India Group Medical Insurance for Onsite Assignees and Localized Associates at Americas, EMEA and APJ

Key definitions & related documents

Key definitions

Policy Period: Duration of one year starting from **November 01, 2024 - October 31, 2025.**

Enrollment window: Associates who wish to modify/add dependents may do so during the enrollment window once in a year at the time of renewal or at the time of joining.

Midterm: In the middle of the policy period.

Coverage: The extent of the sum insured provided under this policy.

Base policy (GMC): Base Policy provides hospitalization benefits for three India based dependents enrolled by the associate.

Parents: Biological Parents (as per regulatory guidelines), excludes stepparents and in-laws.

Children: Refers to a biological or legally adopted child, unmarried, financially reliant on the insured (Associate), and does not have an independent source of income. The child must be under the age of 25 to qualify as a dependent.

Spouse: Legally married, not under the purview of child marriage guidelines (minimum age limit of 21 years).

AMC (Additional Member Cover) **policy:** Associate can add two (2) additional dependents limited two (2) biological children, parents, parents in law, siblings (special child or unmarried sister) by paying additional premium.

Top-up policy: Associate can enhance coverage for Base cover or Base and AMC cover by paying additional premium.

Day Care Treatment: A patient who is admitted in a registered hospital or nursing home or clinic for treatment that does not require an overnight admission or 24 hours hospitalization.

Outpatient Department (OPD): Treatments that don't require a patient to get admitted in the hospital or nursing home or clinic.

Inpatient: Treatments that requires a patient to get admitted in the hospital for more than 24 hours with an active line of treatment.

Pre-Existing Disease: Any existing ailment/disease/injury that the person has, prior to the commencement of the policy.

Primary Insurer: The insurance provider for this policy.

Third Party Administrator (TPA): A registered body engaged by the insurer for processing claims.

Network Hospitals: List of hospitals empaneled by TPA / Insurer.

Non-Network Hospitals: Hospitals that don't fall under the empaneled list of TPA / Insurer.

Registered Hospital / Nursing home / Clinic: Hospital/Nursing home/clinic registered under any local government authority or has at least 15 beds, with qualified nurses round the clock, qualified duty doctors along with a fully equipped operation theatre.

Congenital Anomaly: Presence of an ailment since birth and that is abnormal with reference to form, structure, or position.

Co-pay: Refers to the portion of claim that must be borne by the Associate.

Room Rent: Rent and boarding expenses as provided by the hospital including nursing charges.

Proportionate Deduction: Ratio by which room rent and boarding charges exceed the room rent limit. The claim admissible amount excluding the pharmacy is reduced by the same proportion.

Loss of pay (LOP): Payment made by insurer in lieu of loss of salary with respect to any critical illness as defined in the policy.

Maternity Expenses: Expenses that are traceable to childbirth or lawful termination of pregnancy.

Localization: ending the India employment contracts of Associates on long-term international assignments, while offering or continuing employment in the country in which they are currently working.

Related policies & processes

FAQs

Scope

This policy is available to the following Associates to purchase cover for their eligible dependents residing in India:

- Associates hired in India and then deputed on global assignment with a payroll transfer to Americas (NA, Canada, LATAM), Asia Pacific Japan (APJ) or Europe Middle East Africa (EMEA). These Associates can purchase coverage under the G2 plan.
- Associates above who are subsequently localized in a country other than India. These Associates can purchase coverage under the G3 plan.

The policy only covers treatment in India.

Guiding principles

This policy provides hospitalization benefits for enrolled India based dependents of Associates as outlined in the scope.
The policy is administered through:

- **Primary Insurer**: The New India Assurance Company Limited, herein referred to as NIA.
- **Third Party Administrator (TPA):** Medi Assist Insurance TPA Private Limited, herein referred to as Medi Assist.

Associate must declare or nominate their dependents every year during open enrollment/Enrollment window. There is no option to automatically carry forward dependent coverage from the previous year to the current year. Associates cannot make any changes to their dependent details in the Base, AMC, and/or Top-up policy (if any) at any time during the policy period or after returning to India on a payroll transfer or during a short-term assignment to India. Changes to the dependent details can be made only at the time of renewal during the Enrollment window.

As no enrolment/dependent changes are permitted outside the Enrolment window, if Associates have eligible dependents currently residing with them at onsite outside of India, Associates must register them during the enrolment period. While there will be no premium payable, registering them is the only way to ensure they will be eligible for coverage under the policy in the event Associate transfers back to India payroll during the policy year. To register these dependents, Associate must submit their information and uncheck the checkbox under the coverage tab in the Medi Assist portal during the Enrollment window.

Associates also have the option to pay the premium and voluntarily elect coverage for their eligible dependents who remain in India while they are onsite. To confirm coverage, associates must submit information for these dependents, click the check box under coverage tab, and pay the applicable premium.

Associate can purchase the Base cover for a maximum of three dependents based in India at the time of renewal during the Enrollment window. Associates can also purchase AMC (Additional Member Cover) and Top-up cover for their dependents based in India at the time of renewal during the Enrollment window. There will be no change in sum insured due to promotion during the entire duration of the policy period.

Coverage

The policy provides coverage for hospitalization expenses, with an active line of treatment which fulfills a minimum requirement of 24 hours of hospitalization, with time limit waiver for certain ailments (Day Care Treatments). Associate's dependents are covered through a floater coverage in the base policy. Coverage is provided for newborn from the date of birth. Pre-Existing conditions are covered under the policy from day one of joining Cognizant.

Eligible Dependents under Base Policy

Associates can enroll a maximum of three dependents, that include:

- Spouse
- Parents
- Children

For detailed definition of dependents mentioned above, please see the 'Key Definitions' section.

Note:

- Foster parents are not eligible for coverage.
- Adopted children can be enrolled into the policy within 45 days, once the legal adoption certificate is received.

Eligible Dependents Under AMC Policy

Associates can enroll a maximum of two (2) dependents, that include:

- Parents
- Parents-in-law (as per regulatory guidelines)
- Children
- Disabled dependent sibling.
- Unmarried sister

For detailed definition of parents and children mentioned above, please see the 'Key Definitions' section.

Note:

- Foster parents not eligible for coverage
- Maximum of three (3) children can be added in the base policy and AMC policy.
- Adopted children can be enrolled into the policy within 45 days, once the legal adoption certificate is received.

Base policy Coverage limits

The following table describes the dependents coverage limits under the Base Policy based on the level of an Associate:

Levels	Coverage (Floater Sum Assured)
Levels up to Associate	INR 250,000
Senior Associate and Managers	INR 300,000
Senior Managers & above	INR 500,000

Room rent cap (including boarding and nursing expenses) as per levels for Base Policy is as follows:

Room rent cap for Base policy			
Level	**Sum Insured**	**Eligible room rent (per day inclusive of nursing charges)**	**Eligible ICU room rent (per day)**
Up to Associate	INR 250,000	INR 4,000	On Actuals
Sr Associate & Managers	INR 300,000	INR 4,000	On Actuals
Sr Managers & above	INR 500,000	INR 6,000	On Actuals

Expenses Covered

Expenses covered under hospitalization include:

- Surgeon, Anesthetist, Medical Practitioner Consultants, Specialists Fees.
- Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs & Cost of Organs, and similar expenses.
- Ambulance services per hospitalization is 1 % of sum insured or INR 2000, whichever is lesser.
- Refer Annexure I for non-medical expenses excluded from coverage.

Additional Member Cover (AMC) policy

Associates can at the time of joining Cognizant or during renewal of the policy/Enrollment window, opt for an Additional Member Cover

- The premium for AMC must be paid by the Associate.

- Upon opting for AMC, the Associate may choose to include a maximum of two (2) additional dependents into the policy.
- Associate may add a newborn baby within 45 days from the date of birth, subject to availability of vacant slots. No other changes can be done to the AMC enrollment Midterm.
- Any claim pertaining to the new member prior to enrolment / endorsement / premium payment will not be admissible.

The premium details for AMC are as mentioned below:

AMC Sum Insured (INR)	AMC policy premium– Age band (in years) and premium per member (in INR) W.E.F. November 01, 2024							
	0-35	36-45	46-55	56-65	66-70	71-75	76-80	Above 80
100,000	4,557	5,221	7,887	16,543	18,541	21,209	22,539	24,802
200,000	7,133	7,941	11,987	27,366	30,605	34,649	37,081	40,802
300,000	9,181	10,031	15,982	34,685	38,932	44,880	47,431	52,188

- The premium towards AMC as mentioned in the above table is inclusive of GST. However, this is subject to change from time to time based on changes in GST rates.
- The additional members opted under AMC policy would have the applicable room rent / ICU limit (including boarding and nursing expenses) as mentioned below:

AMC Sum Insured	Eligible room rent (per day inclusive of nursing charges)	Eligible ICU room rent (per day)
INR 100,000	INR 2,500	On Actuals
INR 200,000	INR 2,500	On Actuals
INR 300,000	INR 3,000	On Actuals

Top-up policy

The Top-up policy allows the Associate to increase the sum insured under the Base policy as well as AMC policy.

- Top-up for AMC policy will be applicable only when the sum insured opted under AMC is INR 300,000. Associates who have availed AMC with a sum insured of INR 100,000 or 200,000 are not eligible for a top-up of the AMC policy.
- The premium for Top-up policy must be paid by the Associate.
- Once an Associate opts in for Top-up policy and opts out in the subsequent year, the Associate will not be permitted to top-up at later years.
- Room rent is capped as per the policy (Base or AMC) of the member. Associates opting for a higher category of room will have to bear the room rent difference as well as the proportionate expenses. This will apply to both cashless and reimbursement claims. Maximum deduction under proportionate charges is limited to 20% of claim admissible amount for all claims under Base, AMC and Top-up policies.
- No changes can be done to the Top-up policy during the Midterm including increasing / decreasing the Top-up sum insured.
- There are twelve coverage options to choose from and the premium rates below are effective **November 01, 2024.**

Top-up policy Premium

Top-up Sum Insured (INR)	Premium (INR)	
	Applicable to Base policy only	Applicable to Base + AMC Policy
100,000	5,533	7,744
200,000	6,916	9,681
300,000	9,681	12,449
400,000	11,917	15,045
500,000	18,356	22,847
600,000	23,953	28,745
700,000	28,745	32,336
800,000	32,851	36,954
900,000	39,594	44,543
1,000,000	43,997	49,493
1,500,000	75,015	84,385
2,000,000	100,022	112,513

The premium towards Top-up policy mentioned in the above table is inclusive of GST. However, this is subject to change from time to time based on changes in GST rates.

The Additional Member Cover (AMC) and Top-up cover opted (if any), for the Policy Period will get expired at the end of the Policy Period. Hence, Associates are required to revisit the Medi Assist app, during the renewal enrolment period and opt for AMC and Top-up benefit to increase their insurance cover.

Validity of AMC & Top-up covers

Category	AMC validity period	Top-up validity period
Associates hired in India and currently at onsite or localized	**Active in Cognizant:** Valid till the end of the Policy Period. **Separation**: Valid till the Last Working Day (LWD). **Travel on global assignment:** Till the end of the Policy Period.	**Active in Cognizant:** Valid till the end of the Policy Period. **Separation:** Valid till the LWD. **Travel on global assignment:** Till the end of the Policy Period.

Proportionate Deductions

If the insured is admitted in a higher room rent category, the Associate shall bear the room rent difference as well as the proportionate expenses on all other charges. This shall apply to both cashless and reimbursement claims.

- Proportionate deductions are applied on charges towards the surgeon, assistant surgeon, operation theater, anesthetist investigations and any other charges that may vary as per room category.
- Maximum deduction under proportionate charges is limited to 20% of claim admissible amount for all claims under Base, AMC and Top-up policies.
- Weighted average method will be used for determining proportionate deductions regarding room rent.

Co-pay

- A Co-pay of 10% shall be applicable on the admissible claim amount for the hospitalization (including Pre and Post Hospitalization) of the Associate's dependent, spouse and children

- A Co-pay of 15% shall be applicable on the admissible claim amount for the hospitalization (including Pre and Post Hospitalization) of the Associates' dependent parents, parents-in-law and siblings.

Claimant	Applicable Co-pay	Illustrative claim amount	Co-pay calculation	Co-pay
Spouse	10% of the admissible claim amount	INR 90,000	INR (10% x (90,000))	INR 9,000
Parents	15% of the admissible claim amount	INR 90,000	INR (15% x (90,000))	INR 13,500

Pre & Post Hospitalization Expenses
These are medical expenses that are incidental to the hospitalization. Prehospitalization expenses refer to the expenses that are incurred for a period of 30 days before the date of hospitalization and post hospitalization expenses refer to the expenses incurred for a= period of 60 days from the date of discharge.

- For example, while expenses incurred on a routine (medical) scan are not covered under the policy, expenses incurred on such scans leading to the diagnosis of an included ailment and to subsequent hospitalization for its treatment, will be covered.
- While routine consultation fee paid to the medical practitioner is not covered under the policy, should such consultation result in the diagnosis of an included ailment and to subsequent hospitalization for its treatment, the expenses incurred will be covered.
- In simple terms, any medical expenses incurred 30 days before the hospitalization which is related to the ailment diagnosed will be covered under pre-hospitalization. Similarly, after discharge any medical expenses incurred for 60 days will be covered as post hospitalization expenses.

Specific coverages

Maternity Benefits
The annual maternity cap only for dependent Spouse (sub limit to the floater coverage) will be INR 50,000 for normal delivery and INR 75,000 for C-Section and is limited to the first two living children. This cap is inclusive of both pre & post hospitalization expenses. Those insured persons who are already having two or more living children will not be eligible for this benefit.

- No cap for abdominal operation for extra uterine pregnancy (Ectopic / Tubular pregnancy). Associate shall provide all necessary documentation that include ultra-sonographic report and a medical certificate from a gynecologist that it is life threatening.
- If both the Associate and the Associates' Spouse are on the rolls of Cognizant India, both can avail the maternity benefit subject to proper bills that are reasonable and customary.
- Expenses incurred in connection with voluntary medical termination of pregnancy during the first 12 weeks from the date of conception are not covered.
- Expenses relating to the baby at the time of delivery (normal baby care) will be covered within the maternity cap.
- Pre-natal and post-natal expenses are not covered unless admitted in the hospital and treatment is taken there. Hospitalization related to maternity during the gestation period will be processed within the maternity cap limit only.

Infertility
Treatment of infertility will be covered, subject to maximum of INR 40,000, for spouse, only if there are no living children. Cost needs to be incurred at a hospital; however, the 24-hour hospitalization clause does not apply. Once utilized, there will be no payment in subsequent years for self and spouse.

Hysterectomy
Treatment of hysterectomy will be covered, subject to a maximum of INR 75,000 per claim.

Total Knee Replacement
Treatment of total knee replacement will be covered, subject to a maximum of INR 200,000 per knee and INR 300,000 for bilateral replacement (two knees) in a single admission. This cap limit is inclusive of both pre & post hospitalization expenses.

Cataract
Cataract surgery is capped at INR 35,000 per eye.

Covid
Covid coverage is limited to inpatient, hospitalization for minimum 24 hours.

Ayush
Expenses incurred for Ayurvedic / Homeopathic / Unani treatment are admissible provided the treatment for Illness and accidental injuries, is taken in AYUSH Hospital (Government Hospital or in any institute recognized by Government and /or accredited by Quality Council of India / National Accreditation Board on Health, excluding centers for spas, massage and health rejuvenation procedures)

External Congenital Illness (covered only under GMC policy)
External congenital illness (a condition existing at birth and often develops during the first month of life) is covered. The list of congenital external disorders that are covered under the policy is as below:

Face, Neck & Head
- Cleft Lip
- Cleft Palate
- Congenital Thyroid Cyst
- Obstructive Hydrocephalus

ENT
- Microtia/Anotia
- Cup & Bat Ears

Eye
- Congenital Cataract
- Ptosis
- Entropion
- Strabismus diagnosed within 3-6 months of birth

Genitourinary System
- Testicular Torsion
- Varicocele
- Orchidopexy
- Undescended Testis
- Hypospadias (Coverage is limited to INR 50,000)

Orthopedics
- Crowe Grade III & IV of Congenital Hip Dysplasia
- Congenital Kyphosis
- Knee Dislocation
- Congenital Talipes Equinovarus (Club Foot)
- Congenital muscular torticollis
- Pes Cavus
- Syndactyly
- Pectus excavatum

Neurological
- Spina Bifida
- Meningocele
- Craniosynostosis

Dermatological

- Hamartoma Excision
- Hemangioma Excision
- Congenital Dermal Sinus

Other Benefits

- Outpatient coverage for a maximum limit of up to INR 5,000 per child will be covered during the Policy Period, for children with disability.
- Lasik power correction surgery is applicable for eye power +/- 5 and above for insured members in Base Policy (GMC) and + / -7.5 and above for insured members in AMC.
- Cochlear implant is covered up to 50% of the balance sum insured.
- 50% Co-pay will be applicable on the initial surgical proceedings in case of Cyber knife / Stem cell treatment, inclusive of the hospitalization expenses of the donor.
- Hospitalization expenses incurred on the donor during an organ transplant will be a part of the main claim.
- Coverage for treatment of genetic disorders ailments.
- Air Ambulance in case of emergency not exceeding INR 100,000 per incident and INR 1,000,000 per year (for the entire organization). Air Ambulance can be utilized only in case of emergency for critical ailments listed in the policy and where there are no hospitals in the vicinity of 75 kilometers. For e.g., in case of immediate hospitalization required for cardiac arrest / cancer and if there are no hospitals in the vicinity of 75 kilometers, the member can utilize air ambulance service to reach the hospital as early as possible.
- Coverage for modern treatments or procedures: The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to the limit specified against each procedure during the policy period.

Modern treatment or Procedure	Limit (Per Policy Period)
Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	Up to 20% of Sum Insured subject to Maximum Rs. 2 Lakh
Balloon Sinuplasty.	Up to 20% of Sum Insured subject to Maximum Rs. 2 Lakh
Deep Brain stimulation.	Up to 50% of Sum Insured subject to Maximum Rs. 5 Lakh
Oral chemotherapy.	Up to 10% of Sum Insured subject to Maximum Rs. 1 Lakh.
Immunotherapy- Monoclonal Antibody to be given as injection.	Up to 25% of Sum Insured subject to Maximum Rs 2 Lakh.
Intravitreal injections.	Up to 10% of Sum Insured subject to Maximum Rs.75,000.
Robotic surgeries.	Up to 50% of Sum Insured subject to Maximum Rs. 5 Lakh.
Stereotactic radio surgeries.	Up to 50% of Sum Insured subject to Maximum Rs. 3 Lakh.
Bronchial Thermoplasty.	Up to 50% of Sum Insured subject to Maximum Rs. 2.5 Lakh.
Vaporization of the prostrate (Green laser treatment or holmium laser treatment).	Up to 50% of Sum Insured subject to Maximum Rs. 2.5 Lakh.
IONM - (Intra Operative Neuro Monitoring).	Up to 10% of Sum Insured subject to Maximum Rs. 50,000.

Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered.	Up to 50% of Sum Insured subject to Maximum Rs. 2.5 Lakh.

Coverage for Hospitalization/Day Care Procedure
Where admission for a period of less than 24 consecutive hours.

Anti-Rabies Vaccination	Hysterectomy
Appendectomy	Inguinal/Ventral/Umbilical/Femoral Hernia
Coronary Angiography	Lithotripsy (Kidney Stone Removal)
Coronary Angioplasty	Parenteral Chemotherapy
Dental surgery following an accident	Piles / Fistula
Dilatation & Curettage (D & C) of Cervix	Prostate
Eye surgery	Radiotherapy
Fracture / dislocation excluding hairline Fracture	Sinusitis
Gastrointestinal Tract system	Stone in Gall Bladder, Pancreas, and Bile Duct
Hemodialysis	Tonsillectomy
Hydrocele	Urinary Tract System

Aside from those on the afore mentioned list, any further surgeries or procedures that are agreed upon by the TPA or insurer and necessitate less than a 24-hour hospital stay are also covered.

Terms and Conditions

Medical Expenses Falling Under Two Policy Periods
If the claim event falls within two Policy Periods, the claims shall be paid taking into consideration the available sum insured of the expiring policy only. Sum Insured of the renewed policy will not be available for the hospitalization (including Pre & Post Hospitalization expenses), which has commenced in the expiring policy. Claim shall be settled on per event basis.

Fraud, Misinterpretation, Concealment
The policy shall be null, and void and no benefits shall be payable in the event of misinterpretation, misrepresentation, or nondisclosure of any material fact/particulars if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the insured person or by any other person acting on their behalf.

Notice of claim
Preliminary notice of claim with particulars relating to policy number, name of insured person in respect of whom claim is to be made, nature of illness / injury and name and address of the attending medical practitioner / hospital / nursing home should be given to the company / TPA within seven (7) days from the date of hospitalization in respect of reimbursement claims.

Final claim along with hospital receipted original bills / cash memos**,** claim form and documents as listed in the claim form below should be submitted to the policy issuing office / TPA not later than 30 days of discharge from the hospital. The insured may also be required to give the Company / TPA such additional information and assistance as the company / TPA may require in dealing with the claim.

- Bill, receipt and discharge certificate / card from the hospital.
- Cash memos from the hospitals(s) / chemists(s), supported by proper prescriptions.
- Receipt and pathological test reports from pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such pathological tests / pathological.
- Surgeon's certificate stating nature of operation performed and surgeons’ bill and receipt.
- Attending doctor's/ consultant's/ specialist's / anesthetist’s bill and receipt, and certificate regarding diagnosis.

- Certificate from attending medical practitioner / surgeon that the patient is fully cured.

Waiver
Waiver of period of intimation may be considered in extreme cases of hardships where it is proved to the satisfaction of the company/TPA that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time limit. This waiver cannot be claimed as a matter of right.

Physical Examination
Any medical practitioner authorized by the insurer shall be allowed to examine the insured person in case of any alleged injury or illness requiring hospitalization when and so often as the same may reasonably be required on behalf of the insurer.
The insurer shall not be liable to make any payment under this policy in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the insured person or by any other person acting on his behalf.

Multiple Policies
- In case of multiple policies taken by insured person during a period from insurer or one or more insurers to indemnify treatment costs, insured person shall have the right to require a settlement of insured person's claim in terms of any of one of the policies. In all such cases the insurer, if chosen by insured person, shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of this policy.
- Insured having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies, even if the Sum Insured is not exhausted. Then insurer shall independently settle the claim subject to the terms and conditions of this policy.
- Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.
- The insured person must disclose such other insurance at the time of making a claim under this policy.

The scope of ailments covered under this policy is as per the Group Mediclaim Policy issued by the primary insurer. The same shall be applicable to all Associate's enrolled dependents under the Base Cover / Additional Member Cover (AMC) /Top-up Cover, which will be a floater policy.

Refer Annexure I, for details on non-medical expenses not covered by this policy, items that are to be subsumed into costs of treatment, items that are to be subsumed into procedure charges and items that are to be subsumed into room charges. For general exclusions, refer Annexure II.

In the event, an insured person has any grievance relating to the hospitalization claim, they may contact HR talent partner/HR business partner/TPA/location HR leads. The case would be further referred to Cognizant ombudsman team.

Allowance in lieu of premium paid
India hired Associates on onsite assignment in Americas, EMEA and APJ countries, who elect to enroll their eligible dependents remaining in India, for coverage in the group medical policy, will be entitled to a flat, average allowance on a monthly basis, in lieu of the premium paid towards the Base Policy.

Levels	Regions	Allowance Per Month
Up to Associate	APJ, EMEA & Americas*	USD 15
Sr. Associate & Manager	APJ, EMEA & Americas*	USD 20
Sr. Manager and above	APJ, EMEA & Americas* (excludes NA)	USD 25

Localized Associates are not eligible for this allowance
- Only Associates who are opting coverage for their dependents in India by paying premium shall be entitled to this allowance.

- Allowance is determined based on the grade-wise average premium (as determined by Cognizant India) paid towards the base cover.
- Allowance will be paid through host country monthly payroll and will be subject to taxes as per the host country tax regulations.
- Allowance is payable in the local currency if the eligible Associate is active in the onsite payroll as of the payroll cut-off date.
- Note: Exchange rate for the local currency will be as decided by the host country payroll team.
- Allowance payout will be applicable as per policy guidelines pertaining to the geography to which eligible Associate is tagged as on the date of payout.
- In the event of a payroll transfer to India or upon your termination, allowance payout shall cease.
- The allowance payout is limited to the policy period 2024-25.

Premium Refund

If the Associate has opted for the Base cover at the time of renewal or during their travel to the onsite geography and has paid the premium for the same, in the event of their travel back to India on a payroll transfer or on separation from Cognizant, the pro-rated premium for the inactive period at the onsite geography shall be refunded to the Associate's India bank account by the Insurer only if no claim is registered.

- The Associate shall furnish the India Bank Account details in Medi Assist portal to facilitate the refund.
- Premium is refundable only in case there are no claims registered during the active policy period.
- Premium refund is not applicable in case of any claim registered during the active policy period.
- Only Base Cover premium is eligible for a refund on a prorated basis.
- Premium refund is not possible under any other circumstances.
- The refund shall be initiated:
  - After the end of the policy period in case of travel back to India on a payroll transfer.
  - After the last working day in case of separation from Cognizant.

Process

Claim Submission Process

- Medical Insurance may be availed through cashless transaction (via Network Hospital) or reimbursement process, by submitting claim documents to Medi Assist team at Cognizant MEPZ office, Chennai at the below mentioned address:

  Cognizant Technology Solutions India Pvt Limited
  Payroll & Benefits shared services (PF & EPS Team)
  MEPZ-Special Economic Zone,
  Plot No A-17, D-2, C-10 & C-1, A-15 to 17, B-20 & A-33
  National Highway 45, Tambaram, GST road, Chennai 600045.

  Alternately, hard copies can also be couriered to Medi Assist Chennai address as mentioned below Medi Assist (TPA)

  RWD Atlantis Building, 2nd Floor,
  Door No: 24, Nelson Manickam Road,
  Aminjikkarai, Chennai 600029
- All reimbursement claims will be settled by the insurer and NEFT will be initiated directly by the insurer to the bank account of the associate as updated in Medi Assist app.
- For any assistance during hospitalization, Associates may contact the 24/7 dedicated India toll free number 1800-258-5895, Toll number +91 7337700014 which is exclusive for Cognizant Associates in India.

- Associates from outside of India, can get in touch with Medi Assist on their International landline number - (International call prefix) 91 80 67617555 (chargeable as per Telecom tariff).

Claim Submission Process for Network Hospitals

- The period of hospitalization should be greater than 24 hours with an active line of treatment.
- Claim for hospitalization in a network hospital will be taken care through the cashless mode.
- Associates will have to submit the pre-authorization form by clicking “Intimate e-Cashless Hospitalization” in the Medi Assist app, seven (7) days prior to the date of admission for a planned hospitalization, to avail the cashless benefit.
- Medi Assist shall validate and provide necessary approvals for the pre-authorization submitted.
- The Associate will receive a pay confirmation receipt, once Medi Assist approves the pre-authorization via e-mail. The Associate can also access the information by logging into the Medi Assist app under “Your Claims”.
- The cost of non-medical expenses, (refer Annexure I) Co-pay, proportionate charges or any other deductions as per the policy will have to be borne by the Associate.
- In case of any denial of cashless claims, Associates can claim through the reimbursement mode (subject to terms and conditions of the policy).
- Associates will have to claim pre and post hospitalization only through the reimbursement mode.

Claim submission process for Non-Network Hospitals

- The treatment can be taken from any of the Registered Hospitals / Nursing Home / Clinics in India.
- The period of hospitalization should be greater than 24 hours with an active line of treatment.
- Associates will have to send intimation about their reimbursement claim before the discharge from the hospital by clicking “Intimate Reimbursement” in the Medi Assist app.
- Associates will have to declare and submit their reimbursement claims within 30 days from the date of discharge by clicking “Submit claim” in the Medi Assist app.
- Associates should fill in the claim form completely, take a printout and attach it along with the original documents required.
- Mandatory documents required to claim reimbursement include original hard copies of bills, breakup of bills, prescriptions, discharge summary, receipts and investigation reports.
- Associates will have to ensure that the claim documents reach Medi Assist Chennai office address mentioned above within 30 days from the date of discharge.
  Note:
  - Original reports must be furnished with original bills and receipts. In case of X-rays, an X-ray original report from the hospital needs to be submitted.
  - If Associates are attaching medicine bills, it must be accompanied by corresponding original prescriptions.
  - All bills for medical investigation and diagnostic tests must be accompanied by original reports.
  - Associates should retain photocopies of all documents/reports/bills submitted for further reference as documents once submitted will not be returned by the insurance company.

Claim	Timelines for submission
Main Hospitalization Claim	Within 30 days from the date of discharge
Pre-Hospitalization expenses	Within 30 days from the date of discharge
Post-hospitalization expenses	Within 30 days from the completion of post hospitalization period Post hospitalization period: 60 days from the date of discharge

Claim submission process in case of additional documents

- In case of any additional documents required, three reminders will be sent to Associates over a period of 21 days mentioning the documents required.
- Reminders will be sent to Associate's Cognizant e-mail ID.
- In case the Associate does not respond to the e-mails, the claim will be repudiated as "document recovery failure". Claims shall not get processed until the Associate submits the pending documents.
- Associates will have to collect the required pending documents and send it to Medi Assist within 10 days from the date of third reminder, along with a delayed submission clarification letter.
- The discharge summary issued by the hospital should include the details in the hospital's letter head, duly signed by the concerned doctor and affixed with the hospital's seal.
- Medi Assist will process the Associate's claim as per the norms of the insurance policy. If all the documents have been submitted, the claim will be validated, post which, the same will be sent to the insurance company for reimbursement.
- Typical processing time is 30 days from the date of submission of hard copies of documents to Medi Assist Chennai office.
- Claim can be tracked through the Medi Assist app.

Midterm enrolment process

- Associates can make changes to their dependent details, only at the time of joining or during the renewal of the policy (Enrollment Window period). However, Midterm inclusion of newly wedded Spouse and newborn child can be done in the Medi Assist app.
- Associate will be able to add their newly wedded Spouse as their dependent within 45 days from the date of marriage by raising a GSD or by writing to Mediassist at ctsenrollment@mediassist.in.
- Associate will be able to add their newborn child as their dependent within 45 days from the date of birth. Addition is subject to availability of vacant slots in the base / AMC policy. If there are no vacant slot available in the Base and AMC Policy, Associate may replace any one of the existing dependents in the Base Policy who has not made any claim during the current policy period. Under the AMC policy, no change to existing dependents will be allowed during the middle of the policy period.

Medi Assist mobile app

- Associates can alternatively use the Medi Assist mobile app for medical insurance services.
- Medi Assist mobile app can be downloaded from the Play store or Appstore.
- Associates will have to use their Cognizant mail id and windows password to login to the Medi Assist app.
- The app facilitates the following services:
    - Check claim status!
    - View / Download Medi Assist e-cards.
    - Finding the nearest Network Hospitals.
    - Book appointments for Master Health Checkup.
    - Review e-cashless transactions & processes
    - Receive alerts on reimbursement, etc.

Responsibility Matrix

Associate

Submit claim documents to the Medi Assist helpdesk at MEPZ Chennai Cognizant office.
For an interim period, all hard copies are to be couriered to Medi Assist Chennai office address.

Medi Assist (TPA)
RWD Atlantis Building, 2nd Floor,
Door No: 24, Nelson Manickam Road,
Aminjikkarai, Chennai 600029

Medi Assist
Third party claim administrator.

Exception management

The benefits of this policy are governed by the terms and conditions of employment in practice at Cognizant. This is subject to change from time to time. Cognizant reserves the right to amend its policies as necessitated. All statutory requirements are applicable as mandated by law. All exceptions to policies will be directed to the HR India Benefits.

Policy modifications

Cognizant reserves the right to amend its policies as necessary. Any changes to the India Group Medical Insurance for Onsite Assignees and Localized associates at EMEA and APJ will be approved the Head of Human Resources – India. Associates are required to raise GSD through service now for any queries.

Version history

Revision date	Description of change
Nov-01-2017	Based on practice and precedence in Cognizant India. Introduction of new levels, titles, template, and version control
Nov-01-2018	Updates on enrollment changes through the active policy period
Nov-01-2018	Annual review and process changes
Nov-01-2019	Annual review and process changes, Introduction of Covid19 rider for Covid 19 treatment, Increase in Top-up Limits, enhanced Maternity Limits
Nov-01-2020	Top-Up Coverage for Covid 19 for India based dependents of India hires deputed onsite
Nov-01-2021	Annual review and process changes
Nov-01-2022	Standardization of the Template Annual review and process changes, Changes in Covid 19 rider plan benefit
Nov-01-2023	Annual review and process changes
Nov-01-2024	Annual review, Change in Co-pay for spouse, children. No ICU room rent capping; Change of address
Feb-14-2025	The definition for dependents updated

Policy control information

Policy Name: India Group Medical Insurance for Onsite Assignees and Localized Associates at EMEA and APJ

Department: Human Resources

Revision Date: FEB-14-2025

Effective Date: NOV-01-2024

Policy Owner: Head of HR – India

Annexure I

List I – Items for which coverage is not available in the policy

S No	Item
1	Baby food
2	Baby utilities charges
3	Beauty services
4	Belts / braces
5	Buds
6	Cold pack / hot pack
7	Carry bags
8	Email / Internet Charges
9	Food Charges (other than patient's diet provided by hospital)
10	Leggings
11	Laundry Charges
12	Mineral Water
13	Sanitary Pad
14	Telephone Charges
15	Guest Services
16	Crepe Bandage
17	Diaper of any type
18	Eyelet Collar
19	Slings
20	Blood Grouping and Cross Matching of Donors Samples
21	Service Charges Where Nursing Charge Also Charged
22	Television Charges
23	Surcharges
24	attendant charges
25	Extra Diet of Patient (other than that which forms part of bed charge)
26	Birth Certificate
27	Certificate Charges
28	Courier Charges
29	Conveyance Charges
30	Medical Certificate
31	Medical Records
32	Photocopies Charges
33	Mortuary Charges
34	Walking Aids Charges
35	Oxygen Cylinder (for Usage Outside the Hospital)
36	Spacer
37	Spirometer
38	Nebulizer Kit
39	Steam Inhaler

40	Arm sling
41	Thermometer
42	Cervical Collar
43	Splint
44	Diabetic Footwear
45	Knee Braces (Long / Short / Hinged)
46	Knee Immobilizer / Shoulder Immobilizer
47	Lumbo Sacral Belt
48	Nimbus Bed or Water or Air Bed Charges
49	Ambulance Collar
50	Ambulance Equipment
51	Abdominal Binder
52	Private Nurses Charges - Special Nursing Charges
53	Sugar Free Tablets
54	Creams Powders Lotions (Toiletries Are Not Payable, Only Prescribed Medical Pharmaceuticals Payable)
55	ECG Electrodes
56	Gloves
57	Nebulization Kit
58	Any Kit with No Details Mentioned (Delivery Kit, Ortho kit, Recovery Kit, Etc.)
59	Kidney Tray
60	Mask
61	Ounce Glass
62	Oxygen Mask
63	Pelvic Traction Belt
64	Pan Can
65	Trolly Cover
66	Uro meter, Urine Jug
67	Ambulance
68	Vaso fix Safety

List II - Items that are to be subsumed into room charges

S No	Item
1	Baby Charges (Unless Specified/Indicated)
2	Hand Wash
3	Shoe Cover
4	Caps
5	Cradle Charges
6	Comb
7	Eau-De-Cologne/Room Fresheners
8	Foot Cover
9	Gown
10	Slippers
11	Tissue Paper
12	Toothpaste
13	Toothbrush
14	Bed Pan
15	Face Mask
16	Flexi Mask
17	Hand Holder
18	Sputum Cup
19	Disinfectant Lotions
20	Luxury Tax
21	HVAC
22	House Keeping Charges
23	Air Conditioner Charges
24	Im Iv Injection Charges
25	Clean Sheet
26	Blanket/Warmer Blanket
27	Admission Kit
28	Diabetic Chart Charges
29	Documentation Charges/Administrative Expenses
30	Discharge Procedure Charges
31	Daily Chart Charges
32	Entrance Pass/Visitors Pass Charges
33	Expense related to prescription on discharge
34	File Opening Charges
35	Incidental Expenses/Misc. Charges (Not Explained)
36	Patient Identification Band/Name Tag
37	Pulse Oximeter Charges

List III - Items that are to be subsumed into procedure charges

S No	Item
1	Hair Removal Cream
2	Disposables Razors Charges (For Site Preparations)
3	Eye Pad
4	Eye Shield
5	Camera Cover
6	DVD, Cd Charges
7	Gause Soft
8	Gauze
9	Ward And Theatre Booking Charges
10	Arthroscopy And Endoscopy Instruments
11	Microscope Cover
12	Surgical Blades, Harmonic scalpel, Shaver
13	Surgical Drill
14	Eye Kit
15	Eye Drape
16	X-Ray Film
17	Boyles Apparatus Charges
18	Cotton
19	Cotton Bandage
20	Surgical Tape
21	Apron
22	Torniquet
23	Ortho bundle, Gynaec Bundle

List IV - Items that are to be subsumed into costs of treatment

S No	Item
1	Admission/Registration Charges
2	Hospitalization For Evaluation/Diagnostic Purpose
3	Urine Container
4	Blood Reservation Charges and Ante Natal Booking Charges
5	Bipap Machine
6	Cpap/Capd Equipment
7	Infusion Pump – Cost
8	Hydrogen Peroxide/Spirit/Disinfectants Etc
9	Nutrition Planning Charges - Dietician Charges - Diet Charges
10	HIV Kit
11	Antiseptic Mouthwash
12	Lozenges
13	Mouth Paint
14	Vaccination Charges
15	Alcohol Swabs
16	Scrub Solution/ Sterillium
17	Glucometer & Strips
18	Urine Bag

Annexure II

General Exclusions

- 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.
- Surgery for correction of eyesight, cost of spectacles, contact lenses, hearing aids.
- Any dental treatment or surgery which is corrective, cosmetic or of aesthetic procedure, filling of cavity, root canal including wear and tear unless arising from disease. Except for injury due to accident and which requires hospitalization for treatment.
- Convalescence, general debility, “run down” condition or rest cure or defects or anomalies, sterility, or assisted conception procedure, venereal diseases, intentional self-injury/suicide, all psychiatric and psychosomatic 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.
- Any cosmetic or plastic surgery except for correction of injury.
- Expenses incurred at hospital or nursing home primarily for evaluation / diagnostic purposes which is not followed by active treatment for the ailment during the hospitalized period.
- Expenses on vitamins and tonics unless forming part of treatment for injury or disease as certified by the attending physician.
- Any treatment arising from or traceable to pregnancy, miscarriage, abortion, or complications of any of these including changes in chronic condition as a result of pregnancy except were covered under the maternity section of benefits.
- Doctor's home visit charges, attendant / nursing charges during pre and post hospitalization period.
- Treatment which is continued before hospitalization and continued even after discharge for an ailment/ disease/ injury different from the one for which hospitalization was necessary.
- Naturopathy treatment, unproven procedure, or treatment, experimental or alternative medicine and related treatment including acupressure, acupuncture, magnetic and such other therapies.
- 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 of any kind, diabetic footwear, glucometer / thermometer, and similar related items and any medical equipment which is subsequently used at home etc.

  Note: Cost of braces will not be covered if cosmetic in nature.
- All non-medical expenses including personal comfort and convenience items or services such as telephone, television, aaya / 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 pathy to other pathy unless being agreed / allowed and recommended by the consultant under whom the treatment is taken.
- Treatment of obesity or condition arising therefrom (including morbid obesity) and any other weight control program, services or supplies etc.
- 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.
- Massages, steam bathing, shirodhara and alike treatment under ayurvedic treatment.
- Any kind of service charges, surcharges, admission fees / registration charges levied by the hospital.
- Outpatient diagnostic, medical or surgical procedures or treatments, non-prescribed drugs and medical supplies, Hormone replacement therapy.
- 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.
- Intentional self-Injury, outpatient treatment.
- Family planning surgeries (Vasectomy or tubectomy).
- 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.
- External and or durable Medical / Non-medical equipment of any kind used for diagnosis and or treatment like prosthetics etc.
- Lasik treatment or any other procedure for correction/enhancement of vision is < +/- 5.
- Any device/instrument/machine that does not become part of the human anatomy/body but would contribute/replace the function of an organ is not covered.
- Warranted those treatments on trial/experimental basis are not covered under scope of the policy.
- Coverage for palliative care and palliative chemotherapy is limited to 50% of the current base sum insured for dependents.
- This policy does not cover expenses incurred on account of domiciliary hospitalization (a situation where medical treatment is administered within the precincts of the patient's residence).
- This policy does not cover any other Outpatient treatment except OPD treatment for children with disability and for Associates with suspected head/skull injury due to accidents.
- This policy also doesn't cover hospitalization for observation/ evaluation/ diagnostic/ investigation procedure and oral medications (except those covered under pre and post hospitalization expenses).
- Medical treatment such as ongoing hormone therapy, voice correction, vocal cord alignment and cosmetic surgery will not be eligible for Coverage.
- Outpatient treatment for gender realignment will not be eligible for Coverage.
- Dependents are not eligible for coverage of gender realignment benefit.
- Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
- Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.
- Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
- Expenses related to sterility and secondary infertility. This includes.
  - Any type of contraception, sterilization
  - Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
  - Gestational Surrogacy
  - Reversal of sterilization
- Treatment taken outside India.

- Change of treatment from one system to another unless recommended by the consultant / hospital under whom the treatment is taken.
- Service charges or any other charges levied by hospital, except registration/admission charges.
- Treatment such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.
- If cap limits are met there is no coverage for pre and post hospitalization expenses.