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TCS India Policy – Health Insurance

VERSION 23.0

Document Release Notice

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This document is subject to TCS Document Control Procedure.

Softcopy of the latest version of this document is available in MyHR in Knowmax.

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Contents

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).

- ACE Interns, Global Interns & BPOS

This policy is not applicable to:

- Business Associates, Academic Interns & Contract Consultants

Introduction - Health Insurance Scheme

For TCS, the health and wellbeing of all employees and their family is paramount. Hence, TCS provides them with easy access to best-in-class medical facilities through a comprehensive Health Insurance Scheme.

Family in this context implies spouse, children, parents and parents-in-law only. TCS has tied up with the Insurance Company to offer a comprehensive Health Insurance Scheme (HIS) to its employees. Insurance Company has in turn appointed a Third Party Administrator (TPA) to facilitate the claim processing, settlements and hospitalisation process for the employees and their beneficiaries.

TCS reviews the scheme and its provisions from time to time. Hence, the scheme is subject to a revision, which may result in a corresponding change in the entitlements, the extent of coverage, the premium amount payable, beneficiaries who can be covered, etc.

Note: *Period to be considered for payment of premium and coverage to employees and their beneficiaries is the financial year from April to March.*

Provisions

1. Benefits/ Entitlements and Coverage:

Employees and their enrolled beneficiaries are eligible for Domiciliary and Hospitalisation covers as per the default plan applicable. These benefits are extended on payment of applicable premium as per the scheme.

There are various Health plans namely Gold, Gold Plus, Platinum & Platinum Plus. At the beginning of the enrolment period employees will continue to be tagged to their existing plan and will have the option to upgrade to the immediate next higher health plan only if not upgraded previously.

Employees can view coverage,premium and plan details via the path below:

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

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 avail benefits under ESIC or TCS HIS. For more details, you may connect with your location HR.*

Domiciliary Cover: This is a provision to enable employees and their beneficiaries to cover the cost of any domiciliary treatment (including dental treatments).

a. **Base Cover:** This is a provision to cover the cost incurred on hospitalisation treatments up to a specified limit.

   The Domiciliary and Base cover limit is defined for each insured person per annum. Hence, unused sum of one beneficiary cannot be used towards treatment of other beneficiaries.

b. **Floater Cover:** This benefit covers the hospitalisation expenses incurred over and above the basic hospitalisation cover limit. All employees are covered under the Floater Cover and will continue to be covered throughout their tenure in TCS. This cover is also extended to all beneficiaries enrolled under HIS.

   The Floater Cover is a family floater i.e. the coverage is defined on a per family basis. Hence, 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.

c. **Personal Accident Insurance:** This is applicable only to active employees at no additional cost.

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

Event	Amount Limit (In Rs.)
Permanent Total Disability	Minimum of Rs. 11 lakhs or 6 times of employee's annual compensation whichever is higher subject to maximum of Rs. 20 Crore
Permanent Partial Disability	6 times employee's annual compensation subject to a maximum of Rs. 20 Crore (This is based on a percentage defined under ***Appendix B: Schedule of Indemnities and %*** of Sum Insured

d. **Critical Illness – LWP Benefit Cover:** This is applicable in case of below scenarios :

   - When employees who are on Leave Without Pay for Medical reasons and suffering from tertiary / critical illness as defined below ***(Refer List of Tertiary/ Critical illness)***, such benefit can be provided. This request is reviewed only post a hospitalisation claim has been made. The benefit can be availed only once during his/her tenure with the organization and can be provided for a maximum period of 52 weeks only.

- When employees suffer any bodily injury caused due to accidents / occupational hazards arising out of and in course of employment and are on Leave Without Pay, such benefit can be provided.

List of Tertiary/ Critical illness:

Cancer Nephritis of any etiology plus bacterial renal failure requiring kidney transplantation and dialysis, Cerebral or vascular strokes, Open and closed heart surgery, Malignant diseases confirmed by histopathological reports, Viral encephalitis, Brain surgery, Liver cirrhosis associated with hepatitis B\C, Compound\multiple fracture of femur, Intra cranial injury, Coma, Spinal injury resulting in Paraplegia, Cerebral haemorrhage, Third degree burns, Major organ transplant and Multiple Sclerosis.

Amount payable as Weekly Benefit is:

Computed based on 66% of employee's monthly compensation / number of weeks in a month
OR

Rs. 40,000/- per week payable on monthly basis, whichever is lower.

The amount is credited in the salary account of the employee by the end of every month. This amount will be calculated on a prorata basis.

e. **Hospitalisation Cash Benefit (applicable only for the employee and not for beneficiaries):** This is applicable only in case the employee is hospitalised for more than 5 consecutive days. Starting from the 6th day, he/she will be eligible for Hospital Cash @ Rs.1, 000/- per day until the time he/she gets discharged. Employee need not apply for this benefit but will be payable by default post the verification of necessary documents.This is applicable only if hospitalisation expenses are payable and length of stay is justified with necessary documentary evidences.

f. **Trauma Care Support (applicable only for the employee and not for beneficiaries):** In case the employee is hospitalised owing to a Personal Accident and post discharge from the hospital continues to be on leave for recuperation, the trauma care expenses would be payable from the day the employee exhausts all the available paid leaves and if he/she continues to be on LWP. Employee will be eligible for Trauma care expenses of Rs.5, 000 per week upto a max of Rs.60, 000 and is applicable only if Base and Floater covers are not fully exhausted.

Employee need not apply for these benefits but will be payable by default post the verification of the necessary documents.

Note: *Wherever, both Trauma Care and LWP Financial Assistance is applicable, only one benefit will be extended (whichever is more beneficial to the employee)*

g. **Ambulance expenses**:

- Air Ambulance: These expenses are payable upto a limit of Rs. 1,00,000 per event and Rs. 20,00,000 during the Financial Year. Air Ambulance is payable subject to the below conditions:

  - Medical condition of the patient is very critical and requires emergency Hospitalization for survival

- When the patient is based out of a remote location and / or Other modes of transport are inadvisable as per the treating doctor.

- Transportation by Air Ambulance is to the nearest Healthcare facility where patient can be treated

- Road Ambulance: These expenses are payable upto a limit of Rs. 2,000 per family during the Financial Year. Road Ambulance is payable to shift the insured person to the nearest Healthcare facility and/or from one Healthcare facility to another for better treatment/diagnosis.

h. Cancer Benefit:

- The employee and beneficiary will be eligible for a monetary benefit of Rs 25, 000/- over and above the sum insured.

- This request is reviewed post a hospitalisation claim.

- The benefit can be availed only once during the entire tenure with the organization.

2. Enrollments under HIS:

a. An employee is automatically covered under TCS India HIS and is tagged to the existing plan by default. Employee's will have the option to upgrade their existing health plan to the immediate next higher plan, only if not upgraded previously.

b. Under no circumstances will an employee be allowed to downgrade his/her plan throughout the tenure. Also, there shall be no change to the plan during the course of the year.

c. New Joinees will be covered by their default plan and will have the option to choose the immediate next higher plan, if needed, only during subsequent enrolment period.

d. There is also a provision to cover beneficiaries i.e. the employee's Spouse, Children and Parents/Parents in-law. However, all beneficiaries have to be explicitly enrolled within 90 days from date of joining/ date of marriage / birth date to cover them under the HIS Scheme.

e. The path to add/delete beneficiaries is as follows:

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

f. For employees who want to add their Spouse on marriage, they should first update their marital status and Contact details via ***Ultimatix → Employee Services → Employee Self Services → Global ESS → My Profile → About → Basic Details***. Without this update, the option to add the Spouse/Parents-in-Law will not be available under the 'HIS Beneficiary details' link. Details for spouse should be added/updated within 90 days from date of marriage / joining. However, if the employee does not enrol his spouse within 90 days from date of Marriage, he/she can add them during the subsequent window period in the next financial year.All employees have the option to cover parents OR parents-in-law OR a combination of each upto a maximum of two, i.e. they can cover 1 Parent and 1 Parent-in-law. If he/she chooses not to include parents / parents in law within the permitted enrollment period, he/she can add them only during the subsequent enrolment window. For any new addition of parents / parents–in-law as beneficiaries, pre-existing ailments or disease/ailments/conditions other than those defined under 'List of Tertiary/ Critical illness' will not be covered in the first year of enrolment. However this will not be applicable to beneficiaries added within 90 days from date of joining or

marriage. Re-enrollment of parents/in-laws who were deleted earlier, will be possible from FY21 with a lock-in period of 3 years. Once enrolled, the employee will not be able to delete them at least for the next 3 years, except in case of their unfortunate demise.

g. While deleting the beneficiaries, the employee will have to select the appropriate reason for deletion.

h. However, if the employees delete their parent / in-law details, they will not be able to re-enroll them for the next 3 years.

i. 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 should be done only in the beginning of the next financial year, as the coverage will be effective from next financial year..

j. Expiry of personal/official insurance coverage of parents/parents-in-law exiting their own business will not be considered as an acceptable situation warranting an addition of parents/parents-in-law in the scheme, as employees can cover their parents/parents-in-law even if they are working or if they have any personal/official mediclaim/insurance policy.

k. Children cannot be enrolled, if they are employed/married/more than 25 years of age. For existing enrollments, employees should delete such records, else these records will be purged at the start of the next financial year.

l. In case of addition of a new born child, employee will have the option to enrol the child within 90 days from date of birth. 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.

m. 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.

n. Retired employees may choose to continue the HIS cover post retirement, for self and spouse, on payment of applicable premium. The revised retirement benefits would be applicable from the next financial year. For the year of the retirement the current benefits will apply. Coverage can continue for the spouse, post death of the retired employee, upon payment of the applicable premium

o. Retired employees would be tagged to the same health plan that they were tagged to at the time of retirement.

p. Employees are required to declare and update details of relatives in GESS to avoid dual enrollments in the policy.

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

r. Addition of beneficiaries 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. There is a separate link viz.'India HIS Beneficiary details' under GESS to enrol the beneficiaries. Similarly, overseas employees have

to specifically enroll 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.

Enrolments under India HIS should be completed as per specified timelines and under the link mentioned earlier. Employees have no restriction on maintaining dual coverage for spouse and beneficiaries under India HIS and overseas Insurance.

s. The 90-days timeframe to update beneficiaries 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. All employees who join TCS in the last quarter of the financial year/New additions on account of life changing eventsare advised to enroll their beneficiaries soon after joining/immediately after life changing event, in order to avail the HIS coverage effective from the date of joining/birth/marriage.

t. The benefits under HIS can only be availed after the beneficiaries are enrolled in the system. The exception to this will be in case of cashless hospitalisation of the new born child soon after birth. (If cashless is availed for new born child soon after birth, then 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). Modifications made under GESS in Ultimatix in the 'HIS Beneficiary Details' link will reflect in the TCS Health Insurance Portal within 15 to 20 days.

Refer to Appendix A: Coverage and Scenarios related to enrolment for further details

3. Deletion from HIS

a. Employee continues to be covered year on year throughout his or her tenure in TCS. The cover ends only when the employee separates from TCS.

b. Beneficiaries who are covered will continue to remain covered throughout the employee's tenure in TCS, unless :

- the employee explicitly deletes them

  Note : *However, if the employee deletes their parents / in-law details, they will not be able to re-enroll them for the next 3 years*

- the employee separates from TCS. In this case, the date of release/ date of intimation of separation, whichever is later, is considered as the last day of coverage for the employee and the enrolled beneficiaries.

Note: *TCS reserves the rights to recover the amount if an employee has availed cashless facility for self or for beneficiaries post release from TCS. Same may be adjusted or recovered in through the FFS of the employee*

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.

4. Premium:

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

a. **Base Cover Premium** towards basic hospitalisation and domiciliary cover for employee, spouse and 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.

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

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

For complete details refer to Global GESS via the path:

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

Base Premium for Parents/Parents-in-law will be prorated for new joinees and for employees getting married during the financial year.

Premium that is paid for employee and beneficiaries is for the entire financial year. 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 or cessation of the employment of the insured beneficiary
- Cessation of Insurance cover as provided by the employer of the insured beneficiary

Note:

1. *The premium, as applicable and payable by the employee, is deducted through the employee's payroll.*
2. *GST is applicable to all the premium amounts.*
3. *Premium paid by the employee qualifies for tax benefits as per relevant applicable taxation laws in the country.*

For 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 full and final settlement (FFS)

- In case the employee resigns while on LWP or 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.

Claim Procedure

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 hospitalization, except in case of an emergency. This is applicable for both cashless and reimbursement mode. Such intimation must be provided through our Health Insurance portal accessible via the below path or through the MediBuddy Mobile App which can be downloaded on Android and iOS.

Ultimatix → Employee Services → Health & Wellness → TCS Health Insurance Portal → Cashless → Intimate e-Cashless

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.

Treatments availed at GIPSA governed hospitals will be covered upto 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. Reimbursement from these hospitals will be restricted to GIPSA rates for applicable procedures. 10% deduction would be applicable on admissible amount incase of availing reimbusement from a network hospital.

1. Reimbursement of Claims

a. Employees must opt for hospitals which are part of the network list and avail the cashless facility. Prior intimation of at least 72 hours is mandatory to avail cashless facility, except in case of emergencies / accidents. The list of network hospitals can be accessed through the Health Insurance Portal or through MediBuddy Mobile App. 10% deduction on the admissible amount will apply in case of requests for reimbursements for hospitalisation in a network hospital.

b. In case of Hospitalization in a non-network hospital, an advance notice of Hospitalization is mandatory (except in case of emergencies / accidents). Only in case advance intimation of at least 72 hours is not provided, 10% deduction on the admissible amount will apply.

c. Employees can pre-intimate hospitalisation details either through Health Insurance portal on Ultimatix or through Medibuddy Mobile App. The details for the same will be released shortly.

d. Employees can register their Domiciliary or Hospitalisation claims through the TCS Health Insurance Portal. To access the TCS Health Insurance Portal, employee needs to log in Ultimatix and access the below link:

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

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

f. All reimbursement claims should be raised against the appropriate heads of Domiciliary or Hospitalisation 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 hospitalisation claims).

g. Claim documents must be submitted within 24 hours from the date of registration of claims. The Submission date should be accordingly mentioned in the claim form.

h. All claims to be entered through TCS Health Insurance Portal only. No claims will be accepted manually.

i. Associate should retain scanned or photo copies of all the documents, so that the same can be produced if/ when required.

j. Insurer reserves the right to reject claims raised after the mentioned timeline. Concerns related to claims processing should be raised within 30 days from date of approval/rejection of the claim. No queries raised beyond this period will be taken up.

k. 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.

2. Cashless Facility

The Insurance Company/TPA has empanelled specific Hospitals through which a cashless 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 to the Hospital through the TPA.

10% deduction on the bill amount will apply in case of requests for reimbursements and/or cases where the employee opts for hospitals outside the network list.

For more details, please refer the cashless procedure available on TCS Health Insurance Portal

Type of cashless Hospitalisation:

a. 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. Process to be followed for the same is updated on the Health Insurance portal.

b. Emergency Cashless Hospitalisation*:*

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

Note: *While availing cashless facility employee/patient may need to pay the deposit amount as per the hospital policy/requirement. Employee may claim the same as reimbursement on submission of the original deposit receipt or request hospital to refund the deposit amount once the cashless is settled by TPA.*

3. Domiciliary Hospitalisation

If the medical condition legitimately requires Hospitalisation but the condition of the patient is so serious that he/she cannot be moved to the Hospital OR there is no accommodation available in the Hospital, then treatment may be carried out at home.

Illustration *- 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.*

- Claims 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.

- 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).

- The following ailments shall not be covered under the domiciliary Hospitalisation benefits:

  1) Asthma 2) Bronchitis 3) Chronic Nephritis & Nephrotic Syndrome 4) Diarrhoea & all types of dysenteries including gastro-enteritis 5) Diabetes Mellitus & Insipid us 6) Epilepsy 7) Hypertension 8) Influenza, Cough & Cold 9) All Psychiatric & Psychosomatic Disorders 10) Pyrexia of Unknown Origin 11) Tonsillitis & Upper Respiratory Tract Infection including laryngitis & Pharyngitis 12) Arthritis, Gout & Rheumatism 13) Peritoneal Dialysis

4. Dental Treatment

The expenses towards dental treatment or surgery does not include any of the cosmetic surgeries including crowns, dental implants, artificial dentures, braces, bridges, orthodontics, prognathism, retrognathism, etc. Major dental surgeries such as maxillo facial surgery or any life threatening surgeries are covered under Hospitalisation only if necessitated by accident and/or hospitalisation is for more than 24 hours. However, cosmetic surgeries and tooth implants are not covered under the scheme.

Expenses for extraction, fillings, medicines, consultation fees, root canal expenses and x-ray charges are only reimbursed under Domiciliary Dental Coverage.

Case summary (date wise treatment details) or x-ray films are mandatory to process any dental claim.

Note*:*

i. *Employees should refer to the contact matrix before initiating any queries via an email to Corporate HIS.* ***Refer to Contact Matrix and address for Claim Submission available on the TCS Health Insurance Portal Homepage***

ii. *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* ***30^{ht} 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 incurred at overseas..*

iii. *For hospitalisation that begins in March and extends to April: Any hospitalisation that starts (date of admission) on or before 31st March and continues beyond that, including post hospitalisation, will come under the purview of that particular financial year limits only (Year in which patient is admitted in the Hospital). For all such hospitalisation claims, associates are required to raise the claim with an approximate amount (as per the estimation given by the concerned doctor/hospital)*.

Terms & Conditions

a. TCS/Insurance Company solely act as facilitators for the disbursement/administration of the insurance benefits. TCS/Insurance Company undertakes no responsibility 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.

b. 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.

c. 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.

d. 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.

Defined Benefits

Defined Benefits are applicable to all employees including employees at onsite (Defined limit or Hospitalisation limit/GIPSA limit whichever is lesser would be considered). The defined limits are inclusive of related complications and expenses incurred one month prior & post the hospitalisation.

1. Maternity Benefits

- Maternity expense / treatment shall include the following Medical treatment Expenses:

  a. Medical Expenses for a delivery (including complicated deliveries and caesarean sections) incurred during Hospitalisation;

  b. The lawful medical termination of pregnancy during the Policy Period limited to three deliveries or terminations or either during the lifetime of the Insured Person;

  c. Pre-natal and post-natal Medical Expenses for delivery or termination.

  d. Any complications arising during the course of pregnancy and prior / post delivery

- Maternity related expenses including medicine expenses, doctor's consultation fees, routine check-ups and diagnostic tests conducted during the maternity period will not be covered under domiciliary under HIS.

- The total amount payable for any maternity related hospitalisation resulting in normal delivery/ instrumental delivery (forceps/ vacuum/etc.) will be limited to Rs 50,000/- for the entire maternity related hospitalisation episode.

- The total amount payable for the maternity related hospitalisation resulting in C-section delivery will be limited to Rs. 75,000/- for the entire maternity related hospitalisation episode.

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

- The above limits on hospitalisation expenses exclude the expenses incurred on the new born child.

- New born baby expenses –The Hospitalisation expenses of the new born child will be covered only if the child is suffering from any ailment/illness/disease/condition which requires in-patient treatment in the Hospital 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. Well Baby Care expenses (if any) may be considered only within the Maternity limit of Rs. 50,000/- or Rs. 75,000/- depending upon the mode of delivery and subject to the Insurance company review and decision.

- The overall limit for maternity benefits is valid even in case of multiple Child birth (twins/triplets) or complications related to maternity.

- An employee can avail Maternity benefits for the birth of first three children only, irrespective of whether earlier maternity benefits where claimed through this policy.

- Surgical intervention for treatment of Infertility and / or IVF, irrespective of the gender of the beneficiary is admissible subject to a maximum limit of Rs 1,00,000.

- Only 2 episodes of treatments towards Infertility / IVF procedures may be claimed throughout the employee's tenure.

- Non-surgical intervention (Intra Uterine Insemination) or. Medical Management for treatment for infertility is admissible under Domiciliary limit.

- Sterility/ family planning treatments are not admissible.

2. Cataract Treatment

- An upper limit on Hospitalisation expenses (including Floater Cover) has been defined at Rs 30,000 towards correction of cataract in a single eye. This is inclusive of all the expenses incurred towards correction of cataract including the lens charges and pre and post hospitalisation expenses, (if any) pertaining to one month prior and post hospitalisation.

3. Joint Replacement

- The upper limit for Single Joint Replacement is Rs. 2,50,000 and Rs. 4,00,000 for Bilateral Joint Replacement. The limits are inclusive of pre and post hospitalisation expenses, (if any) pertaining to one month prior and post hospitalisation.

- There should be a minimum gap of one month between two single joint replacements.

4. Hysterectomy Expenses

- The upper limit for Hysterectomy expenses including pre and post hospitalisation expenses, if any pertaining to one month prior and post hospitalisation has been capped at Rs. 75,000 per beneficiary in a policy year.

- Hysterectomy includes Hysterectomy with or without Salpingo-oopherectomy.

5. Cancer Care:

- Conventional/Parenteral chemotherapy or Radiotherapy is covered under the purview of the policy.

- Other therapies including Oral/Targeted/Hormonal Chemotherapy are also covered subject to a maximum limit of the Base Sum insured per year per Family.

6. Treatment of Multiple Sclerosis

- OPD/Daycare Medical expenses incurred for the treatment of Multiple Sclerosis for the Employee are payable subject to maximum limit of Rs 2,50,000 per annum.

7. Cochlear Implants

- Hospitalisation expenses for Cochlear implantation are payable subject to 50% of actual expenses or 50% of the Base sum insured plus Floater sum insured whichever is less.

8. Treatment for Obstructive Sleep Apnea

- These expenses will be payable upto 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.

9. 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

10. Treatment of obesity or conditions arising thereof (including morbid obesity)

- These expenses are covered under the purview of the policy.

- 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.

- This is applicable for Employees only and not for other beneficiaries.

11. Stem Cell Therapy

- The treatment with Stem cell Therapy is applicable for employees only and is payable upto a maximum limit of 50% of the Base Sum Insured per employee.

- This provision is available only to those employees where the treating Doctor has certified that the Stem Cell Therapy is recommended for treatment of an illness other than Hematologic Cancer

12. DIVYAANG Benefit

- This benefit is provided to differently abled Children of the employees and is payable upto Rs 10,000/- per annum per child.

- Employee can claim this amount by raising a request under the Hospitalization category.

13. Sex / Gender Reassignment Surgery (SRS)

- Surgical procedures for Sex / gender reassignment are payable up to a maximum of 50% of the total expenses, capped at Rs. 2,00,000 per employee.

14. Insanity/ Anxiety / Mental Illness

- Treatment for Insanity / anxiety / mental Illness is payable under the Domiciliary limit. In case of hospitalization with an active line of treatment, medical expenses for treatment of certain psychiatric and Psychosomatic Disorders or Mental Illness are payable upto Rs. 2,00,000 per family. This benefit is extended to all beneficiaries. Hospitalization purely for rehabilitation/observation ordiagnostic purpose is not payable.

15. Treatment outside India

- Hospitalisation treatment taken outside India by insured persons who travel out of India on official work is covered under the Basic HIS Policy. The hospitalisation expenses incurred outside India may be claimed by employees. ***Refer to Provisions - Benefits / Entitlements and Coverage section for Base Cover limit.***

- the expenses on domiciliary treatment incurred outside India will not be covered under the HIS scheme.

- In case the employee is covered by Overseas Mediclaim Policy (OMP), benefits should be first availed against the OMP and only then claimed under the HIS subject to maximum limit per insured person per annum

- In case the employee is not covered by an OMP, the employee may claim benefits under the Basic HIS policy.

- The process for raising claims for treatment taken outside India will be the same as followed for hospitalisations in India

- In case of expenses which are incurred outside India and for which the settlement under OMP is pending, employees should raise the claim for an amount upto the Base Cover limit under India HIS within 90 days from the date of discharge/before the year-end deadlineand thereafter submit the documents once they have the bills to support the same or when the settlement is complete. Relaxation of additional 60 days will be given only for document submission in such scenarios.

- 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.

16. Alternative System of Medicines

- Expenses incurred for Ayurvedic/Homeopathic/Unani treatment are payable up to a maximum limit of 25% of the Basic Sum Insured 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 payable.

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

17. 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.

  For details on treatments and expenses related to it refer to Appendix C: Commonly used terminologies

Exclusions under Hospitalization and Domiciliary

There are certain exclusions in HIS due to which NO benefits are payable. This list of exclusions (enumerated below) is only indicative and not exhaustive.

a. Expenses towards Health Check-ups, correction of eye sight, cost of spectacles, contact lens, cost of braces, cost of scaling of teeth, hearing aid, Nebulizer, beauty treatment, external congenital defects/diseases/anomalies i.e. the defects/conditions/anomalies which are visible at the time of birth; and anaemia, etc. are not covered by this policy.

b. Lasik/Laser surgery and advanced surface ablation surgery are not covered under domiciliary or Hospitalisation.

c. Vaccination, Inoculation, Baby Check-up charges (MMR/BCG/Polio/Anti Typhoid) Circumcision (other than on medical grounds), Strictures, 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.

d. Convalescence (which expression shall also cover general debility “run down” condition and general “over haul”) or Rest Cure, Rehabilitation, Venereal Disease, , Intentional self-injury, Intemperance or disease or condition or accident arising out of the use of intoxicating drugs or liquor or alcohol or any disease directly or indirectly due to any one or more of them. Use of tobacco leading to cancer.

e. Health routine check-up examination / Master Check-up unless necessary positive existence for treatment of any medical condition.

f. 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 Hospitalisation.

g. Weakness related treatments are not payable.

h. 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.

i. 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), War, Invasion, Act of Foreign Enemy, Hostilities or Warlike Operation (whether war be declared or not), Riot or Civil Commotion or Breach of Law or hunting.

j. 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 or bodily injury sustained as a result of participating in any criminal act, Breach of Law, injury sustained whilst or as a result of participating in any hazardous sport or hunting. 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.

k. Nutritional Supplements, Expenses on vitamins and tonics, etc. unless forming part of treatment for injury or disease as certified by the attending physician.

l. Genetic disorders like Colour Blindness, Sickle Cell anaemia, Haemophilia, Down Syndrome, etc. and stem cell implantation or associated surgeries.

m. 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

n. Instruments, CAPD procedure and all related expenses, for treatment of Dialysis, external equipment or prosthetic devices , ambulatory devices like walker, crutches, Belts, collars, Caps, Splints, Slings, Stockings, diabetic foot wear etc.

o. Experimental and unproven treatment, not recognized by the Indian Medical Council.

p. Treatment of Age related Macular Degeneration (AMRD), Rotational Frequency Quantum Magnetic Resonance therapy (RFQMR), External Enhanced Counter Pulsation (EECP) therapy etc.

q. Robotic surgeries, Cyberknife surgeries are not payable unless there is no other alternative available.

r. Procedures and treatments usually done in outpatient department are not payable under the policy 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.

s. Non-Medical expenses such as Telephone, Television, Ayah, Private Nursing, diet charges, baby food, cosmetics, tissue paper, diapers, sanitary pads, toiletry items and similar expenses as listed under IRDA guidelines.

t. Maternity and maternity related expenses are not payable for more than first three living children.

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

v. Check up and diagnostic tests done during maternity period.

w. 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 for which confinement at a hospital or nursing home is required

This exclusion shall not apply to injury resulting from an accident to a fully licensed standard type of aircraft operated by a recognised airline on a fully regular scheduled air route in which the insured person is travelling as a bonafide passenger.

Following services are considered as non-medical items and will not be reimbursed.

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

- Registration/Admission Fees
- Telephone charges.
- Visitor's charges, attendant's charges.
- Service charges, surcharge and/or any other Charges like Medico Legal Charges (MLC), Medical Record Charges etc.
- Diet charges, which are not part of the administered treatment. Non-medical expenses such as Equipment, Television, Ayah, Private Nursing, baby food, cosmetics, tissue paper, diapers, sanitary pads, toiletry items and similar expenses.

Appendix A: Coverage and Scenarios related to enrolment

Coverage for family members is subject to the following conditions**.** The term 'family' is inclusive of people from the lesbian, gay, bisexual, transgender and queer (LGBTQ) community:

Family Member	Condition
Spouse	- Should be legally married to the employee. - This also includes same sex partners irrespective of their marital status. - In case employed in another organisation, the employee may claim HIS benefits subject to the following: i. In case the Spouse does not get medical benefits/insurance cover from that organisation, he/she may claim benefits under this scheme. ii. In case medical benefits/insurance cover is provided by that organisation, he/she must first recover the expenses from that organisation to every extent possible. After the sum insured is exhausted from HIS of the other organisation, the employee may claim for the remaining amount under TCS HIS. An employee whose spouse is also a TCSer should ensure that; both of them do not enrol each other and the same beneficiaries (parents/children) for HIS coverage. Such enrolment is considered as dual coverage which is not permitted under any circumstances.
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. - Should not be gainfully employed for wages or profit in any service, business or profession. - 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 pays the cost of premium for the remaining children. In case the employee does not

Family Member	Condition
	cover the remaining children, TCS will also not cover the first three children.
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, i.e. they can cover 1 Parent and 1 Parent-in-law. -

Note:

i. As applicable in the case of Spouse, enrollment of the same set of beneficiaries by an employee and any other relative, who is also a TCSer, will also be considered as dual coverage under HIS and is not permitted under any circumstances.

ii. In case of TCSer spouse, who may need to be enrolled post separation from TCS, employee should enrol these records under GESS enrolments link within 15 calendar days from date of separation and/or contact corporate.his@tcs.comfor further advice.

iii. In case of multiple Child birth, all Children need to be considered separately under dependent coverage. Premium of first 3 children will be borne by TCS.

Scenarios related to enrolment

New Joinee/ Existing Employee	Scenarios	Process for Enrolment
New Joinee	**Employee is single on the date of joining and continues to remain single during the financial year.**	Employee will be automatically covered for self w.e.f the date of joining. Employee has a provision to enrol Parents and Children (in case, employee is a single parent). There would be no option to enrol Spouse, Parents-in-law. Parents and/or children should be enrolled within first 90 days from date of joining TCS to get benefit of the cover w.e.f from date of joining. If he/she chooses not to include the details of parents within the permitted enrollment period, he/she can add them only during the subsequent enrolment period. For any new addition of parents / parents–in- law as beneficiaries, pre-existing ailments or disease/ailments/conditions other than those defined under 'List of Tertiary/ Critical illness' will not be covered in the first year of enrolment. However this will not be applicable to beneficiaries added within 90 days from date of joining or marriage. If children are not enrolled within 90 days

New Joinee/ Existing Employee	Scenarios	Process for Enrolment
		from date of joining, he/she can add them during the subsequent window period.
	Employee is single on date of joining and gets married subsequently during the financial year	**<u>For Self, Parents and Children</u>** Employee will be automatically covered for self w.e.f the date of joining. Employee has a provision to enrol Parents and/or Children (in case, employee is a single parent). Parents and/or children should be enrolled within first 90 days from date of joining to get benefit of the cover w.e.f from date of joining. If not enrolled within 90 days then details of Parents can be enrolled during the subsequent enrolment period. For any new addition of parents / parents–in- law as beneficiaries, pre-existing ailments or disease/ailments/conditions other than those defined under 'List of Tertiary/ Critical illness' will not be covered in the first year of enrolment. However this will not be applicable to beneficiaries added within 90 days from date of joining or marriage. If the employee does not enroll his children within 90 days from date of joining, he/she can add them during the subsequent window period. Spouse, Parents-in-law and Children of spouse (from earlier marriage) should be enrolled within first 90 days from date of marriage to get benefit of the cover w.e.f from date of marriage with the employee. Parents-in-law can be enrolled only if employee's parents are not already enrolled. If parents-in-law are not enrolled within the first 90 days from date of marriage, they can be enrolled during the subsequent enrolment period. For any new addition of parents / parents–in-law as beneficiaries, pre-existing ailments or disease/ailments/conditions other than those defined under 'List of Tertiary/ Critical illness' will not be covered in the first year of enrolment. However this will not be applicable to beneficiaries added within 90 days from date of joining or marriage. If spouse and children are not enrolled within 90 days from date of marriage, he/she can add them during the subsequent window period.

New Joinee/ Existing Employee	Scenarios	Process for Enrolment
New Joinee	**Employee is married on date of joining**	Employee will be automatically covered w.e.f the date of joining. Employee has a provision to enrol spouse, parents OR parents-in-law and children. Spouse, parents OR parents-in-law and children should be enrolled within first 90 days from date of joining to get benefit of the cover w.e.f from date of joining. If parents/ parents-in-law are not enrolled within first 90 days from date of joining, then they can be enrolled only during the subsequent enrolment period. For any new addition of parents / parents–in- law as beneficiaries, pre-existing ailments or disease/ailments/conditions other than those defined under 'List of Tertiary/ Critical illness' will not be covered in the first year of enrolment. However this will not be applicable to beneficiaries added within 90 days from date of joining or marriage. If spouse and children are not enrolled within 90 days from date of joining, he/she can add them during the subsequent window period.
Existing Employee	**Status change for an existing employee (that is, employee gets married during the financial year)**	Spouse, parents-in-law and children of spouse (from his/her earlier marriage) should be enrolled within first 90 days of date of marriage to get benefit of the cover w.e.f from date of marriage. If not enrolled within 90 days, they can be enrolled only during the subsequent enrolment period. For any new addition of parents / parents–in- law as beneficiaries, pre-existing ailments or disease/ailments/conditions other than those defined under 'List of Tertiary/ Critical illness' will not be covered in the first year of enrolment. However this will not be applicable to beneficiaries added within 90 days from date of joining or marriage. Re-enrollment of parents/in-laws who were deleted earlier, will be possible from FY21 with a lock-in period of 3 years. Once enrolled, the employee will not be able to delete them at least for the next 3 years, except in case of their unfortunate demise. If spouse and children are not enrolled within 90 days from date of joining, he/she can add them during the subsequent window period.

New Joinee/ Existing Employee	Scenarios	Process for Enrolment
	Life changing event for an existing employee (child is born or child is adopted during the financial year)	New-born child or adopted child should be enrolled within first 90 days of date of birth/date of adoption to get benefit of the cover w.e.f from date of birth/adoption as applicable. If child is not enrolled within 90 days, he/she can add them during the subsequent window period.

Appendix B: Schedule of Indemnities and % of Sum Insured

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

Event	% 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 Disablement from injuries other than those named above (PTD)	100
4. Permanent Partial Disablement (PPD) as per percentage of Sum Insured as shown below.	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
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

Parts Lost	Compensation As percentage of Sum Insured
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 C: Commonly used terminologies

1. Domiciliary Treatment

- Domiciliary treatment benefits are applicable only when the insured person undergoes treatment at a dispensary or in a hospital, as an outpatient.

- Domiciliary treatment includes pharmacy cost, consulting fees of the doctor, investigatory tests, etc.

2. Hospitalisation

Means admission in a Hospital/Nursing Home for a minimum period of 24 consecutive hours for in-patient Care except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

Note:

i. 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.

ii. 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).

3. 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.

4. 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.

5. 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:

- *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.*
- *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*

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.

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 D: List of Day Care Procedures where Hospitalisation benefits are applicable

6. 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.

7. 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.

8. 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.

9. 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.

10. 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.

11. 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.

12. 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.

13. 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.

14. 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.

15. 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.

16. 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.

17. 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.

18. Room Category:

Employees on Gold Plan are eligible for double occupancy (twin sharing) AC room. Parents/Parents-in-law will be eligble for double occupancy (twin sharing) AC room across all

health plans, except Platinum Plus where Parents/Parents-in-law will be eligible for Single Private AC room.

In case the employee chooses a room which is higher than his / her 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 you have chosen (General, Shared, Private, Deluxe, Super Deluxe etc.). Incase you avail a room higher than your eligibility then the proportionate amount will be deducted not only for the additional room charges over and above your eligibility but also for all other hospital charges that are linked to the room you have 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 your default plan or opted plan in case of an upgrade will be taken into consideration for cashless approvals/reimbursement.

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 D: 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 outpatient department 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
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
22.0	01 October 2019	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

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	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
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

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	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
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 enrolment 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

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	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
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

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	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 enrolment. 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
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

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	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
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

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	Basic Hospitalisation renamed to Base Cover and Higher Hospitalisation cover renamed to Floater Cover.	Provisions	Policy review	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 enrolment.	Provisions – Enrollments under HIS	Review of the policy and scheme	Modify	Policy 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

Revision No.	Policy Effective date	Document Release /Revision Date	Revision Description	Section No.	Rationale for change	Change type	Policy revision/ Document 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	Modify	Policy Revision
16.0	01 Apr 2016	01 Apr 2016	Enrolment 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 enrolment.	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

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	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