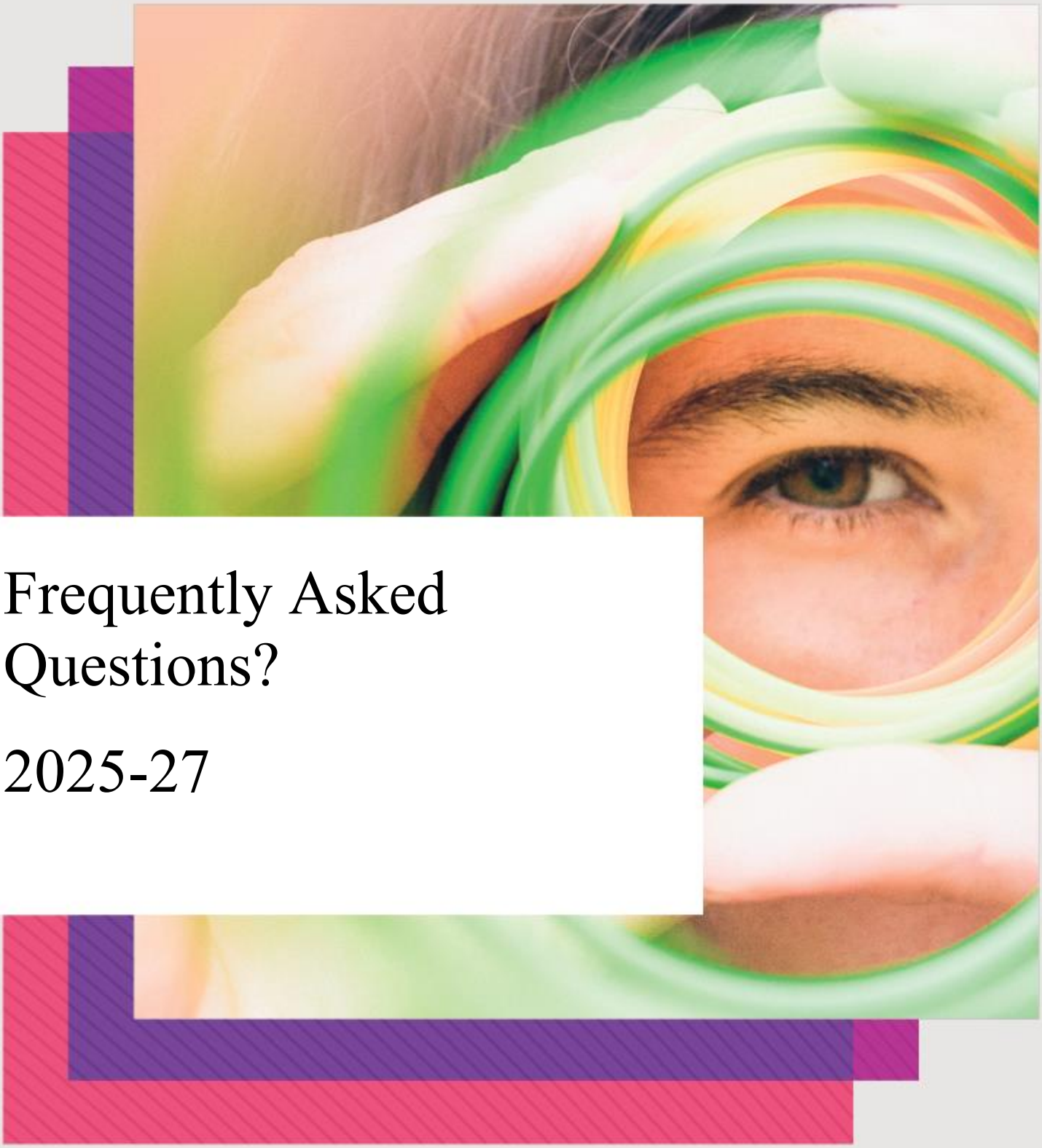

Frequently Asked Questions?

2025-27

General

When does my coverage begin under BT Insurance Benefits?

If you are an existing employee, your coverage will begin on November 8, 2025. If you are a new hire enrolling post November 8, 2025, your coverage will begin from your joining date with BT.

What are the Base benefits?

These are the traditional benefits offered by BT to its employees. In case any employee does not participate in the enrolment process, he/she will stay in the default/core benefit.

Benefit Type			
	Plan Type	**Beneficiaries**	**Sum Insured**
Group Medical Insurance	Default	Employee, Partner Children	600,000
	Core	Employee Only	600,000
Group Personal Accident	Default	Employee Only	3 times of FTE with a minimum of INR 1,500,000 and maximum up to INR 30,000,000
Group Term Life	Default	Employee Only	2.5 times the FTE with a minimum t of INR 20,00,000 and maximum INR 30,000,000

* Core/Default depending on the family definition available in the system.

What changes can I make in my plans once enrolment window is closed?

Once you have made your enrolment choices, you cannot make any changes on your coverage during the plan year.

What happens if I leave BT?

In the event of exit from BT during the year, employee sponsored premium against the chosen medical insurance options will be refunded on pro rata basis only subject to no claims being paid or reported under plans. In case any claim is reported or paid, there will be no prorated refund of the premium.

Please note the will be no refund for voluntary wellness plans.

What do we mean by Portability under Group health insurance policy?

Please find below Portability process and guidelines

Insured should have the option to continue the group Mediclaim policy upon ceasing to be an employee of that organization: We can agree as per below conditions: --

a) Employees who are leaving the organization can take our retail/ individual policy as per the underwriting guideline of standard retail product.
b) Coverages would be same as per our retail product without any change.

c) Continuity benefit will be offered as per portability guideline.
d) The request for portability should be raised 45 days prior to last working day in BT.

What is the policy tenure this year?

This year policy is applicable for 17 months – 8th November 2025 – 31st March 2027.

Important points to note:

- Employees will be selecting the plans for 17 months and enrolment portal will not open again for 2026-27 policy.
- The selected 'Base Sum Insured' will be reinstated on 1st April' 26 for the next 12 months.
- For opted Top up and opted Parental Plans, the Sum Insured will be applicable for 17 months and post 31st March '26, the residual Sum Insured will be passed on to next year. In case Sum Insured is exhausted in first 5 months, No Sum Insured will be applicable to be passed on to next year
- Selected voluntary wellness plans will be applicable for 17 months and employees can utilize the same post leaving BT. No pro rata refund will be applicable.
- Policy number will change, and New e-cards will be issued from 1st April 2026 policy
- Entry & exit clause is applicable this year.

What is the entry exit clause?

- Employee has to cover **both the parents (mother and father) compulsory**, provided they are alive. The insurance company can seek for a death certificate, if only 1 parent is enrolled
- If someone quits a plan, there will be a **cooling off period of 2 policy years** and during this time the employee will not be allowed to enroll again
- The **sum insured cannot be lowered** in the next renewal, only increased.
- Anyone who is opting for enrolment **cannot quit for the next 2 policy years** in case they have taken a **claim** under the policy . In other words, a lock-in period of 2 policy years will apply if an employee makes a claim in the policy
- You cannot **remove/ change/ add dependents** during renewal if already covered in expiring policy unless justified. Under the employee top up plan, the **dependents will be same** as under the employee's base medical plan. In the parent's policy, **one cannot opt for parents in 1 policy year and parents in law in another policy year (and vice versa),** unless this is justified.

Group Medical Insurance

What is group medical insurance?

Group Medical insurance, also known as health insurance, is a contract between a corporate and an insurance company. It provides financial coverage for medical expenses, including hospitalization and day care treatment for employee and their family.

Who is our Insurance Company for Group Medical Policy (GMC)?

ICICI Lombard General Insurance Company Limited

Who is our Third Party Administrator?

ICICI Lombard inhouse TPA

Who is our Advisor on Employee Benefits?

WTW (Willis Towers Watson India Insurance Broker Private Limited).

Why do I need medical insurance?

Medical insurance helps you manage and mitigate the financial burden of healthcare costs. It ensures employee can access necessary medical care without worrying about the high expenses associated with it.

Who can be covered in the medical insurance plan?

- The plan starts with core or default plan of 6 lac Sum Insured. Employees are placed in either the Family definition of Employee only (Core) or Employee, Partner, Children (Default) basis last year employee family selection. For employee, Partner and Children last year family definition will be prepopulated in portal for existing employees.
- Employee has an option to Top up their Sum Insured.
- Employees have an option to Cover Parents or Parent in laws under the plan on voluntary basis.
- In case employee selects employee only plan and gets married during the mid-year. There will be 2 scenarios-
    - In case there are available flex points, the same will be used to change the family definition and add partner. Employee can login to the portal and add him/her under life event.
    - In case there are no flex points that are available, addition of partner will be taken care via payroll. Employee can login to the portal and add him/her under life event.

How much is the value that me and my family are covered?

- BT offers default plan (Employee, Partner, Child) of INR 600,000 per family and Core plan (Employee only) with INR 600,000. Employees opting for Core plan will be eligible to earn Flex points also.
- Further there is an option to enhance the sum Insured by buying Top Up.

Are there any age limits for my dependents to be eligible for BT Insurance Benefits?

- Partner: Partner's age to be greater than 18 years. Partner includes legally wedded spouse, live in partners, same sex partners as per the corporate policy of BT.
- Dependent children: Children between Day 1 and 25 years of age, must be dependent on employee for financial support are eligible. Children may include adopted kids.
- Parents/in-law: Maximum entry age 85 years.

Are OPD expenses covered under the Medical Plan?

OPD plan is available as a separate module and can added to the medical insurance plan. Please note that it is an optional coverage (part of Voluntary Wellness plan). This year BT has extended the facility of ' Discounted OPD' also to all the employees.

What is a pre-existing condition, and how does it impact my coverage?

Pre-existing conditions are health issues employee had before getting their insurance policy. At BT it is covered from day 1.

Are pre-existing diseases covered under the policy?

Yes, pre-existing diseases are covered under the policy.

Is Maternity covered under the policy?

Yes, maternity benefit is covered for Employee/Partner for first 2 deliveries of insured lifespan INR 80,000 for Normal & C-Section. In case of TWINS – INR 95,000 for Normal & C-section

What do you mean by pre- and post-natal expenses? Is it covered in the policy?

Expenses arising before delivery are known as pre-natal expenses and those arising after delivery are known as post- natal expenses. Pre- and Post-natal expenses are covered within the maternity limit for up to INR 5,000 on OPD basis.

Is the Newborn Baby Covered?

Yes, Newborn Baby is covered from day one within the family floater subject to declaration sent to the HR within 30 days from Date of birth of the child. Please register the newborn baby on the Embark under life events or you can reach out to concerned SPOC's.

How do I enroll my new eligible dependents under the policy?

If employee want to enroll new eligible dependents, employee can do so only during the enrolment period through the WTW portal Embark.

In case of life events like marriage or child birth, employee would need to register their dependent within 30 days from the date of event. Employee can either declare the new eligible dependents via embark (click on the life events and update information) or reach out to their HR & WTW SPOC.

Are Dental treatments paid under the Mediclaim Policy?

Default coverage covers dental treatment only in accidental cases that require 24 hours of hospitalization.

What are the General Policy Exclusions operating on all policies in the country?

- Injuries or diseases caused by war and war like operations
- Circumcision, Vaccination, Inoculation, Cosmetic treatment, Plastic surgery
- Cost of Spectacles, Contact Lenses
- Convalescence, General weakness, congenital external, Sterility, Venereal disease, Alcohol use, Self-injury
- Hospitalisation for diagnostic test only and expenses without any disease
- Vitamins and Tonics unrelated to treatment
- Injuries or diseases caused by nuclear weapons
- Abortion during first 12 weeks of pregnancy
- If there is no active line of treatment during the period of hospitalisation
- Any cosmetic treatments, plastic surgery, surgery for change in gender

Which are the other expenses that are excluded apart from those mentioned under general exclusion?

- Registration Fees, Service Charges, File opening fees
- Telephone, Internet charges and other non-medical charges
- Food and refreshments supplied to visitors and attendants
- Television charges
- Any other expenses not related to treatment of illness

Will change in names in between policy period matter?

Yes, according to the Insurance Company the claim will not be settled (unless prior intimation provided to Insurance company) if there is any alteration in the name. It has to be intimated to respective Insurance Co. & requisite endorsement for the change in name needs to be passed by Insurance company. This must be done immediately and not at the time of claim. Employees need to intimate such changes to HR department vide an email, who will in turn intimate the request to the insurance company.

What is covered in domiciliary hospitalisation?

Domiciliary hospitalisation is treatment taken at home. The expenses of the treatment at home gets covered when the duration of the treatment is more than 3 days. Also, hospital must declare that there is unavailability of beds in the hospital, or the patient is immobile. Other T&C has to be followed as per policy guidelines.

Is genetic disorder covered in the main policy?

No genetic disorders are a standard exclusion in the main policy.

Can I add dependent parents / in-laws in between the policy?

No. Midterm addition of parents for existing employees is not allowed in the policy.

Why should I enhance my benefits?

You are the decision maker for you and your family. You know what is best for when it comes to hospitalization requirements, hence it's advisable to make an informed decision and exercise the best possible plan that ensures optimum coverage for you and your family.

What is the eligibility of partner enrolment in the policy?

- Partner includes legally wedded spouse, live in partners, same sex partners as per the corporate policy of BT.
- The enrolment of a partner (other than legally wedded spouse) will be taken against a self-declaration from the employee.
- The partner can be changed only once in a policy period.

How can I add more than 2 children to the medical insurance policy?

There is no limitation on adding number of children under the plan however children should be dependent and age up to 25 years. You need to add these names at the time of enrollment.

What if I have only 1 alive parent, can I cover my parent-in-law? Also, what will the cost be?

No cross combination of parents is not allowed. Also, in case of 1 alive parent, the premium is different. Please refer to the benefit manual for premium details.

What is a network, and how does it affect my coverage?

- Insurance plans often have a cashless network of hospitals. Network Hospitals offer negotiated rates for insurance company and TPA, resulting in lower claim cost for employee. Going to an out-of-network provider may result in higher out-of-pocket expenses.

- For these network hospitals, employee can claim for Cashless, for non-network hospitals employee can file for reimbursement.

What is e-card?

E-cards are generated once the enrollment is completed based on the information provided. These are identity cards accepted at hospital network to avail cashless plans. These will be made available to employees through emailers/Embark. Please use the login credentials shared over the email. It's good to download the mobile application and keep all the information ready for emergencies.
For the new joiners where cards are yet to be issued, for any cashless claim, please connect with the SPOC.

How do I file a claim for medical expenses?

- When employee receive medical services, TPA/insurance company will often handle the insurance claim process for employee. Employee may need to provide their insurance information and pay their copayment or non-payable expenses at the time of cashless claim.
- To access claim form, please reach out to the benefit manual as given on Embark platform or reach out to WTW SPOC's.

What are the basic requirements to avail a claim under Mediclaim?

- The Mediclaim policy stipulates that a claim is admissible when the insured (beneficiary) is admitted in a hospital for a minimum of 24 hours for the treatment of an illness (except in daycare procedures)
- Also, the Hospital has to be a government registered hospital with below conditions:
  A hospital 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 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient 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 authorized personnel.
- There has to be an active line of treatment for taking claim
- The above list is not exhaustive. There could be other conditions as well that needs to be fulfilled before getting admitted (Case to case basis)

What is a "prior authorization or "pre authorization," and when is it required?

Prior authorization/Pre authorization is a process where employees need approval from insurance company before receiving certain medical treatments or procedures. This helps

ensure that the treatment is medically necessary and covered under your policy at the time of Cashless. Please contact SPOC for any discussion on claims/claim related queries.

What happens if I leave my company (resign/retire) and want to continue with my policy?

- Employee may have the option to port their health insurance coverage through PORTABILITY benefit or explore individual health insurance plans. Be sure to understand the options available to you during transitional periods. For portability the intimation should reach insurance team 45 days prior to last day at work.
- The terms & conditions of the portability plan are standard as per IRDAI rules and regulations, please understand them and then make a choice. The rates applicable under portability are based on retail prices and non-negotiable. The product is also as per the retail product of insurance company.
- Final decision of acceptance will be at the discretion of the insurance company.

Do I get refund for the premium charged during exit process (Resign/Retire)?

- In case of no claim, premium can be refunded for the insured benefits in case the benefit premium is deducted from payroll at the time of enrollment. In case it is BT sponsored plan, then no refund will be made to employee.
- For voluntary care plans there will be no refund.

What is reimbursement claim? How can I register pre and post hospitalization claim?

- In case the hospitalisation is availed at non network hospital, employee can submit the claims document along with the claim form online at the ICICI Lombard link. Please ensure that the claim documents are shared within 30 days from the date of discharge on the portal. Please follow the insurance guidebook (Benefit Manual) for checklist and detail procedures.

- Pre 30 days and Post 60 days hospitalization claim can be submitted once the main hospitalization claim is registered. Pre hospitalization claim (example: pathology tests cost, consultation etc.) can be submitted along with the main hospitalization bill. Post hospitalization claim (example: pharmacy, consultation, pathology related to the same hospitalization) can be submitted within 10 days from the last day of the treatment. Please mention the main hospitalization claim number as reference for better processing and settlement

Is the 24 hours hospitalization applicable for all ailments?

Yes, the 24 hours hospitalization is a must. However, this time limit is not applied to specific treatments (referred as day care hospitalization) i.e. Dialysis, Chemotherapy, Radiotherapy, Eye Surgery, Tonsillectomy etc. taken in the Hospital/Nursing Home and the Insured is discharged on the same day. The treatment will be considered under hospitalization Benefit. Please note that these treatments will have to be necessarily availed as an inpatient only.

Will I receive confirmation of my benefits elections once I have enrolled?

Yes, employee will receive a confirmation mail through the system however they need to download their selection by visiting Embark. In case the mail is not received please write to BT@wtwco.com

What changes can I make in my plans once open enrolment has ended?

Once employee have made their enrolment choices, employee must remain within that plan for the rest of the plan year. In case of qualified life events like marriage, childbirth etc. employee would have to update the details of the new member on Embark within 30 days of the event.

Can I make multiple changes to my selection while the window is open?

Yes, employee can make multiple changes and the final selection before the close of window will be considered as their plan for rest of the year.

What happens if I don't complete my enrolment by the deadline?

If you do not enrol for benefits during annual enrolment, you will be automatically enrolled in the default/core level for each benefit (basis last year selection). Employees who do not make any changes in parents during enrolment timeline, the cover for parents will be removed. You will not be able to make any changes to these elections during the plan year unless you experience an eligible life event change.

If you are a new hire and you do not complete enrolment within your initial enrolment period (two weeks from your date of joining), you will be enrolled in the Core plan only.

What expenses are payable by the policy?

Expenses such as –

- Room & Boarding and ICU – Single private AC room & ICU charges on actual basis, however
  highest category is single AC private room. Room should not be classified as deluxe/ suite/executive etc. In case, any employee opts for a higher category room (deluxe/suite/executive), pro rata deduction will be done **NOTE:** The Room rent capping will be applicable on the enhanced Mediclaim benefit also.
- Doctor Fees, Nursing Expenses, Consultant Specialist Fees
- Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines, Drugs,
  Diagnostic Materials & X-ray etc.
- Ambulance charges (INR 2,500 per hospitalisation claim) where the patient has to be shifted from residence to hospital in case of admission in emergency ward/I.C.U. or from one hospital/nursing home to another home for better medical facilities. These expenses are payable only when registered
  ambulance is used.

How long does it take for reimbursement claims to be settled?

The claim settlement should take place within 10-15 days if the required documents are made available. If there are any documents missing and you have been requested to furnish the same, then it may result in extended days for the settlement.

Please do keep watch on emails for any follow-up questions that insurance team may share with you. You can also check for the claim status on Embark portal or mobile application. You can as well contact the helpdesk team at your location or reach out to the escalation matrix.

Are medical expenses prescribed after discharge (pre & post-hospitalization expenses) payable?

Relevant medical expenses incurred during period up to 30 days prior to hospitalization, and the relevant medical expenses incurred up to 60 days post discharge from hospitalization is payable.

How can employee avail Health Check-up provided by BT?

Health check-up process is available on Embark portal, please do note the health check-up cost is borne by BT and this option is available only for employees on cashless basis.

If you are an employee of BT you can login to the Medibuddy portal/app with your official email id and can avail this service only once during the policy period.

What are the limitations for cataract treatment?

- No capping on Lens for Cataract claims (all type of lenses to be covered). Maximum amount – INR 80,000 per eye
- Reasonable & Customary clause will be applicable.

What are the limitations for Ayush treatment?

- What is the coverage amount/capping: Ayush treatment is restricted to 25% of sum insured.
- How can this benefit be claimed: This can be claimed as per regular claim. 24 hr admission is mandatory. OPD, day care and pre-post hospitalization is not covered. Hospital should be a government Hospital or in any
  Institute recognized by government and/or accredited by Quality Council of India / Nation al Accreditation Board on Health, excluding
  centers for spas, massage and health rejuvenation procedures.
- Exclusions- Comfort treatments involving steam bath/sauna/oil massages are excluded. Such treatments being combined with any stay packages at resorts where the treatment forms a part of an overall leisure package shall not be covered under the insurance policy.

Are there any exclusions in Medical Insurance?

Exclusions may vary depending on the policy, but common exclusions include self-inflicted injuries, injuries resulting from drug or alcohol use, injuries from engaging in illegal activities etc. please refer the benefit manual for detailed list of standard exclusions list.

Where can look for detailed information on my benefits?

You can refer to the Benefits Manual available on Embark.

Where can I look for checklist, claim forms or any other document required for claim submission?

You can refer to the Benefits Manual available on Embark.

Can my family use the telehealth facility?

Yes, Telehealth facility is for all employees. Process to avail the same is available on Embark.

What should I do if I have questions or need assistance with my medical insurance?

If you have questions about your policy or need assistance, reach out to helpdesk or write to bt@wtwco.com.

Frequently Asked Questions

Flex Plan

What is flexible benefit insurance?

Flexible benefit insurance typically refers to a type of employee benefits program that allows employees to choose from a menu of benefits.

What is Flexi health insurance Plan?

BT Group Flexi health insurance Plan gives you greater flexibility and choice, by providing you the freedom to design your personal benefits package with your unique needs in mind.

They're your benefits and choose your benefits with confidence!

As an existing or new employee with the Company, you are immediately entitled to a standard benefits package (core coverage or default coverage) which includes insurance coverage under Medical, Personal Accident and Term life.

Core Benefits include:

▪ Group Medical Insurance – Cover Employee only for a sum insured of INR 600,000 / Employee, Partner & Children for INR 600,000 (default)*

▪ Group Personal Accident Insurance – 3 times of FTE with a minimum of INR 1,500,000 and maximum up to INR 30,000,000

▪ Group Term Life – 2.5 times the FTE with a minimum of INR 20,00,000 and maximum INR 30,000,000

*Employee will be placed in core or default basis the family selection last year
Over and above each employee will receive flex points basis the selection made in level 1 (base plan).

Employee can choose how to spend those Flex points to purchase Optional benefits.

Optional Benefits include:

▪ Medical Insurance –
- Option to buy top up policy for Self, partner, children, (If included under the plan). Sum insured ranging from 2 lac / 4 lac / 6 lac / 8 lac / 10 lac / 15 lac/50 lacs / 1 cr.
- Option to buy voluntary parent/parent in law policy.
- Voluntary Wellness plans

Employee/Employee Partner Child				
Plan Features	**Downgrade Options**			**Default Plan**
	Option 1	**Option 2**	**Option 3 – Core plan**	**Option 4 - Default**
Eligibility	Employee Only	E,PA and Ch	Employee Only	E,PA and Ch
Sum Insured	400,000	400,000	600,000	600,000
Additional Sum Insured Options (Employee Paid)				
Additional Family Sum Insured Top-up	2 lac / 4 lac / 6 lac / 8 lac / 10 lac / 15 lac + 50 Lac & 1 Cr			
Family Definition	Employee/Employee, Partner & Child			
Separate Parent Policy				
1st Level Selection	Single Parent / Double Parent			
2nd Level Selection	5Lac/ 10 Lac			
3rd Selection	10% or 20% or 30%			
Complimentary Benefit	Additional Ambulance of INR 1000 for Parents Basic Home Sample collection			

What are flex points?

- The points allocated Basis the plan selected.
- 1 flex point = INR 1
- You can avail these points to make your choice for insurance purchase for enhanced medical Sum insured, change in family definition, opting for parent policy, opting for voluntary plans or opting for Critical Illness coverage under Group Term life.
- These points will lapse once the enrollment window is closed for opting any voluntary plans.

How will I enroll under Flexi health insurance program?

You can enroll into the BT Group Flexi health insurance program by logging on to the Embark when enrollment window is live.

What should I do if I have positive balance flex points?

You can avail these points to make your choice for insurance purchase for enhanced medical Sum insured (Top up), opting for voluntary parent policy, opting for voluntary plans or opting for Critical Illness coverage under Group Term life. Please note these flex points can only be used at the time of enrollment and will lapse post enrollment closure.

How can I enhance my options if I have negative balance flex points?

You can enhance the options, the premium for the upscaled option would be deducted from your salary.

How is the premium collected for the higher plans?

The premium calculation based on your choices would be visible on the enrollment portal. The premium for selected benefit would be deducted from your salary or from flex points (in case available).

How can I avail the voluntary wellness packages?

Please visit embark for detailed write up on each plan.

Can I take voluntary package for noninsured dependents also?

No, in case an employee has not declared and added the dependents under the plan, the voluntary wellness packages cannot be taken for them.

Can I continue with Voluntary Wellness plans after leaving BT?

Yes, you may continue the subscription for selected voluntary wellness plan after leaving BT.

In case I do not participate in enrollment, can I use flex points in the mid-year for enhancing or opting for voluntary wellness plans?

No, flex points will lapse post enrollment window is closed for opting any voluntary plans.

Remember that this FAQ is a general guide, and the specifics of insurance policy may vary. Final Terms and conditions written in the policy document will be considered and stand valid in case of any discrepancy. Always refer to Benefit Manual and contact HR team in case of any grievances.