Medical Checkup Policy

Objective
To ensure that all new employees fit the guidelines of health and fitness as required to perform their day to day activities in their appointed roles. This policy will provide guidelines about Pre-employment medical check up for new hires and regular medical checkup for existing employees.

Applicability
The policy shall be applicable to all potential/regular employees of HCL TECHNOLOGIES Limited, at the company's various locations and facilities, working in India, whose medical check up have been sought by the client as a part of their agreement.

Policy Details

- New hires or regular employees will undergo a medical checkup under a company nominated Physician/hospital only if the client has sought for the same.
- The Pre medical health check-up is designed to ensure that employee is fit to perform a particular job and to ensure a healthy and safe work environment for others. It prevents employee from any check-up which is prohibited by law. The fitness testing (and accompanying results) will not lead to any subjective, discriminatory or unethical actions.
- This may include the testing of usage of banned substances (drugs) for reasons of workplace safety, productivity, and employee health or the check up can also be client specific.
- The entire cost of the medical checkup and tests will be borne by the company or the client, as the case may be.

Medical Insurance Policy (Effective Oct 1, 2022)

Objective
To provide for, comprehensive health insurance coverage, arising owing to medical exigencies to employees & their immediate family dependents and suitably support with adequate financial assistance.

Applicability

- The policy is applicable to all employees on payrolls of HCL Technologies Ltd and its subsidiaries located in India
- Employees do not have an option to opt out of Medical Insurance Policy, enrolment of "Self" is mandatory
- Probationers on payrolls of the Company are also covered under the policy.

Please Note:

- **ESI Employees:** Employees covered under ESI, would by default not be covered under HCL's corporate Medical Insurance policy, however, onetime option to enroll under this policy will be available for employees when the enrolment window is open for dependent declaration or within 21 days of DOJ for a new joiner. Sum insurance coverage limit will be as per the employee band. In such a case, the additional cost of annual medical premium has to be borne by the employee as per terms and conditions elucidated in this policy.

Employees once opted for the benefit, will not be allowed to opt out until the policy lock-in till Sep'23.

- **Contract Employees:** Contract employees under direct payroll (i.e. CS, CR, CT, AT and TS) would by default not be covered under HCL's corporate Medical Insurance policy, however, one-time option to enroll under this policy will be available for employees when the enrolment window is open for

dependent declaration or within 21 days of DOJ for a new joiner. Sum insurance coverage limit will be as per the band that employee has retired/last applicable. The additional cost of annual medical premium has to be borne by the employee as per terms and conditions.

Employees once opted for the benefit, will not be allowed to opt out until the policy lock-in till Sep'23.

- **EMCP Employees:** GHMI medical coverage is extended to dependents of employees transferred to Onsite, kindly refer to EMCP (Extended Medical Coverage Plan) policy in policy hub.
- **Retiring Employees and Employee equal to or more than 10 Years of experience:** Employees retiring or exiting HCL with 10 or more years of experience during the policy cycle will have an option to continue their coverage in the policy by paying the premium on pro-rata basis for the remaining period of the policy. In the year of retirement, they will have to continue with the dependents already declared in the policy and pay premium as per last drawn 'Insurance and Medical Benefits' component. They will have to inform about their coverage in the policy 30 days before retirement/LWD. Next year onwards as well, they will have an option to opt for this benefit, however same set of dependents will continue until Sept'23 with no changes, except in case of life changing events. The premium payable will be applicable as per the policy terms & conditions and sum Insured limit will be as per the last employee band before retiring or exiting HCL.
- **Medical Allowance**: Domiciliary claim(s) is not a part of this Medical Insurance policy.
- **Medical Insurance Portability:** Upon leaving the organization, if employee wishes to he / she can port the base policy as per the Happy Family Floater policy terms of Oriental Insurance

Example: If an employee's base Sum Insured is INR 7 Lacs. If he/she quits, then he / she can port base sum insured of INR 7 Lacs. All the conditions applicable will be as per Happy Family Floater policy of Oriental Insurance. Change in SI limit and selection of dependents would not be allowed at the time of porting the policy.

Employee need to reach out at dryagdeep.chugh@indiainsure.com /ashish.s@indiainsure.com 15 days prior to their LWD for portability.

Enrolment Guidelines

- With 3 years lock-in period till 30th Sept'23 as communicated during the enrolment process in 2020–21 and onwards, all dependents declared at the time of enrolment in 2020–21 and 2021-22 policy cycles are locked till 30th Sept'23 barring natural additions/deletions due to life-changing events like marriage/divorce, child birth/demise, Parents' retirement etc.
- With 3 years lock-in period till 30th Sept'23, all employees who have either Opted for Top-up and/or OPD coverage during open enrollment window in policy cycles 2020-21 and/or 2021-22 are also locked for next policy cycle till 30th Sept'23. However, incase employee has not enrolled, there is no option to opt-in for these plans till the end of the lock-in period and the next opportunity to enroll would be provided in 2023-24 policy cycle.
- New Joiners can declare their dependents and/or opt for Top-up & OPD policy within 21 days of joining HCL in Benefit Portal. The premium payable for medical policy & Top-up policy will be pro-rated from date of joining till policy end date i.e. 30 Sept'23. The OPD policy premium will not be prorated, policy will be applicable from date of joining till policy end date i.e. 30 Sept'23. Since the policy premium is not prorated hence the sum-insured limit is also not pro-rated.
- Employees getting transferred at onsite can opt for EMCP in Benefit Portal for dependents residing in India that they have already declared by selecting "Yes" in their TMS in EMCP section. The premium payable for EMCP will be pro-rated from date of transfer till policy end date i.e. 30 Sept'23.

Dependents Definition

- A maximum of seven dependents can be declared

- Spouse, dependent son/adopted son (who is dependent and below 25 Years), dependent daughter/adopted daughter (who is dependent and below 25 years), parents/parents-in-law, dependent brothers & sisters (below 21 years)
- Divorced/separated/widow sisters/daughters if unemployed will be considered as dependents. Specially, abled siblings if unemployed will also be considered as dependents.
- Definition of spouse under dependents has been updated to enable same sex spouse declaration
- Combination of parents and parents-in-law will be allowed only if natural set is broken due to demise during policy period and request for the addition of other member has been raised within 60 days from the incidence rate
- An employee opting for surrogacy and after completion of necessary legal formalities will be entitled to include the Child as a dependent
- An employee who legally adopts a child following due procedures will also be entitled to include the child as dependent
- Dependent addition during existing policy period will only be allowed on account of natural additions i.e. addition due to change in marital status, due to child birth, retirement of parents.
- Dependent deletion during existing policy period will only be allowed on account of natural deletions such as demise or divorce.
- Employees have to necessarily follow the process of adding/deleting dependents under natural additions/deletions within the stipulated period and after submission of necessary documents. The timelines for natural additions/deletions are as follows:

Categories	**Addition/Deletion**	**Timelines**
Addition of new born baby	Addition	Allowed within 60 days from date of birth
Adoption	Addition	Allowed within 60 days from date of adoption
Demise of dependent	Deletion	Allowed within 60 days from date of death
Marriage	Addition	Allowed within 45 days from date of marriage
Divorce from spouse	Deletion	Allowed within 30 days from date of divorce
Retirement of parents	Addition	Allowed within 30 days from date of retirement
Addition of In-laws post marriage	Addition	Allowed within 45 days from date of marriage

Important - If employees miss out declaring natural additions/deletions within the stipulated time frame, he / she will not be able to add/delete such dependents until the next enrolment window is opened in policy period 2023-24.

Deletion of dependents within policy cycle is only allowed for natural deletions (demise or divorce). However, if a claim for the dependent has been taken within the same policy cycle, deletion will not be allowed till policy end date i.e. 30 Sept'23.

Siblings/Children

- Siblings/children can be covered under the policy subject to their age below 21 years for siblings and 25 years for children respectively.
- If employees miss out deleting siblings who have crossed the age of 21 years, medical claims for said siblings will not be honored by the insurer.
- Divorced/separated/widow sisters/daughters if unemployed will be considered as dependents. Specially, abled siblings if unemployed will also be considered as dependents.

New Joiners

- Newly joined employees will have 21 days from their DOJ to declare dependents on Benefits Portal.
- The Insurance Company will not entertain any addition / deletion after the last date of open enrolment window on the Benefits portal. If dependents are not declared on or before the last date of enrolment, they will not be covered in the current medical policy (1 Oct'22 – 30 Sept'23).

Premium contribution for Insurance coverages: The coverage for dependents has been segregated into four plans, with the option given to the employees to select his / her medical plan coverage. The premium contribution towards various Insurances facilitated by HCL as given below:

Plan	Category	2022-23*	Insurances Covered
A	Self	70%	Medical, Life & Disability
B	Spouse	15%	Medical
C	Per Child	7.5%	
D	Per Parent / in-laws	45%	
E	Per Sibling	20%	

The above mentioned %ages are applicable on the amount mentioned under 'Insurance & Medical Benefits' component of your compensation structure.

All employees are by default covered under Plan A. Employees have the choice to opt for coverage under the other plans; the additional premium for such plans will be applicable accordingly based on a one-time declaration by the employee.

The amount mentioned in your salary structure under 'Insurance and Medical Benefits' is equal to 100% of premium contribution percentage.

- If an employee chooses to go only for plan "A" then the differential of the contribution (i.e. 100% - 70% = 30% of 'Insurance and Medical Benefits') will be paid as taxable salary as equated payroll addition every month.
- Similarly, if an employee chooses to opt for other plans, then the medical premium contribution will increase. Such additional premium contribution will be deducted from the employee's salary. E.g. an employee chooses Plan A, B, C & D whereby the total contribution comes up to 70% + 15% + 7.5% (assuming 1 child) + 90% (assuming one set of parents, 45% for each parent) + 20% (assuming one sibling) = 202.5% Since the medical premium amount mentioned in the compensation structure is only 100% of 'Insurance and Medical Benefits' component, 202.5% - 100% = 102.50% of 'Insurance and Medical Benefits'; will be recovered from such employees through equated payroll deductions every month.

Policy Details

Medical Insurance Coverage

Benefits under scope of Medical Insurance Policy are:

- Medical insurance Base Plan:
- Hospitalization (minimum 24 hours)
- Non-Hospitalization / Day Care (less than 24 hours)
- Maternity
- Domiciliary/ OPD plan
- Top-Up Plan

We have empaneled The Oriental Insurance Company Ltd. as our Insurer and Vidal Health TPA Pvt Ltd. as our Third Party Administrator (TPA).

Medical Insurance Base Plan

Band	Benefit Limit (INR)	Premium (INR)
E0 & E1	3,60,000	10,000
E2 & E3	5,00,000	20,000
E4 & above	7,00,000	35,000

Benefits under the Policy

- Pre-Existing diseases are covered from day one.
- Pre and post hospitalization expenses payable for 30 days prior the date of admission and 60 days from the date of discharge.
- Post-hospitalization physiotherapy treatment will be covered up-to 90 days.
- Coverage for hospitalization due to terrorism.
- Inclusion of psychiatric coverage only for employees.
- Cervical cancer vaccination is applicable only for female employees.
- Employees (dependents are not entitled) will be entitled for proactive vaccination as a preventive measure against Cervical Cancer
- % of the cost of vaccine ONLY will be paid by Insurer and remaining amount by the employees per sitting. Maximum 3 sittings will be covered under this benefit.
- Artificial life/limb support:
- Expensive items like a pacemaker, artificial limbs replacement arising out of accident ONLY during the policy period etc., are covered in the policy; expenses of such items would be reimbursed by the Insurer at actuals subject to the available limit under Hospitalization and other policy terms and conditions.
- Congenital Diseases: Hospitalization expenses for congenital internal diseases are covered and congenital external diseases are covered only if it is for non-cosmetic medical reasons.
- Hospitalization Claim for Homeopathic & Ayurveda Treatments
- Homeopathy and Ayurveda treatments are covered under hospitalization. However, Unani, Electropathy, Siddha and such other therapies are not covered. Treatment in Government Hospitals, Medical College /NABH accredited hospitals / hospitals approved / authorized by Quality Council of India (QCI) hospitals only are covered under this benefit.
- Facial Corrections
- On recommendation of a Registered Practitioner, the expenses towards facial corrections, except for cosmetic/aesthetic purposes, are considered under the policy subject to available limit under Hospitalization.
- Maternity Benefit

- Benefits for maternity are applicable for self or spouse
- The maximum amount of claim under maternity for delivery is INR 50,000; in case of twins/triplets the maximum amount of claim under maternity for delivery is INR 70,000.
- Claim in respect of delivery for only first two (2) children and/or operations associated therewith will be considered in respect of any INSURED PERSON covered under the policy.
- The new born baby will be covered within the overall sum insured
- The newborn/adopted should be added as dependent within two months (60 days) from the date of birth of the child/date of adoption, to the list of dependents.
- However, in case a child faces any complications, then the baby's expenses will be part of the family hospitalization expenses and will not be considered a part of the maternity sublimit.
- In case of Maternity related complications employee will be able to avail the claim under the family sum insured limit.
- Maternity cannot be claimed under two policies.
- Maternity benefit entitlements are capped.
- Termination of Pregnancy: This is covered under the Hospitalization limits, but only if done on the advice of a qualified doctor and on account of medical reasons. Expenses arising out of voluntary termination of pregnancy are not covered. However, medical expenses arising out of spontaneous termination of pregnancy (commonly termed as miscarriage) are covered.
- Hospitalization Covered & Day Care Treatment
- Hospitalization coverage is applicable for admission for more than 24 hours
- However, the time limit does not apply for day care treatments. The list of such day care treatments are given in Annexure 1
- Loss of Pay is covered for employees only. Employee is eligible for the limit of INR 25000/- per week or weekly gross salary, whichever is lower for 52 weeks. This benefit will trigger after employee has exhausted all the leaves and goes on Leave without Pay (LWP).
- Trigger: Non-attendance of work due to critical illness (Annexure 2)
- This benefit can be availed only on completion of necessary documentation from HR Partner who need to certify the Absence and Exhaustion of leaves
- Stem Cell / related surgery payable up to 100% within sum insured for all types of treatments as approved by FDA / ICMR
- Bone marrow transplant is payable up to 100% within sum insured
- Robotic Surgery / Gamma Ray Surgery (within employee's family Sum Insured limit) payable only for cancer treatment
- Mobility & Disability extensions for Persons-with-disabilities – This is covered for employees only. Reimbursements on helping aids covered upto INR 25,000 per employee.
- Cyber-knife surgery payable up to 100% (within employee's family Sum Insured limit) of entitled amount for all types of treatments
- Hepatitis virus (injection charges) paid 50% of the injection charges are payable within sum insured
- Expenses incurred due to Antidotes taken due to animal/dog bites covered.
- Donor expenses in case of transplants up to INR 1 lac for employees and dependents within the family sum insured limit
- Cochlear Implant Cost of surgery up to 100% (within employee's family Sum Insured limit) shall be covered.
- Ambulance charges in case of emergency hospitalization (per event) INR 2,000 is covered for shifting patient from place of incidence to hospital, hospital to residence and shifting patients within

hospitals as advised by treating hospitals. Air ambulance charges will be covered up-to INR 3 lakhs over and above the SI limit

Other Benefits: Non – Hospitalization

Oral Chemotherapy	Will be payable if approved by FDA and ICMR
Dental Treatment	Dental coverage for employee, Spouse and children as follows Employee < 40 years – Limited to INR 5,000 Employee > 40 years – Limited to INR 10,000
Life-saving Injections	Life-savings Injections (as approved by FDA and ICMR) administered under OPD basis will be payable under the policy terms and conditions, subject to overall terms and conditions of the policy being met
Preventive Health Check-Up	Employees above the age of 40 are eligible to claim expenses of self-Master / Executive / Comprehensive Health check up to a maximum limit of INR 3500.
	Employees below the age of 40 are eligible to claim expenses of self-Master/Executive/Comprehensive Health check up to a maximum limit of INR 2000.
	Employee is eligible for health checkup after 1 month of joining HCL and the entitled amount can be claimed for one-time in every policy cycle.
Mobility / Disability Extension	INR 5000 (crutches, wheelchair etc.)

Capped Ailment

Ailment (No Co-Pay is applicable)	Capped Amount (INR)
Cataract	30,000 per Eye
Hysterectomy	75000
Haemorrhoidectomy / Piles	50000
Cholecystectomy (Gall bladder stone removal)	75000
Fistulas / Fistulectomy	45000
Lasik surgery for eye (employees only)	30000 per eye (only if the refractive error is +/- 7)
Infertility (employees only)	40000
Bariatric surgery (employees only)	200000
Knee Joint Replacement	200,000 per Knee
Hernia / Hernioplasty	80000

Hip Replacement	325,000 per Hip
Coronary Angiogram	22000

- Amount claimed is subject to Sum Insured available/remaining SI or capped ailment amount whichever is lower
- Any complications arising out of 'Ailments Capped' will be restricted within the above-mentioned limits only and above limit is including pre and post hospitalization expenses. Also note that the limits mentioned above are NOT over and above the Sum Insured limit.
- The coverage for Lasik surgery is applicable only if the refractive error is +/- 7.
- Capped Ailments cannot be claimed under two policies.

Room Rent:

- Room rent per day, nursing and boarding expenses eligibility is 1% of Base Sum Insured (excluding top-up) in case of hospitalizations other than for ICU
- ICU is on actuals.
- In case the employee or his/her dependents get admitted in higher category, the difference in room rent & related charges calculated pro rata will be borne by the employee.

Co-Pay

Category	Co-pay w/o Top-up	Reduced Co-pay with Top-up	Reduction in slab
Self, Spouse, Children & Siblings	10%	5%	50%
Parent/In-Laws	20%	15%	25%

Important *- In case of planned hospitalization, an employee needs to intimate the TPA at least 72 hours in advance (by emailing on hclintimation@vidalhealth.com). In case of failure in adhering to the timelines mentioned above, Co-Pay of 5% will be imposed over and above the normal Co-Pay limits.*

Co-Pay Calculation

Co-Pay is applicable on all payable claims unless it is a capped ailment. First the admissible claim amount is calculated based on the non-payable expenses (like non-medical charges, telephone charges, food expenses, etc. are also deducted at this point in time). List of non-admissible charges are available in Annexure 3.

Kindly refer to the illustrative example given below (Amount in INR). E.g. for an E2 band employee, when hospital intimation was done 72 hours in advance. *Please note that this is an illustrative example only. Actual facts and circumstances will differ from case to case.*

Charge Type	Hospital Bill Amount	Payable / Entitlement	Non Payable	Remarks
Room Rent	4,800	4,000	800	Difference in room charges
Medical Accessories / Admission Charges	12,038	11,667	371*	Oxygen accessories, Filter, Cover kit, Gauze, Gloves, Admission charges etc., are non-payable

OT Charges	15,400	12,834	2,566	Pro-rata deduction; Basic room rent charges, following will be calculation on non-payable charges – e.g. for OT charges 4000/4800*15400 = 12834 & likewise for the other line items
Consultation	820	683	137	
Surgeon Charges	63,000	52,500	10,500	
Total	**97,058**	**82,684**	**14,374**	

Amount non-payable by Insurer: INR 14,374

- Assuming hospitalization is for Spouse / Children / Siblings
- Co-pay amount: INR 8,268.40 (10 % of INR 82,684)
- Amount payable by Insurer: INR 74,415.60 (INR 82,684 – INR 8,268.40)
- Amount payable by Insured: INR 22,642.40 (INR 14,374 + INR 8,268.40)
- Assuming hospitalization is for parents / parents-in-law
- Co-pay amount: INR 16,536.80 (20 % of INR 82,684)
- Amount payable by Insurer: INR 66,147.20 (INR 82,684 – INR 16,536.80)
- Amount payable by Insured: INR 30,910.80 (INR 14,374 + INR 16,536.80)

Amount is illustrative; any of the admission charges/mentioned accessories charges will not be in scope of hospitalization coverage.

Top-Up Plan

In case you feel that there is a need to additionally secure dependents from medical insurance perspective, we have negotiated with Insurance Company for providing the employees on the option to increase the sum insured on special rates.

Advantages of opting for Top Up policy:

- Reduced Co-pay % by enrolling under Top-up voluntary plan

Category	**Co-pay w/o Top-up**	**Reduced Co-pay with Top-up**	**Reduction in slab**
Self, Spouse, Children & Siblings	10%	5%	50%
Parent/In-Laws	20%	15%	25%

- Enhancement of insurance coverage to meet unforeseen medical exigencies.
- Varied Sum Insured Limits at subsidized premium rates are offered.
- Top Up is portable plan (policy issued on employee's name) in case employee exits the organization before policy end date, policy continues till 30th Sept.
- It covers all pre-existing ailments from day one.
- Top Up Sum Insured opted by employee will be applicable for all dependents declared.

- Insurer will provide tax exemption certificate on receipt of payment for Top-up premium to the enrolled employees to claim tax benefit under Section 80D.
- Top Up premium is pro-rated. However, no refund of premium, either in part or full will be made are during mid-policy cycle.

Important- *If you have enrolled for Top-up plan from policy cycle 2020-21 onwards, you will be locked in the policy till 30th-Sept-2023 and auto-enrolled for policy cycles 2021-22 & 2022-23. In case not enrolled in policy cycle 2020-21 or 2021-22, then option to enroll would only open in policy cycle 2023-24.*

Premium Details for 2022-2023:

Base Policy Sum Insured Limits	**Sum Insured & Premium (in INR) without GST**					
3,60,000	**3 Lacs**	**4 Lacs**	**8 Lacs**	**12 Lacs**	**16 Lacs**	**20 Lacs**
	3,947	4,305	9,021	13,393	16,836	18,006
5,00,000	**3 Lacs**	**5 Lacs**	**10 Lacs**	**15 Lacs**	**20 Lacs**	**25 Lacs**
	3,655	5,116	10,630	13,487	16,185	17,803
7,00,000	**3 Lacs**	**7 Lacs**	**14 Lacs**	**21 Lacs**	**28 Lacs**	**35 Lacs**
	2,924	5,847	10,099	12,544	15,055	16,560
10,00,000	**3 Lacs**	**10 Lacs**	**20 Lacs**	**30 Lacs**	**40 Lacs**	**50 Lacs**
	2,631	7,653	11,002	16,130	19,355	21,292

Note:

- *All figures mentioned above are annual figures and currency is INR.*
- *Additional GST will be applicable on premium payable mentioned above.*
- For new joiners, premium calculation will be on pro-rata basis

Top Up Exclusions:

- Top-up policy will come into force only when the employee exhausts his/her base sum insured.

For Example: If an employee's base Sum Insured is INR 7 Lacs and he/she has opted for a Top Up of INR 3 Lacs. Let us assume the employee has utilized INR 4 Lacs during his/her tenure with HCL Technologies Ltd. then his/her remaining Sum Insured is INR 3 Lacs when he/she quits. In case an employee incurs a hospitalization expense of INR 4 Lacs post his/her leaving HCL Technologies Ltd. then he/she is eligible for INR 1 Lac from Top Up Policy as Top Up Policy will come into force only when the employee exhausts his/her remaining Sum Insured (INR 3 Lacs in this case).

- **OPD/ Domiciliary Plan**

OPD plan helps Domiciliary benefit can be opted for any of the dependents combination as mentioned below:

- Parent Category
- Non-Parent Category

OPD can be opted only at the start of the policy cycle or when the declaration window gets open. This cannot be opted in mid of the policy in case of natural additions.
Advantages of opting for OPD policy:

- Coverage for cost incurred during treatment like doctor's fees, medical check-ups, dental, hearing-aid and spectacles.
- OPD is portable plan (policy issued on employee's name) in case employee exits the organization before policy end date, policy continues till 30th Sept.
- Insurer will provide tax exemption certificate on receipt of payment for OPD premium to the enrolled employees to claim tax benefit under Section 80D.
- OPD policy premium will not be prorated, policy will be applicable from date of joining till policy end date i.e. 30 Sept'23. Since the policy premium is not prorated hence the sum-insured limit is also not pro-rated.

Important- *If you have enrolled for OPD plan from policy cycle 2020-21 onwards, you will be locked in the policy till 30th-Sept-2023 and auto-enrolled for policy cycles 2021-22 & 2022-23. In case not enrolled in policy cycle 2020-21 or 2021-22, then option to enroll would only open in policy cycle 2023-24.*
The various options and the negotiated denominations in which this benefit can be availed for 2022-23 policy cycle are mentioned below

Benefit Category / Benefit Level		**Non-Parents**			**Parents**		
		Option 1	**Option 2**	**Option 3**	**Option 1**	**Option 2**	**Option 3**
Medicines / Doctor' Fee's		14,000	20,000	26,000	11,000	15,500	18,500
Investigations/Preventive Health Check up		4,000	4,000	4,000	4,000	4,000	4,000
Dental Procedure/Spectacles/ Hearing aid		8,000	11,000	14,000	11,000	15,500	21,500
Total Sum Insured Limit (INR)		**26,000**	**35,000**	**44,000**	**26,000**	**35,000**	**44,000**
Options	**Coverage**	**Premium**	**Premium**	**Premium**	**Premium**	**Premium**	**Premium**
A	One parent Premium	NA	NA	NA	8,127	10,667	13,517
B	2 parents Premium	NA	NA	NA	10,234	13,432	17,020
C	Only Employee	5,635	7,375	9,323	NA	NA	NA
D	Employee + 1 Life	6,574	8,604	10,878	NA	NA	NA

E	Employee + 2 Lives	7,231	9,464	11,966	NA	NA	NA
F	Employee + 3 Lives	7,983	10,447	13,209	NA	NA	NA
G	Employee + 4 Lives	8,541	11,179	14,133	NA	NA	NA
H	Employee + 5 Lives	9,100	11,910	15,058	NA	NA	NA
I	Employee + 6 Lives	9,659	12,641	15,982	NA	NA	NA
J	Employee + 7 Lives	10,234	13,432	17,020	NA	NA	NA

Please Note:

- *All figures mentioned above are annual figures and currency is INR.*
- *Additional GST will be applicable on premium payable mentioned above.*
- For new joiners, annual premium will be applicable irrespective of joining dates.
- Premium for OPD will not be pro-rated from their date of joining and employee can claim reimbursements max upto the sum insured of their opted plan(s).
- No premium refunds, either part or full will be made for members enrolled under OPD plans during mid-policy cycle; in case of mid-term deletion of enrolled dependent from base policy due to demise or divorce.

Policy Principle and Exclusions

Fraudulent Claims: If an employee is found guilty of making fraudulent claims under the Medical Insurance Policy and / or violates the Company's Code of Conduct, then apart from recollecting claimed amount back from employees for fraudulent claims appropriate disciplinary action including termination of employment shall be taken against such employee in accordance with the procedures set out in the Company's 'Code of Business Ethics and Conduct' "(COBEC)" policy available in Policies Hub portal.

Principle:

Medical Insurance would pay for expenses (excluding non-medical items which are not payable as mentioned in Annexure 3) which are "reasonable*" during hospitalization of any dependent i.e. within alternatives of treatment available, the GHMI program would reimburse / pay for THE MOST REASONABLE OPTION AND NOT OTHERWISE.

Should an employee / dependent choose any other option beyond the reasonable option, the difference in cost has to be borne by the employee

Example: The below mentioned table clearly indicates 5 treatments where there are multiple treatment options (from a cost standpoint) which are available. The list of treatments mentioned below is for example only and the list is not exhaustive.

Cataract	Unifocal	18000-29000
	Multifocal	35000-60000
Prostate	TURP	50000-80000

	Laser	90K- 1.5L
Robotic	Lap Cholecystectomy	50K-1.2K
	Robotic Cholecystectomy	>2.5L
Hormonal Therapies in Cancer	Depends on the type of drug and duration of therapy	

The Company shall not be liable to make any payment under this policy unless they are specifically covered under the policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

- Injury or disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, War like operations (whether war be declared or not) or by nuclear weapons / materials.
- Circumcision (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident), vaccination, inoculation or change of life or cosmetic or of aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.
- Lucentis / Avastin injections are not payable.
- Treatment which is continued before hospitalization and continued during and after discharge for an ailment / disease / injury different from the one for which hospitalization was necessary.
- Convalescence, general debility, "run down" condition or rest cure, congenital external diseases or defects or anomalies, sterility, venereal diseases, intentional self-injury/suicide, all psychiatric and chosomatic disorders and diseases / accident due to and or use, misuse or abuse of drugs / alcohol or use of intoxicating substances or such abuse or addiction etc. Psychiatric treatments are payable for employees only.
- All expenses arising out of any condition directly or indirectly caused by, or associated with Human T-cell Lymphotropic Virus Type III (HTLD - III) or Lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of similar kind commonly referred to as AIDS, HIV and its complications including sexually transmitted diseases.
- Charges incurred at Hospital or Nursing Home primarily for diagnosis x-ray or Laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of positive existence of presence of any ailment, sickness or injury, for which confinement is required at a Hospital / Nursing Home or at home under domiciliary hospitalization as defined.
- Expenses on vitamins and tonics etc. unless forming part of treatment for injury or disease as certified by the attending physician.
- Any Treatment arising from or traceable to pregnancy, childbirth, miscarriage, caesarean section, abortion or complications of any of these including changes in chronic condition as a result of pregnancy.
- Naturopathy treatment, unproven procedure or treatment, experimental or alternative medicine and related treatment including acupressure, acupuncture, magnetic and such other therapies etc.
- Expenses incurred for investigation or treatment irrelevant to the diseases diagnosed during hospitalization or primary reasons for admission. Private nursing charges, Referral fee to family doctors, out station consultant's / Surgeons fees etc.
- Doctor's home visit charges, Attendant / Nursing charges during pre and post hospitalization period
- External and or durable Medical / Non-medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Infusion pump etc., Ambulatory devices i.e. walker, Crutches, Belts, Collars, Caps, splints, slings, braces, Stockings etc. of any kind, Diabetic foot wear, Glucometer /

Thermometer and similar related items etc. and also any medical equipment which is subsequently used at home etc.

- All non-medical expenses including Personal comfort and convenience items or services such as telephone, television, Ayah / barber or beauty services, diet charges, baby food, cosmetics, napkins, toiletry items etc., guest services and similar incidental expenses or services etc.
- Change of treatment from one system of medicine to another system of medicine unless being agreed / allowed and recommended by the consultant under whom the treatment is taken.
- Any treatment required arising from Insured's participation in any hazardous activity including but not limited to scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing etc. unless specifically agreed by the Insurance Company.
- Any treatment received in convalescent home, convalescent hospital, health hydro, nature care clinic or similar establishments.
- Any stay in the hospital for any domestic reason or where no active regular treatment is given by the specialist.
- Outpatient Diagnostic, Medical and Surgical procedures or treatments, non-prescribed drugs and medical supplies, Hormone replacement therapy, Sex change or treatment which results from or is in any way related to sex change.
- Massages, Steam bathing, Shirodhara and alike treatment under Ayurvedic treatment.
- Any kind of Service charges, Surcharges, Admission fees / Registration charges etc. levied by the hospital.

Contact details

Cashless Request

- All employees should /must inform **TPA 72** hours before a planned hospitalization.
- The dedicated helpline numbers are **1860-425-0255/ 08049166705 / 08049166706** or **08046267022**
- Drop a mail to hclintimation@vidalhealth.com and provide relevant details (hospital name, SAP ID, patient name etc.).

*If an employee does not follow the process mentioned above in case of a treatment that could have been planned, an additional **Co Pay of 5%** will be imposed over and above the co-pay limits mentioned in the policy section.*

Apart from cashless requests, all claims must be submitted within 45 days from the date of expense incurred or date of discharge from the hospital (incase of hospitalisation).

Reimbursement Process

In the event of opting for a **"reimbursable"** mode for claims – following procedure would apply (documentation requirements).

- Submit all your medical hospitalization claims, through the **"Medical Claims"** portal available MyHCL
- MyHCL>>in Search bar type Medical claim. You can also visit Benefits portal>>Medical Insurance policy>>quick links>>Raise a claim.
- Visit www.myhcl.com> in search bar type <<Medical Claim>> or You can also visit Benefits portal>>Medical Insurance policy>>quick links>>Raise a claim.
- Portal will open>>on right hand side top you can select the options as New claim – Hospitalization, Pre & post, dental claim, OPD etc.
-
- **or https://bserv.myhcl.com >>My Page >> Medical Claims**
- Fill in the claim details in the application using **"New Claims"** option.
- Fill the details of your claim online and submit.
- Attach the documents (whatever is applicable) with the print out.
- Please drop the stapled claim documents in Medical Hospitalization Drop Box kept in your facility.

Please raise SSD for any assistance:
HCLT & Infra : Myhcl > Smart Service Desk > Service Request > HR (under Business Group) > HR Benefits & Policy Clarification – India Medical Benefit programs (under Business process)
BSERV: iAssist> Smart Service Desk > Application issue/Service request/Process & Data Issue > HR (under Business Group) > HR Benefits & Policy Clarification (under Business process) > Medical Insurance Policy (under Business sub-process)
Or you may contact on : 24 X 7 Helpdesk : 1860 425 0255 / 080-46267022
Remember to make the entry of your claim in the register kept near Medical Drop Box.
Enclosed in the Form Section on Policy Portal

- Annexure 1: Day Care Procedures
- Annexure 2: Critical Illness
- Annexure 3: List of Non Admissible Expenses
- Annexure 4: List of Network Hospitals
- Annexure 5: Delisted Hospitals
- Annexure 6: Standard Definitions
- Annexure 6: Claims Form for Seperated Employees

Exceptions
Disclaimer – The company reserves the right to alter, append or withdraw this policy either in part or in full based on management's discretion.

Process for Dependent declaration and TOP UP/ OPD Plan

- Please log into My HCL > Benefits Portal > Group Health Medical Insurance > Initiate Enrollment or Medical Dependent Declaration
- Please add your dependents in the columns provided along with Gender, Relation, DOB, and Marital Status. Self-Details are picked by default hence no need to add self as a dependent.
- Click on Submit button once dependents are added
- You will be able to see your declared dependents as part of reconfirmation. Click "Cancel" in case you want to make any changes/ corrections or "Final Submit" if details are correct
- Dependents will not be enrolled till the time you click on "Final Submit"
- Premium for Top-Up and/or OPD plans opted by the employee will be recovered as a one-time deduction for annual coverage from their upcoming month payroll.
- Employees who do not wish to take TOP UP/ OPD plan just needs to submit their dependents on Benefits Portal > Medical Dependent Declaration and log out.
- GHMI is optional for ESI employees. If they still want to take GHMI in addition to ESI, they need to click on checkbox enabled for them as part of their consent. Applicable premium for GHMI coverage will be recovered from them in addition to ESIC premium contribution.

Retiring employees

- **Retiring during policy period 2021-22:** Employee have to raise SSD to inform about their coverage in the policy before 2 weeks of retirement.

Claim Process - Health Check-up / Cervical Cancer Vaccination

- Submit all your General / Master / Executive / Comprehensive Health check-up claims, through the 'Medical Claims' portal available on www.myhcl.com > My Transactions > Medical Claims or iAssist (www.hclbpo.net -> My Page -> Medical Claim)
- Attach the bills and reports in original with print out of Claim form for expenses incurred and put it in the Mediclaim drop box in your facility by making a clear note on an envelope with the following details.

Mention on the top of the envelope - Proactive Health Check-up or Cervical Cancer Vaccination.
Employee SAP Code & Employee Name.
Claimed Amount

Natural addition/deletions of dependents within policy period

- Employees have to raise SSD (in the navigation path mentio

Claim Number

Claim Process – Day Care Procedures

- For claiming hospitalization expenses, a minimum period of 24 hours of hospitalization is required.
- However, the time limit does not apply for day care surgeries where the insured is discharged on the same day. The list of such day care surgeries are given in Annexure 1
- Day Care Surgeries are treatments; such that:
- It necessitates hospitalization and the procedure involves specialized infrastructural facilities available in hospitals.
- Due to technological advances, hospitalization is required for less than 24 hours only.
- Bills for hospitalization expenses submitted are to be accompanied by the following documents
- Original Discharge summary
- Presenting Illness
- Treatment given/course during hospitalization
- Date & Time of admission & discharg
- Diagnosis FIR/MLC/AR should be attached in case of accident
- Original Hospital Main Bill/IP bill/Final bill
- Original payment receipts made to the hospital
- Original Medicine Bills
- Original Reports/ Tests (except X-Ray / CT Scan / MRI films)
- Original Bills of reports/ Tests
- Break up details for hospitalization Final bill
- Signed Print out of the Claim Form
- Staple all the supports carefully to ensure there is no loss in transit
- While there is no defined category of approved hospitals & nursing homes for this purpose, it is recommended that employees use reputed hospitals or at least one with a minimum capacity of 15 beds as such hospitals then necessarily have to comply with certain minimum infrastructural and other necessary standards.
- Claims from Delisted hospitals will not be entertained (List of such hospitals is provided in Annexure 5)
- The hospitalization expenses pertaining to employees or dependents will be reckoned with, from the "date of admission" to the hospital and not the date of discharge from the hospital. Accordingly, the claims will be honored during the transition period from one policy to another E.g. If an employee or dependent (s) are admitted in the hospital on or before September 30, 2021 and get discharged by the first week of October, 2022 the claim is sustainable under the old policy cycle of 2021-22 and does not come within the purview of the current policy.
- Employee will be allowed to claim the refund under this category only once in a policy cycle. Hence bills and prescriptions of expenses incurred under the definition of this category needs to be preserved so that the same can be submitted while claiming. The current claim cycle is October 1, 2021 to September 30, 2022.

Procedure for Planned Cashless Hospitalization

Employees, must make sure to follow the Planned Hospitalization guidelines and of informing the TPA 72 hours prior to admission. If an employee does not follow the process mentioned above in case of a treatment that could have been planned, an additional co-pay of 5% will be imposed over and above the co-pay limits mentioned in the policy section.

- All employees need to intimate the TPA 72 hours in advance of a Planned Hospitalization. To inform the TPA 72 hours in advance regarding the Planned Hospitalization, please call on the dedicated toll free number for HCL – **1860-425-0255/ / 08049166705/08049166706** or **080-46267022** or drop a mail to hclintimation@vidalhealth.com and provide the hospitalization details in the format mentioned below :

Dear Team Vidal ,

This is to intimate you regarding the planned hospitalization "72 Hours" prior to admission as per below details :

- Employee Name
- Employee Code
- Patient Name
- Hospital Name and Address
- Treating Doctor's Name
- Diagnosis
- Treatment Planned
- Date of admission

Kindly make a note of the same and acknowledge.

- E-Cards for insured individuals will be made available within 7-10 working days post closure of open enrollment window period of 21 days for a new joiner in HCL.
- Cashless Facility is provided by the TPA for hospitalization treatments in the panel of hospitals listed with the insurer.
- It is prudent that every insured individual should carry their Medical E-Card VIDAL ID Card with them at all times. You can never predict an emergency!
- At the time of hospitalization at a network hospital, you will have to produce the E-Card as proof of being covered by a health insurance policy along with some form of government issued photo ID (AADHAR Card, Ration card, Driving license, Voted Id card, etc.) with you to establish your identity.
- The network hospitals have a preauthorization request form available with them (Refer to Annexure 4). The form has to be jointly filled in by you and your treating doctor. Please make sure all the details asked in the form are completely filled. This will ensure speedy processing of your request.
- This form is then faxed by hospital to Vidal Health's toll free fax number or any other method of established communication platform between the Hospital and VIDAL Health TPA
- On receipt of the form, Vidal Health processes the pre-authorization request. The medical team at Vidal Health will determine whether the condition requiring admission and the treatment plan are covered by your health insurance policy. They will also check with other terms and conditions of your insurance policy.
- In case coverage is available, Vidal Health will issue an approval to the hospital for a specified amount depending on the disease, treatment, how much you are insured for, etc. This is sent by fax and/or email (if available). The approval is called a "Preauthorization". This preauthorization entitles you to avail cashless facility at the hospital without paying for the medical expenses. Note: Further enhancement approvals may be issued on request, subject to terms and conditions of the policy.
- At the time of discharge, please make sure that you check and sign the original bills and discharge summary. Please carry home a copy of the signed bill, discharge summary and all your investigation

reports. This is for your reference and will also be useful during your future healthcare needs. All original papers from the hospital are sent to VIDAL Health TPA for the purpose of making payment. You need to ensure that you have a copy of all the reports, bills etc. as originals once submitted will not be made available to the employee / claimant (dependent of the employee);

- The hospital will ask you to pay for all the Non-Medical Expenses & co-payment in your bill. You have to make this payment before discharge.
- In case, for whatever reason, the preauthorization request cannot be approved, a letter denying preauthorization will be sent to the hospital. In this case, you will have to settle the hospital bill in full by yourself.
- In GIPSA cities, cashless facility will be available in ALL NETWORK HOSPITALS of the TPA and not restricted only to GIPSA hospitals.
- The Company /TPA reserves the right to deny pre-authorization in case the hospital / insured person is unable to provide the relevant information / medical details as required by the Company /TPA. In such circumstances denial of Cashless Access should in no way be construed as denial of claim. The insured person may obtain the treatment as per his/her treating doctor's advice and later on submit the full claim papers to the Company /TPA for reimbursement within 45 days of the discharge from Hospital / Nursing Home. On receipt of the claim form and all required documents, the claim will be evaluated and decision to honor the claim or not honor the claim will be taken basis the terms and conditions of our Insurance Policy
- Should any information be available to the Company /which makes the claim inadmissible or doubtful requiring investigations, the authorization of cashless facility may be withdrawn. However, this shall be done by the Company /TPA before the patient is discharged from the Hospital.

In case of Emergency situation, the E-Card can be shown at the network hospital to avail cashless admission facility. The preauthorization request can be sent to Vidal Health within four hours after admission. Whether the situation is an emergency or not will be certified by treating doctor and basis the treating doctor's comments, TPA will ascertain if 5% additional Co-Pay can be waived off or not.
In case of Emergency situation when E-Card is not generated, connect with TPA and provide your details for further assistance.

Claim Process – Hospitalization

In the event of opting for a "reimbursable" mode for claims – following procedure would apply
(Documentation requirements, however, will be common for availing Cashless Facility as well)

- Submit all your Medical Hospitalization claims, through the 'Medical Claims' portal available at www.myhcl. com > My transactions > Medical Claims or www.hclbpo.net –> My Page-> Medical Claims
- Fill in the claim details in the application using "New Claims" option
- Fill in the details of your claim online and submit.
- Attach the documents (whatever is applicable) with this print out:
- Drop it in the medical Hospitalization drop box
- Remember to make the entry of your claim in the register kept near the Medical Drop Box
- Please drop the stapled claim in Medical Hospitalization Drop Box kept in your facility
- Norms of Prescription: Prescriptions should preferably be on the Doctor's or Institution's letterhead, or else the registration number of the signing doctor should be legible. Signature of the Doctor, not below the rank of MBBS or equivalent is mandatory for processing of admission under the scheme. However, for hospitalization, prescription slips for the Institution those are generally given by the nursing staff or purchase of medicines will be adequate.

- Original Bills, reports to be submitted: In case of hospitalization all bills & reports submitted must be in original, as photocopies will not be accepted. It is mandatory to produce all bills, Diagnostic reports, Discharge summaries and Reports of investigations in original. Please note that there will be no exceptions to this.
- All the medical claims in case of Hospitalization should be submitted within 45 days from the date of discharge from the hospital. If the claim along with ALL necessary papers are not submitted within 45 days from the date of expenses incurred it will not be considered for pay-out by the Insurance Company.
- In GIPSA cities, reimbursement claims will be settled as per policy terms and conditions and NOT ON ANY GIPSA rate which could prevail
- Bills for recommended investigations: These, if submitted, must be accompanied by the doctor's prescription as well as the report of the investigation.
- Reasonableness of claims: The policy does not prescribe too many limits on amounts that can be claimed or on medical institutions / practitioners that an employee may approach. However, this is with the overriding provision that the entity concerned, the Insurer, and HCL have the right to question a claim, even if technically correct in all respects, if prima facie the amount claimed is evidently disproportionate to the services rendered by the medical institution or practitioner. Observations in this regard will be referred to medical consultant (appointed by the Company) whose decision will be final and binding on this account.
- The responsibility of implementing the above terms of policy rests with the Insurer and the HR Head.
- Denied/Repudiated claims: Bills pertaining to denied/ repudiated claims would be returned by TPA to the employee and should not be submitted for claims again. Such bills will be returned "defaced" stating "claim repudiated".

Claim Process – OPD/ Domiciliary benefit, DAY CARE Procedures under Top-up

- All claims are to be submitted within 45 days of bill date / discharge date.
- Claim to be raised by the employee in 'Medical Claim' portal available on HCL Intranet. In the remarks section of the claim, add the name and contact no. of the person with whom 'Claim Reimbursement SPOC' can co-ordinate with in case of shortfall / clarification against the documents submitted.
- Employee or dependents may courier the bills and reports in original to 'Claim Reimbursement SPOC' and specify below mentioned details on the envelope:
- Mention on the top of the envelope – GHMI Top-Up/ OPD Claim Reimbursement
- Employee SAP Code & Employee Name.
- HCL mail ID
- Total Claim Amount
- Claim Number
- Status of the claim will be updated through auto mailers to the employee and the nominated person by employee will be informed / updated through phone call by 'Claim Reimbursement SPOC'.
- Below are the various scenarios once claim is submitted online by the employee and courier is received by 'Claim Reimbursement SPOC'.

o Claim Received and in Process - In case no shortfall / clarification is required to process the claim.
o Referred Back - In case of any shortfall / clarification against the documents submitted.

- Reimbursement of all claims will be credited only in India Bank Account.

Claims Process for Separated Employees:

Note: If an employee exist from HCL, in that case:

- The EMCP premium will be refunded on pro-rata basis and coverage under EMCP base plan will cease after employee's last working day in HCL.
- The premium for voluntary Top-Up and OPD plans opted by employee shall not be refunded. However, the coverage of the employee would continue throughout policy cycle 2021-22.
- The coverage will remain active till last day of policy period i.e. 30th Sept'22 and employees can reach out to TPA to raise claims for policy cycle; in spite of their exit from HCL.
- There will be no refund on the voluntary Top-Up and OPD premium.

Claims Process for OPD - for Seperated employees

- To raise claims under OPD, kindly submit the original claim papers/ bills within 30 days of the bill date along with duly filled and signed copy of the IRDAI claim form, ECS form and cancelled cheque copy at below mentioned address.
- If you are filing multiple claims during the policy year, then also it is advisable to provide the copy of ECS form and cancelled cheque copy with each claim.

Noida Office Address
VIDAL HEALTH INSURANCE TPA PVT LTD,
Plot Number C-3, Quantum Building, Basement,
Noida Sector 3, Noida – 201301

Claims Process for Top Up - for Seperated employees

- Claim under Top-up policy will trigger only if your total payable claim amount either in a single event or sum of the multiple claims during same policy period is more than the base Sum Insured limit as per HCL band.
- Top up policy will pay the payable claim value over and above the base Sum Insured limit eligibility as per HCL band only. e.g., Employee eligible for INR 5 Lacs base Sum Insured limit as per HCL band can file a claim for the payable claim amount (Claim amount – Non payable expenses e.g., Co-pay, non-medical expenses etc.) over and above INR 5 Lacs only under HCL Top-up policy.
- In a claim of INR 8 lacs, if payable claim amount is INR 7 Lacs (INR 8 Lacs - Non payable expenses e.g., Co-pay, non-medical expenses etc.), then employee must settle first 5 lacs which is base Sum Insured limit as per HCL band and works as a threshold limit for the Top-up policy from any other personal/corporate policy or out of his/her own pocket and remaining 2 lacs i.e., 7-5 =2 will be picked by the HCL Top-up policy.
- For the calculation of threshold limit, if not breached in a single claim and previously during the same policy period, multiple hospitalizations have taken place for the same family members as covered under the HCL policy, then sum of the payable claim value of these previous hospitalizations will be considered to calculate the threshold limit.
- If there are multiple hospitalizations involved to touch the threshold limit, then kindly provide the bill details and settlement details of previous hospitalizations as well to the TPA along with the main claim papers to calculate the threshold limit.
- Claim settlement would be done as per HCL policy terms and conditions only.
- Employee is supposed to report this claim to Vidal Health TPA at below mentioned address along with the settlement sheet/payment details of primary claim and photocopy of all the claim papers duly attested by the TPA of primary claim.

- If primary claim is not claimed under any policy and employee has paid the same out of his/her pocket, then all the original papers need to be submitted for the payment of remaining amount from the Top-up policy.

Noida Office Address
VIDAL HEALTH INSURANCE TPA PVT LTD,
Plot Number C-3, Quantum Building, Basement,
Noida Sector 3, Noida – 201301

- Duly filled and signed copy of the IRDAI claim form, ECS form and cancelled cheque copy also would be required along with the other documents as mentioned above.