ear	30
4. Loss of four fingers and thumb of one hand	40
5. Loss of four fingers	35
6. Loss of thumb-both phalanges one phalanx	25
7. Loss of index finger three phalanges or two phalanges or one phalanx	10
8. Loss of middle finger three phalanges or two phalanges or one phalanx	6
9. Loss of ring finger three phalanges or two phalanges or one phalanx	5
10. Loss of little finger three phalanges or two phalanges or one phalanx	4
11. Loss of metacarpals first or second (additional) or third, fourth or fifth (additional)	3
12. Any other Permanent Partial Disablement	Percentage as assessed by the Panel Doctor of the Insurance Company.

Appendix B

Commonly used terminologies

1. **Continuous Period of Medical care**

- "Period of Medical care" shall be deemed to mean the period commencing on the first day on which an insured person is under the care of a Medical Practitioner for the treatment of any particular medical condition while the policy is in force and terminating on the expiry of 45 days from the day the insured person resumes normal work or activities. In case the insured person is hospitalised twice during the Period of Medical Care for the same ailment/medical condition, any claims for treatment availed during this period can be claimed as one request.

- In case the medical condition/treatment had commenced prior to the date of insurance, for the purpose of reimbursement, the medical condition shall be deemed to commence from the first day of coverage.

    - ***Illustration****: If the date of cover is with effect from 01 June and the insured person has been undergoing treatment for a medical condition prior to 01 June, all the expenses relating to the medical condition will be covered w.e.f. 01 June.*

- A certificate from the attending Medical Practitioner will have to be submitted certifying that the member had recovered from the medical condition and is fit to resume normal work or activities and stating the date thereof.

2. **Hospital/Nursing Home:**

A hospital/Nursing Home means any institution established for in- patient care and day care treatment of sickness and / or injuries and which has been registered as a hospital with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:

- Has at least 10 in-patient beds, in those towns having a population of less than 10,00,000 and 15 in-patient beds in all other places;

- Has qualified nursing staff under its employment round the clock;

- Has qualified medical practitioner (s) in charge round the clock;

- Has a fully equipped operation theatre of its own where surgical procedures are carried out

- Maintains daily records of patients and will make these accessible to the Insurance Company's /TPA's authorized personnel.

The term 'Hospital/Nursing Home' shall not include an establishment which is a Clinic, Remodeling Clinics, place of rest (Rest Home) and / or recuperation (Recuperation Home/Centre), a place for the aged persons, a rehabilitation centre for drug addicts or alcoholics, detoxification Centres, sanatoriums, Home for mentally disturbed, a hotel or a similar place.

3. Inpatient Care:

Inpatient care means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

4. Day Care Centre:

A Day Care Centre means any institution established for day care treatment of sickness and / or injuries or a medical set-up within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner and must comply with all minimum criteria as under:

- Has qualified nursing staff under its employment

- Has qualified medical practitioner (s) in charge

- Has a fully equipped operation theatre of its own where surgical procedures are carried out

- Maintains daily records of patients and will make these accessible to the Insurance Company's /TPA authorized personnel.

- For Day Care Centres, the minimum beds shall be overlooked but the operation theatre is fully equipped and functioning with advanced technology and infrastructure for surgical operation required in respect of the procedures listed, Day Care Nursing Staff are fully qualified and the doctor performing the surgery or procedure as well as post-operative attending doctors should be fully qualified for specific surgery or procedure.

Note:

(i) The above definition of Hospital/ Nursing Home may not be applicable for Ayurvedic / Homeopathic / Unani procedures which may not require the typical set up of a Hospital/ Nursing Home. However, the expenses incurred for these methods of treatment may be covered under the Hospitalisation benefits subject to a review on a case-to-case basis.

(ii) Incase of Ayurvedic / Homeopathy / Unani treatment, the Insurer shall be liable only when the treatment is taken as in patient in a Government Hospital / Medical College Hospital

5. Day Care Treatment/Procedures:

Day-Care Treatment/Procedure refers to medical treatment and or surgical procedure which is

i. undertaken under General or Local Anaesthesia in a Hospital/Day Care Centre in less than 24 hours because of technical advancement and

ii. which would have otherwise required a hospitalisation of more than 24 hours. Treatment normally taken on outpatient basis i.e. OPD in Hospitals/Day Care Centres is not included under the scope of Day care Procedure.

6. Out Patient Department (OPD) Treatment:

OPD treatment is one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

Typically, day-care procedures are not covered under hospitalisation benefits since Hospitalisation benefits are applicable only if the insured person is admitted as in-patient to a hospital for a minimum of 24 hours. However, there are a few Day-care procedures specified by the insurance provider which may not require 24 hours of in-patient hospitalisation but which are being covered under Hospitalisation benefit due to advancement in medical technology i.e. surgical intervention.
Refer to Appendix C - List of Day Care Procedures where Hospitalisation benefits are applicable

7. Medically Necessary Treatment:

Medically necessary treatment is defined as any treatment, tests, medication, or stay in hospital or part of a stay in hospital which
- Is required for the medical management of the illness or injury suffered by the insured;
- Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- Must have been prescribed by a medical practitioner,
- Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

8. Reasonable Charges:

Reasonable charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.

9. Unproven/Experimental treatment:

Unproven/Experimental treatment is treatment, including drug Experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.

10. Alternative treatments:

Alternative treatments are forms of treatments other than treatment "Allopathy" or "modem medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

11. Active Line of Treatment:

Treatment that is directed immediately to the cure of the disease or injury is called 'Active Line of Treatment'. If admission to a hospital is mainly for diagnosis of an ailment which can be carried out as outpatient or for a routine evaluation of the patient and the treatment involves few oral medications only, it will not be covered under Hospitalisation benefits.

12. Congenital Anomaly:

Congenital Anomaly refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

13. Internal Congenital Anomaly:

Internal Congenital Anomaly is not in the visible and accessible parts of the body is called Internal Congenital Anomaly. This is covered under the purview of the policy, subject to the review of the necessary supporting documents and the medical condition of the patient.

14. External Congenital Anomaly:

External Congenital Anomaly which is in the visible and accessible parts of the body is called External Congenital Anomaly. Such anomalies which are life threatening and non-cosmetic in nature are covered under the purview of the policy, subject to the review of the necessary supporting documents and the medical condition of the patient.

15. Pre-hospitalisation Medical Expenses:

Medical Expenses incurred immediately before the Insured Person is hospitalized, provided that:

- Such Medical Expenses are incurred for the same condition for which the
- Insured Person's Hospitalisation was required, and
- The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

16. Post-hospitalisation Medical Expenses:

Medical Expenses incurred immediately after the Insured Person is hospitalised, provided that:

- Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
- The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

17. Medical expenses:

Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

18. Medical Advice:

Any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

'Hospitalisation' claim for the same medical reason will cover medical expenses for the duration of hospitalisation as well as for a period of up to 30 days prior to admission to a hospital (pre hospitalisation), and up to 60 days from the date of discharge from the hospital (post hospitalisation) for employee, spouse and children. For parents / parents–in-law, post hospitalisation expenses will be covered for a period of up to 30 days from the date of discharge.

21. Cashless Hospitalization Facility:

- The Insurance Company through the TPA provides a Cashless Hospitalisation facility at specific hospitals (empanelled by the TPA). An Insured person who is hospitalised at any of the empanelled hospital can avail this facility.

Note: The list of hospitals made available by the TPA is not exhaustive and is amended from time to time. This list is available on TCS Health Insurance Portal home page.

Appendix C:

List of Day Care Procedures where Hospitalisation benefits are applicable

Surgeries/Procedures

1. Adenoidectomy
2. Appendectomy
3. Anti-Rabies Vaccination
4. Coronary angiography
5. Coronary angioplasty
6. Dilatation & Curettage
7. ERCP (Endoscopic Retrograde Cholangiopancreatography)
8. ESWL (Extracorporeal Shock Wave Lithotripsy)
9. Excision of Cyst/granuloma/lump
10. Following Eye Surgeries:
    a. Cataract Surgery (Extra Capsular Cataract Excision or Phacoemulsification + Intra Ocular Lens
    b. Corrective Surgery for blepharoptosis when not congenital/cosmetic
    c. Corrective Surgery for entropion / ectropion
    d. Dacryocystorhinostomy [DCR]
    e. Excision involving one-fourth or more of lid margin, full-thickness

f. Excision of lacrimal sac and passage
g. Excision of major lesion of eyelid, full-thickness
h. Manipulation of lacrimal passage
i. Operations for pterygium
j. Operations of canthus and epicanthus when done for adhesions due to chronic Infections
k. Removal of a deeply embedded foreign body from the conjunctiva with incision
l. Removal of a deeply embedded foreign body from the cornea with incision
m. Removal of a foreign body from the lens of the eye
n. Removal of a foreign body from the posterior chamber of the eye
o. Repair of canaliculus and punctum
p. Repair of corneal laceration or wound with conjunctival flap
q. Repair of post-operative wound dehiscence of cornea
r. Penetrating or Non-Penetrating Surgery for treatment of Glaucoma

11. Pacemaker insertion
12. Turbinectomy/turbinoplasty
13. Excision of pilonidal sinus
14. Therapeutic endoscopic surgeries
15. Conisation of the uterine cervix
16. Medically necessary Circumcision
17. Excision or other destruction of Bartholin's gland (cyst)
18. Nephrotomy
19. Oopherectomy
20. Urethrotomy
21. PCNL(percutaneous nephrolithotomy)
22. Reduction of dislocation under General Anaesthesia
23. Transcatherter Placement of Intravascular Shunts

24. Incision Of The Breast, lump excision
25. Vitrectomy
26. Thyriodectomy
27. Vocal cord Surgery
28. Stapedotomy
29. Tympanoplasty & revision tympanoplasty
30. Arthroscopic Knee Aspiration if Proved Therapeutic
31. Perianal abscess Incision & Drainage
32. DJ stent insertion
33. FESS (Functional Endoscopic Sinus Surgery)
34. Fissurectomy / Fistulectomy
35. Fracture/dislocation excluding hairline fracture
36. Haemo dialysis
37. Hydrocelectomy
38. Hysterectomy
39. Inguinal/ventral/ umbilical/femoral hernia repair
40. Laparoscopic Cholecystectomy
41. Lithotripsy
42. Liver aspiration
43. Mastoidectomy
44. Parenteral chemotherapy
45. Haemorrhoidectomy
46. Polypectomy
47. Following Prostate Surgeries
    a. TUMT(Transurethral Microwave Thermotherapy
    b. TUNA(Transurethral Needle Ablation)

c. Laser Prostatectomy

d. TURP(transurethral Resection of Prostate)

e. Transurethral Electro-Vaporization of the Prostate(TUEVAP)

48. Radiotherapy
49. Sclerotherapy
50. Septoplasty
51. Surgery for Sinusitis
52. Varicose Vein Ligation
53. Tonsillectomy
54. Surgical treatment of a varicocele and a hydrocele of the spermatic cord
55. Retinal Surgeries
56. Ossiculoplasty
57. Ascitic/pleural therapeutic tapping
58. Therapeutic Arthroscopy
59. Mastectomy
60. Surgery for Carpal Tunnel Syndrome
61. Cystoscopic removal of urinary stones / DJ stents
62. AV Malformations (Non cosmetic only)
63. Orchidectomy
64. Cystoscopic fulguration of tumour
65. Amputation of penis
66. Creation of Lumbar Subarachnoid Shunt
67. Radical Prostatectomy
68. Lasik Surgery (non-cosmetic)
69. Orchidopexy (non-congenital)
70. Nephrectomy

71. Palatal Surgery

72. Stapedectomy & revision of stapedectomy

73. Myringotomy

(OR) any other surgeries / procedures agreed by the TPA and the Company which require less than 24 hours Hospitalization and for which prior approval from TPA is mandatory.

Note: Procedures / treatments usually done in OPD (apart from the Day Care Procedures mentioned above) are not payable under the Policy even if converted as an in-patient in the Hospital for more than 24 hours.

Revision List

Revision No.	Policy Effective date	Document Release /Revision Date	Revision Description	Section No.	Rationale for change	Change type	Policy revision/ Document revision
25.0	01 March 2022	01 March 2022	Expenses towards surgical procedures for sex/gender reassignment revised from Rs 2 lakh per policy year to Rs 5 lakhs per policy year	Criteria for HIS coverage for some specific conditions/ailments/treatments	In line with revisions by insurance service provider	Add	Policy Revision
25.0	01 March 2022	01 March 2022	New Additions- 1. Treatment for Genetic disease or disorders 2. Treatment for Puberty and Menopause related disorders 3. Transurethral Electro-Vaporization of the Prostate (TUEVAP) / Green laser treatment or holmium laser treatment 4. Treatment for age related Macular Degeneration 5. Modern Treatment methods 6. Acquired Immunodeficiency Syndrome (AIDS) 7. Dental Treatment	Criteria for HIS coverage for some specific conditions/ailments/treatments	In line with revisions by insurance service provider	Add	Policy Revision

Revision No.	Policy Effective date	Document Release /Revision Date	Revision Description	Section No.	Rationale for change	Change type	Policy revision/ Document revision
25.0	01 March 2022	01 March 2022	Vaccination towards COVID-19 as per recommended dosages and booster dosages for employees and eligible dependents included under HIS cover	Benefits of being covered under Health Insurance Scheme (HIS)	In line with revisions by insurance service provider	Add	Policy Revision
25.0	01 March 2022	01 March 2022	Personal Accident Insurance cover – Minimum Cover amount in case of Permanent Total Disablement has been revised from Rs. 11 lakhs to Rs. 21 lakhs	Types of cover under HIS	In line with revisions by insurance service provider	Modify	Policy Revision
24.0	01 December 2021	15 December 2021	Inclusion of the IRDA guideline revisions which now mandate inclusion of certain ailments, elaboration of Disability Claims, Coverage towards Sex Reassignment Surgey, psychiatric visits and counseling	Provisions	Inclusion of mandated ailments as per IRDA guidelines, provide more clarity on Disability Claims, LGBTQ Cover revision towards Sex Reassignment Surgey from Rs 2 lakhs to Rs 5 lakhs. Coverage of Hormone Replacement Therapy,	Add/ Modify	Policy Revision

Revision No.	Policy Effective date	Document Release /Revision Date	Revision Description	Section No.	Rationale for change	Change type	Policy revision/ Document revision
24.0	01 April 2021	13 May 2021	Upgradation of HIS plans by two levels from default	Provisions	Employees are now permitted to move 2 levels up their default plan	Add	Policy Revision
24.0	01 April 2021	13 May 2021	Maternity limits towards Normal and C-section Deliveries revised up to INR 75,000 & INR 1,00,000 respectively	Defined Benefits - Maternity Benefits	Maternity benefits revised basis review of HIS	Modify	Policy Revision
24.0	01 April 2021	13 May 2021	Room eligibility for parents/parents-in-law revised to Single Private AC room under Platinum plan	Appendix C	Basis review of HIS	Modify	Policy Revision
24.0	01 April 2021	13 May 2021	Segregation and categorization of various sections and clauses under appropriate heads	Appendix C	Structural Revisions in the document to classify various sections and clauses in the policy appropriatel y	Modify	Document Revision
23.0	01 April 2020	23 April 2020	Re-enrollment of deleted parents / in-laws with a lock-in period of 3 years	Enrollments under HIS and	Policy Review	Modify	Policy Revision
23.0	01 April 2020	23 April 2020	Once enrollment of parents/ in laws has been deleted , they will not be able to renroll them for next 3 years	Deletion from HIS	Policy Review	Added	Policy Revision

Revision No.	Policy Effective date	Document Release /Revision Date	Revision Description	Section No.	Rationale for change	Change type	Policy revision/ Document revision
22.0	01 October	21 October 2019	Inclusion of Same sex partners as beneficiaries	Appendix A	Policy Review	Modify	Policy Revision
22.0	01 October 2019	21 October 2019	Added Sex Reassignment Surgery and Mental Illness to the defined list of benefits	Defined Benefits	Policy Review	Add	Policy Revision
22.0	01 October 2019	21 October 2019	Maternity delivery charges to be payable up to 3 children	Defined Benefits	Policy Review	Add	Policy Revision
22.0	01 October 2019	21 October 2019	Other cancer therapies covered subject to a maximum limit of the Base Sum insured per year per family. (Limit of Rs. 60000 per year in case of other benefeiciaries/family has been removed)	Defined Benefits	Review of the policy and scheme	Modify	Policy Revision
22.0	01 October 2019	21 October 2019	Addition of the GIPSA Clause - GIPSA is an association of Insurance companies that has negotiated rates and packages at GIPSA specific hospitals. Treatments availed at GIPSA governed hospitals will be covered upto the GIPSA rates or rates defined in this policy, whichever is lesser.	Claims Procedure	For additional clarity	Add	Document Revision

Revision No.	Policy Effective date	Document Release /Revision Date	Revision Description	Section No.	Rationale for change	Change type	Policy revision/ Document revision
22.0	01 October 2019	21 October 2019	Additional Calrity on Room Tariffs – Hospital charges differ depending on the room category	Appendix C – Room Category	For additional clarity	Add	Document Revision
21.0	01 April 2018	13 April 2018	Non network hospitals - Advance intimation of atleast 72 hours is required. If not provided, 10% deduction on admissible amount will apply Network Hospitals - Cashless facility must be availed for which prior intimation is required. 10% deduction will apply in case of reimbursement from network hospital. No deductions will apply in case of emergencies / accidents.	Claim Procedure	Review of the policy and scheme	Modify	Policy Revision
21.0	01 April 2018	13 April 2018	Single room facility for parents will be provided to employees holding the Platinum Plus Plan. For all other plans, twin-sharing room for parents will be retained.	Appendix C → Commonly used Terminologies → Room Category	Review of the policy and scheme	Add	Policy Revision

Revision No.	Policy Effective date	Document Release /Revision Date	Revision Description	Section No.	Rationale for change	Change type	Policy revision/ Document revision
21.0	01 April 2018	13 April 2018	Employees can view coverage and premium details of their default health plan and the next higher plan they can opt for via GESS.	Provisions → Benefits, Entitlements & Coverage	Policy review	Delete	Document Revision
20.0	01 April 2018	04 April 2018	Enrollment section detailed to specify that at the start of enrollment period, employee will be re-tagged to the default plan and will have the flexibility to choose the immediate next higher plan, if needed.	Enrollments under HIS	For additional clarity	Add	Policy Revision
20.0	01 April 2018	04 April 2018	Specified that an advance intimation of Hospitalization is mandatory (except in case of emergencies). Employees must opt for hospitals which are part of the network list and avail the cashless facility. A percentage deduction on the bill amount will apply in case of requests for reimbursements and/or for hospitals which are not a part of the network list.	Claim Procedure	Review of the policy and scheme	Add	Policy Revision
20.0	01 April 2018	04 April 2018	Parents/Parents-in-law will be eligible for double occupancy (twin sharing) AC room across all health plans	Appendix C → Commonly used Terminologies → Room Category	Review of the policy and scheme	Add	Policy Revision

Revision No.	Policy Effective date	Document Release /Revision Date	Revision Description	Section No.	Rationale for change	Change type	Policy revision/ Document revision
20.0	01 April 2018	04 April 2018	No Liability on the Insurance company for settlement of claims for any treatment taken from the Black-listed Hospitals/Clinic/Medical Professionals.	Terms and Conditions	Explicitly mentioned in the policy to provide clarity.	Modify	Document Revision
19.0	01 Apr 2017	20 Oct 2017	Benefit in case of Accidental Injury leading to Permanent Total Disability revised from minimum of 10 lakhs to 11 lakhs	Provisions -> Benefits/Entitlements & Coverage	In line with Legal statute	Modify	Policy Revision
19.0	01 Apr 2017	20 Oct 2017	Updated the Ambulance Expenses section to bifurcate Air and Road Ambulance and the respective coverage	Provisions -> Benefits/Entitlements & Coverage	For additional clarity	Add	Policy Revision
19.0	01 Apr 2017	20 Oct 2017	For any new addition of parents/parents-in-law as beneficiaries, specified that any diseases/conditions (other than those defined under Tertiary/Critical Illness) will not be covered in the first year of enrollment. Clarified that this will not be applicable to beneficiaries added within 90 days from date of joining or marriage.	All Sections where applicable	Review of the policy and scheme	Add	Policy Revision

Revision No.	Policy Effective date	Document Release /Revision Date	Revision Description	Section No.	Rationale for change	Change type	Policy revision/ Document revision
19.0	01 Apr 2017	20 Oct 2017	Specified that IUI or any medical treatment for infertility is admissible only under domiciliary limit. Sterility or family planning treatments are not admissible.	Defined Benefits -> Maternity Benefits	Documentation of existing practice	Add	Document Revision
19.0	01 Apr 2017	20 Oct 2017	Cancer care section updated to include Radiotherapy. Limit for other therapies revised from 1 lakh per year to the Base sum insured per year in case of the employee.	Defined Benefits -> Cancer Care	Review of the policy and scheme	Add	Policy Revision
19.0	01 Apr 2017	20 Oct 2017	Clarified that expenses for treatment of Sleep Apnea would be payable only if the employee is using a CPAP or BiPAP machine.	Defined Benefits -> Treatment of Obstructive Sleep Apnea	Review of the policy and scheme	Add	Policy Revision
19.0	01 Apr 2017	20 Oct 2017	Benefit in case of Stem Cell therapy revised from 1 lakh per year to 50% of the Base sum insured per year for the employee.	Defined Benefits -> Stem Cell Therapy	Review of the policy and scheme	Modify	Policy Revision
19.0	01 Apr 2017	20 Oct 2017	Defined a maximum limit of 25% of the Base sum insured for treatment under alternative system of medicines.	Defined Benefits -> Alternative system of Medicines	Review of the policy and scheme	Add	Policy Revision

Revision No.	Policy Effective date	Document Release /Revision Date	Revision Description	Section No.	Rationale for change	Change type	Policy revision/ Document revision
19.0	01 Apr 2017	20 Oct 2017	Inclusion of Floater cover for ESIC associates. Clarified that ESIC associates may avail benefits under ESIC or HIS.	Provisions -> Benefits/Entitlements & Coverage	Documentation of existing practise	Modify	Document Revision
18.0	01 Apr 2017	06 Apr 2017	Revised insurance cover & benefits. Option to choose a higher plan.	Provisions	Review of the policy and scheme	Modify	Policy Revision
18.0	01 Apr 2017	06 Apr 2017	Specified that pre-intimation is required in case of a planned hospitalization.	Procedure	Review of the policy and scheme	Add	Policy Revision
18.0	01 Apr 2017	06 Apr 2017	Basic Hospitalisation renamed to Base Cover and Higher Hospitalisation cover renamed to Floater Cover.	Provisions	Policyreview	Modify	Policy Revision
18.0	01 Apr 2017	06 Apr 2017	Medical Advice section updated on room category details.	Appendix C	Review of the policy and scheme	Add	Policy Revision
18.0	01 Apr 2017	06 Apr 2017	Parents/parents-in-law can be enrolled in subsequent enrollment period. However for such new additions no pre-existing ailments covered in first year of enrollment.	Provisions – Enrollments under HIS	Review of the policy and scheme	Modify	Policy Revision

Revision No.	Policy Effective date	Document Release /Revision Date	Revision Description	Section No.	Rationale for change	Change type	Policy revision/ Document revision
18.0	01 Apr 2017	06 Apr 2017	Peritoneal dialysis added to the list of not covered ailments under the domiciliary Hospitalisation benefits.	Procedure	Review of the policy and scheme	Add	Policy Revision
17.0	01 Apr 2016	12 Aug 2016	Pro - rated basic premium amounts table for Parents and Parents- in-law based on the quarter in which the employee joins or gets married.	Appendix A	Policy review	Modify	Policy Revision
17.0	01 Jun 2016	12 Aug 2016	Renamed LWP financial assistance to Critical Illness – LWP Benefit Cover.	Provisions	Policy review	Modify	Policy Revision
17.0	01 Jun 2016	12 Aug 2016	The weekly amount payable through Critical Illness – LWP Benefit Cover revised.	Provisions	Policy review	Modify	Policy Revision
17.0	01 Apr 2016	12 Aug 2016	Cancer Benefit introduced.	Provisions	Policy review	Modify	Policy Revision
16.0	01 Apr 2016	01 Apr 2016	C5 & equivalent grades moved to higher category for benefits and coverage.	Throughout the document	Review of the policy and scheme	Modify	Policy Revision
16.0	01 Apr 2016	01 Apr 2016	Revised insurance cover & benefits.	Provisions	Review of the policy and scheme	Modify	Policy Revision

Revision No.	Policy Effective date	Document Release /Revision Date	Revision Description	Section No.	Rationale for change	Change type	Policy revision/ Document revision
16.0	01 Apr 2016	01 Apr 2016	Enrollment of Parents/parents-in-law to be allowed once in 3 years.	Provisions – Enrollments under HIS	Review of the policy and scheme	Modify	Policy Revision
16.0	01 Apr 2016	01 Apr 2016	Children above 25 years not eligible for enrollment.	Provisions – Enrollment under HIS	Review of the policy and scheme	Add	Policy Revision
16.0	01 Apr 2016	01 Apr 2016	Air Ambulance Expenses benefit added.	Provisions - Benefits / Entitlement and Coverage	Review of the policy and scheme	Add	Policy Revision
16.0	01 Apr 2016	01 Apr 2016	Defined Benefits section updated with Cancer Care, Daycare Medical Expenses, Cochlear Implants, Treatment for Obstructive Sleep apnea, Treatment of obesity, Stem cell Therapy, DIVYAANG benefit. Additional updates also made to other existing sections.	Defined Benefits	Review of the policy and scheme	Add / Modify	Policy Revision
16.0	01 Apr 2016	01 Apr 2016	Updated Upper limits for Permanent Total / Partial Disability and Joint Replacement expenses.	Provisions & Defined Limits	Review of the policy and scheme	Modify	Policy Revision