Optum

Group Medical Insurance Policy

2024-2025

Frequently Asked Questions (FAQs)

Optum

Section A – General policy & enrolment related questions

Q. Who is the insurer and what is the coverage period for the current insurance policy?

A. The insurer is The New India Assurance Co. Ltd. The coverage period for the current insurance period is from September 23, 2024 to September 22, 2025.

Q. What is a TPA and what are its broad functions?

A. Third party Assistance (TPA) is a vendor who processes claims on behalf of insurer for the insurance policies. Paramount Health will be the TPA service provider for policy period 23rd Sep'24 to 22nd Sep'25.

Q. What is the base coverage and family definition of Medical Insurance Policy?

A. Unmarried / Single employees are covered along with enrolled parents for sum insured of INR 3,50,000 and sub-limit of INR 100,000 for each enrolled parent. Married employees are covered along with enrolled Spouse /Partner + Children + Parents for sum insured of INR 5,00,000 and sub-limit of INR 100,000 for each enrolled parent/parent-in-law

Family Definition in policy – Employee (E) + Spouse or domestic partner (S) + Child/ren (C) and Parents (P) or Parents in law.

Q. How many children can be enrolled?

A. There is no restriction on the number of children as long as the total number of dependents is 5.

Example: If you have not enrolled spouse and parents then you can enrol 5 children. If you have enrolled spouse and 2 parents, then only 2 children can be enrolled.

1. Children up to 25 years are covered in policy. In case children above 25 are enrolled, claim will not be processed for them.
2. There is no age limit to cover children with mental health impairments or special abilities.

Q. What is the sum insured available for parents/parents-in-law in the base plan?

A. Only 2 parents can be enrolled in base policy. You can either enrol your parents or parents-in-law. The sum insured sublimit is INR 100,000 per parent.

Q. What do we mean by the domestic partner or live in partner?

A. Domestic partners may include same sex partners or live-in partners. Once declared, employee will not be able to change the name of partner for that particular year in policy, however, they should notify withdrawal in case of termination of the relationship.

Definition of Domestic Partner /Live in partner includes:

- Meets a minimum age criterion of 18 years or older
- Does not have any blood relation with employee

Q. Can we select any of the parents /parents in law?

A. You will be able to select only 1 set of parents to be enrolled in the base policy.

For example: If you have added your father in the policy, you can only add your mother or if you add your father-in-law, then you can only add your mother-in-law. A combination of 1 parent and 1 parent-in-law is not allowed.

Q. Will there be a lock in period for the selection on parents/ parents-in-law?

A. Yes, there is a lock in period of 3 years for enrolling parental dependents in base policy. For example: if during renewal you have enrolled your father and mother, then you can enrol father-in-law and mother-in-law after completing 3 policy periods.

Q. Will the lock in period be waived off in case of any circumstances?

A. In case of an unfortunate event of death of parents/parents-in-law, the lock in period will be waived off in the next policy period as a one-time option and cross selection will still not be allowed.

For example: if you had enrolled your mother and father during renewal and mother passes away. In the next renewal, you can either continue to enrol your father or you can remove your father as dependent to enrol mother-in-law and father-in-law. You cannot enrol father with any parent-in-law.

Please reach out to groupinsurance@marsh.com in case of such a scenario as the enrolment portal will not allow change in dependents for the duration of lock in period.

Q. How do I access my insurance benefit portal?

A. You can login to the insurance benefit by clicking on this link –Paramount Insurance TPA

Q. How will claims be managed during renewal? (Only for India based OHT – erstwhile Episource team members)

A. In case you are filling a claim with date of admission on or before Sept. 22, 2024, it will fall under policy year 2023-2024 and will be processed by Howden TPA. If there is any admission /reimbursement on or after Sept. 23, 2024, the claim will be processed by the new TPA partner-Paramount health services. (Please see the table below)

Q. How will claims be managed during renewal? (Only for India based team members, except Episource. Episource team members please see the question above)

A. In case you are filling a claim with date of admission on or before Sept. 22, 2024, it will fall under policy year 2023-2024. If there is any admission /reimbursement on or after Sept. 23, 2024. Both claims will be processed by the TPA partner-Paramount health services. (Please see the table below)

Entity	On or before Sept. 22, 2024	On or after Sept. 23, 2024
All entities except erstwhile Episource	Processed under expiring policy 2023-24 by Paramount TPA	Processed under new policy 2024-25 by Paramount TPA
Erstwhile Episource	Processed under expiring policy 2023-24 by Howden TPA	Processed under new policy 2024-25 by Paramount TPA

Q. How do I update my marital status on the portal in order to add the dependents?

A. In order to add the dependents in the medical insurance portal post marriage, you need to first update your marital status on the GSS by following the below steps:

- Login to Global Self Service (GSS) with your MS ID and password
- Click on self service
- Click on personal information
- Click on marital status
- Update your marital status from single to married on GSS

In case the changes are not reflecting on the paramount portal in the next 10 working days, please reach out to optum.mediclaim@paramounttpa.com.

Q. How to remove dependents from the policy after their demise?

A. Employee can write to optum.mediclaim@paramounttpa.com about the same & get the changes updated.

Q. What is the process for discontinuing corporate coverage?

A. All Optum employees are eligible for benefits in base policy, where cost of program is completely absorbed by Optum but in case employee doesn't want to continue, they can raise a ticket on Employee Centre.

Q. What are the documents required for the enrolment of domestic partner or live-in partner to the base plan?

A. Employee needs to submit a proof of co-habitation, some examples are given below:

1. Rent Agreement having the name of the employee along with the domestic partners or live-in partners

2. Joint bank account records having the name of the employee along with the domestic partners or live-in partners

Process for reaching out to Employee Centre:

- Employee who wishes to cover his / her same-gender domestic partners or live-in partners would need to submit a request to Employee Centre though call / online request (add a case)
- Employee to share a necessary proof of co-habitation with the Employee Centre

Employee Centre to share the same with pending_documentation@uhc.com for personal filing.

Process for HR Operations:

- HR operations team to keep the document in the personal file of the employee.

Q. Can I cover my spouse, child, live in or domestic partner in the middle of the year?

A. Existing dependents of an employee need to be added by the employee (on the Paramount portal) during the policy renewal or within 30 days of the date of joining (if employee is a new joiner). If there is a life event like marriage or birth of child, the employee can add dependent spouse/child on the TPA portal within 30 days of date of marriage or date of birth whichever is applicable by writing to optum.mediclaim@paramounttpa.com.

For domestic partner or live in partners, the employee will be able to enrol them during the open enrolment window or within the 30 days of the date of joining (if employee is a new joiner). Any additions in the middle of the year will not be allowed because it is outside the policy terms and conditions.

Q. I am on Maternity leave, any other long leave or short term assignment, interlude leave. How do I go about my enrolment process since I am not available in office during the month of enrolment?

A. In case you are on maternity leave, long leave of absence, then selections from last year will continue. In case you want to add, increase or decrease a top-up plan, please reach out to Manoj.Kumar03@marsh.com. He will share the template to fill in required details and the email to Manoj will be considered as confirmation from your end to edit enrolment details. Premium deduction in case of top-up selection will happen as per regular guidelines for team member on maternity leave. For team members on interlude leave premium deduction will happen post their return to work.

Q. How will employees on long term assignment get recovery of the premium paid by the employee?

A. In case employee has opted for a voluntary top up plan at the start of policy period, it will continue for that policy period. Employee will only be able to recover premium on pro rata basis in case he/she is on long term assignment outside of India or moving out of organization & no claim has been registered during policy period for which premium has been paid.

Q. I have lost one or more of my dependents in the last enrolment period, how do I remove them from the plan.

A. Please note that during the open enrolment period, if you want to remove any of your dependents from the plan, please do so on the TPA portal. If you do not make the required changes in your plan, the same will continue to the next year as well. The top ups if any will also be carried forward and deduction of premiums from your monthly payroll will also be initiated. Once carried forward, no changes can be made till the next enrolment window. In case there is any unfortunate loss of a member during the tenure of the policy, please intimate the same by raising a query on TPA portal. Also mention the reason for removing the dependents.

Q. Can I enrol my siblings to the plan?

A. Please note that as per the current coverage of the policy, siblings are not included in the policy.

Q. How do I get an e-card for self and my dependents? Does this card guarantee pre-approval for cashless?

A. To print e-cards for self and nominated dependents:

Step 1: Click on the **Insurance Benefit Portal** **> Beneficiary Details & E-card**

Step 2: Select a member to print your ID CARD under “E-cards” section

E-cards will be generated and uploaded on the portal in the 1st week of November.

In case of an emergency hospitalisation between renewal period and availability of E-cards, team members can reach out to Optum.mediclaim@paramounttpa.com @ 022- 66629826 for the E-cards.

E- card is a form of identification only and is used to confirm your insurance cover under a certain insurance provider. It does not guarantee cashless claim. To avail a cashless claim pre-authorization process has to be completed.

Q What is a network hospital? Where do I find a list of network hospitals and their contact numbers from the portal?

A. Network hospitals are those hospitals which are on the panel of our Insurer & TPA. Employees can avail cashless services in these hospitals. Employee can visit portal or use below link to know more details about network hospitals.

Step 1: Click on the **Insurance Benefit Portal** **> Hospital Network**

Q. What if I am unable to visit the portal and confirm my selection?

A. In case you are not able to confirm your selections during enrolment window, selections of dependents and top up plan from the previous year will be carried forward.

Section B – Voluntary Top Up Plans

Q. Who all can be covered under the various voluntary plans?

A. Optum policy offers three kinds of voluntary plans to enhance coverage. These are completely Voluntary plans and premium must be borne by employee in three equal instalments deducted through monthly payroll/ salary deductions. All plans are ranging from INR 200,000 – INR 2,000,0000. The 3 types of plans are:

ESC Top Up Plans: There are 4 types of ESC top-up plans. By opting this plan, employee can enhance coverage for themselves, Children & Spouse up to Sum insured of your choice. All top-up options below have plans ranging from INR 2L – INR 20L and increase the sum insured. Each option comes with it's own unique additional benefit.

1) **Classic top-up -**
   Additional benefits – Additional critical illness cover, increased maternity sublimit and pre and post-natal sublimits.

   Example: You have planned for a child in the upcoming months. The current base policy provides INR 75,000 for maternity. You also know that to be able to conceive you'll require rounds of IVF that have a higher cost. In such a scenario it's better to opt for a classic top-up plan that can enhance not only your sum insured but also raise the maternity (IVF) sublimit to cover all costs.

2) **Advanced top-up**
   Additional benefits – Additional critical illness cover, increased maternity sublimit and pre and post-natal sublimit. This top up also provides an OPD cover.

   Example: You have young children who often fall sick due to flu, cold & cough, tummy ache, etc. that require frequent visits to your consulting physician. In such a scenario Advanced top-up that provides OPD cover will be the most beneficial for you.

3) **Critical illness top-up**
   Additional benefit – Extra sum insured in case of a named critical illness.

   Example: You or a dependent is suffering from a critical illness like cancer, heart disease, etc. requiring an expensive surgery. In such a scenario the critical illness top-up will not only increase your sum insured but also provide extra coverage for said illness.

   Base sum insured; INR 500,000

   Critical illness top-up: INR 200,000 (with additional INR 100,000 for named critical illness)

   Final sum insured in case of named critical illness: INR 500,000 + INR 200,000 + INR 100,000 = **INR 800,000**

   Final sum insured for any other treatment: INR 500,000 + INR 200,000 = **INR 700,000**

4) **ESC top-up with co-pay buy back**
   Additional benefit – Removal of copay from all claims.

   Example: You have recurring medical expenses that are covered by insurance

   Base sum insured = INR 500,000

   Copay buyback top-up = INR 200,000 (for a premium amount of INR 25000)

   Total Sum insured = **INR 700,000**

   Treatment cost = **INR 700,000**

   Copay amount (@10% of treatment cost) = INR 70,000

   Since you selected a copay buyback top-up, copay is removed from the entire claim. You paid a premium of INR 25,000 and essentially saved INR 45,000.

***All numbers are hypothetical and used for illustration purposes only.*

Parents or Parents in law Top Up Plan: This plan can be opted **for parents/ parents-in-law enrolled in base policy** on Individual basis. This enhances the overall coverage in terms of sum insured. For example, your base plan has a sublimit of 100,000 for each parent & you feel the need for higher sum insured for your father then you can opt for INR 600,000 of top-up sum insured. In this scenario, your father will be eligible to use INR 100,000 from base policy + INR 600,000 of sum insured from top up plan.

Additional voluntary policy for parents/ parents-in-law: This is a medical insurance coverage for the set of parents/ parents-in-law **who are not enrolled** in the base policy on individual basis.

For example, you enrolled your mother and father in the base policy but do not want to leave your mother-in-law and father-in-law out of insurance coverage, so you can opt for this voluntary plan separately for mother-in-law and father-in-law.

Q. Is parental top-up cover a family floater?

A. No. The additional voluntary policy for parents/ parents-in-law is not floater. You will have to select the sum insured separately for each enrolled parent.

Q. In both ESC top Up & parental Top Up plans, will the terms and conditions of the policy remain same as base policy?

A. The top up policies have the same terms and conditions as the base policy. Top up selection will be allowed only during the open enrolment period. For existing members, it would be start of policy year & for new joiners, it would be within 30 days of their joining date.

Q. What are the instalment schedules for the premium payments for Top up?

A. Premium for Top up plans will be deducted in three equal instalments from employee's monthly payroll/ salary.

Q. What is the process to get a refund in case you have not availed a top up plan?

A. Once opted, employee can't opt out of the policy for that particular policy year. Refund will only be made in case employee is leaving the organization or in unfortunate event of death. Refund will happen on pro rata basis w.e.f date of separation from the organization subjected to the fact that there has been no claim made in the policy. If any claim has been made, then refund is not applicable.

Section C – Policy terms & Conditions

Q. Is there any waiting period applicable for ailments under the corporate policy?

A. Corporate policy doesn't have waiting period. Employee can start using policy for treatment from day 1 subject to inclusion of ailment under group policy terms & conditions.

Q. What is the time period for Pre and Post hospitalization expenses?

A. Employees can file pre & post hospitalization expenses for 60 days & 90 days from date of Admission & Date of discharge respectively.

Q. Why is there a concept of co-pay in our corporate policy and how is the co-pay % divided among employer and employee?

A. Co pay is the amount/share of the claimed amount that employee has to bear out of pocket and it helps insurance company to drive governance and discipline in benefit utilization. It is important as employees are also required to take ownership of their total health expenses to a certain extent. This hygiene factor leads to more prudent use of benefits. Our base policy has following co pay percentage applicable:

- ESC claims – 10% copay on all claims
- Maternity claim - 10% on sublimit of INR 75K
- Parental claims – 20% copay on all claims
- Cochlear implants – 50% on the implant cost and 10% on surgical cost
- Cyber knife treatment – 50% copay

Same copay percentages will be applicable on parental top-up claims and ESC top-up claims (except where you have opted for an ESC copay buyback top-up)

Q. Where should the claim be intimated/submitted, the Insurance company or Insurance TPA Paramount?

A. Claim needs to be submitted with Paramount who is our Insurance TPA & processes claims on behalf of Insurer. Employee can login into Paramount portal Paramount TPA & click on Claim Submission tab to proceed

Q. What is the claim process for Cashless (both planned and emergency)?

A. In case of emergency, employee can visit hospital in network & show e-card of claimant. Hospital will send the treatment details to TPA & if same falls under policy terms & conditions, initial approval will be provided. Final approval will be provided by TPA at the time of discharge once hospital will send complete details and final bill.

In case of a planned hospitalisation, inform the TPA 48 hours in advance and in case of an emergency hospitalisation, inform the TPA as soon as possible.

Q. If I avail the cashless facility, will the insurance company pay the entire bill at the hospital?

A. Insurance company will settle amount basis policy terms & conditions of Optum. There can be some amount which employee has to pay for out of pocket for example copay & non payable items, balance amount exceeding sublimit and sum insured limit.

Q. How to process an OPD claim?

A. OPD can be claimed on TPA portal. OPD benefit is only applicable to employees who have opted for Advanced ESC top-up plans and is covered within network hospitals only.

Q. Is it mandatory to submit a hard copy for claims?

A. Yes. Hard copy of all claim documents is to be submitted as and when mail from Insurer comes in for the same. Processing of claim will not stop because of this but hard copy is mandated & insurer has right to ask for the same anytime for audit and validation.

Q. Is there a minimum time limit for stay within the hospital under the health insurance plan?

A. Insurance plan requires minimum of 24 hrs of hospitalization with an active line of treatment. Hospitalisation for observation purposes is not covered by the insurance policy. There are few procedures which can be considered without 24 hours of hospitalisation. Please reach out to TPA for details of daycare procedures.

Q. Are all the diagnostic tests prescribed by the doctor at a hospital reimbursed under the Health Insurance Plan?

A. No, not all tests can be reimbursed. Additionally, tests can only be reimbursed if one has opted for OPD plans. It is advisable to reach out to TPA with treatment/consultation papers to review coverage.

Q. If I do not get admitted in a network hospital, am I still eligible to claim the expenses?

A. Yes, one can file for reimbursement by accessing the paramount portal.

Q. Can I opt for the reimbursement process in a Network hospital?

A. Yes, you can file for reimbursement claim even at a network hospital but it's not advisable to do so because opting for reimbursement at a network hospital renders the pre-negotiated tariffs cancelled and the discounts offered to the TPA are then borne by employees that appear as "MOU discount" in the settlement letter from the TPA.

For example: If you underwent a treatment at a network hospital the cost for which is INR 100,000 in case of cashless claim, then the same treatment might be INR 150,000 under reimbursement process, and you'll be reimbursed only 100,000 by the TPA. The settlement letter might show INR 50,000 as MOU discount to be borne by you.

Q. If I have not utilized my permissible eligibility amount in a particular policy period, will it get carried forward to the next policy period?

A. No, unutilized sum insured will not be carried forward to next year. With start of every policy period sum insured is reset to original base amount – INR 500,000 for married employees and INR 350,000 for unmarried employees.

Q. What are "Non-Admissible Expenses / Non-Payable Expenses"?

A. Please refer to Non-Admissible Expenses / Non-Payable Expenses list in the additional documents section of the Group Medical Insurance Policy (2024-25) SPARQ page.

Q. What are the list of documents that are required to be submitted to Paramount for a reimbursement claim?

A. Please refer to Claim check list in the additional documents of the Group Medical Insurance Policy – (2024-25) SPARQ page.

Q. What happens when the limit of insurance is exhausted under the group medical insurance policy?

A. Post exhaustion of complete sum insured from Base + Top Up plans (if opted), employee will have to bear the balance cost of treatment /hospitalization.

Q If a claim has been paid for a particular ailment during the policy period, does it become a pre-existing disease for the next policy term?

A. No, claim will be processed irrespective of utilization for treatment in any policy year.

Q. What are the scenarios when claim can be rejected?

A. There are various scenarios as mentioned below

- If claim filled doesn't fall under policy terms & conditions
- If claim belongs to a dependent who is not enrolled in the policy
- If claim pertains to date prior to date of commencement of date of joining in organization
- If claim is found to be fraudulent in nature
- If deficiencies raised by the TPA are not fulfilled either by employee or hospital

Q. What is Deficiency/Query Letter?

A. Deficiency /Query letter is a document shared by TPA with you via email/phone post you file your claim for reimbursement. This mainly informs you about other documents required from you to submit to process the claim.

Q. How many IVF & IUI treatments employee can be claimed in one year?

A. This treatment is a cycle of injections followed with a procedure. The employee can claim for expenses only after the procedure (IVF & IUI) is done, the claim is inadmissible if submitted prior to the procedure. For further queries please contact customer service of Paramount team. There is no limit to the number of claims but the sublimit is up to sum insured for maternity which is INR 75,000.

Q. What if employee claims IVF & IUI in one year and very next year claims for maternity benefit can she avail claim coverage in consecutive years?

A. The employee will get the benefit in both the policy years under maternity sum insured limit because limit is reinstated at the start of policy period.

Q. Is Covid treatment covered under the policy?

A. Yes, Covid treatment as in-patient hospitalization is covered under the policy.

Q. What are the scenarios when cover will get terminated?

A. Cover will get terminated when employee leaves the organization/transferred to another country

Q. What are the important contact details with regards to the medical insurance?

A. Employee can contact below escalation matrix.

ESCALATION MATRIX			
Level of Escalation	**SPOC Location**	**SPOC Email id**	**SPOC email id/Contact no.**

Level 1	All India	Optum.mediclaim@paramounttpa.com	022-66629826
Level 2	Delhi/NCR	Vimla Gupta	8655852701
(Regional SPOC)	Bangalore	Shrinidhi Mokashi	8655852704
	Hyderabad	Hari Vanaparthi	8655852712
	Hyderabad	Arun Kumar Parlapalli	8655852703
	Chennai	Chandramouli R	8655852705
	Pune	Ajinkya	7028942545
	Vijayawada	Arun Kumar Parlapalli	8655852703
	Coimbatore	Karthik	9840448590
	Mumbai	Sandeep Ugvekar	7400406822
Level 3	Central SPOC	Hema Rawat	8655852711
Level 4	Central SPOC	Prasoon K. Jha	8655852706
	Central SPOC	Ashutosh Tiwari	8450960811

Section D – Group Personal & Term life policy

Q. When does GPA & GTL policies gets triggered?

A. Group Personal Accident policy gets triggered in scenario where an employee meets with an accident and as a result is unable to continue working on short term or permanent basis or in unfortunate event of death due to an accident. Sum insured differs for settlement depending on accident case details reviewed by insurer.

Group Term Life policy gets triggered in the unfortunate event of an employee's death due to any reason.

In case of death due to an accident both the policies will get triggered.

Q. What is the eligibility criterion of both GPA & GTL policies?

A. All employees are eligible to be part of these policies & cost of premium is borne by organization. Employees are covered for Sum Assured of 3 times of fixed pay or min of INR 3,000,000 whichever is higher.

Q. Why is it important to add my nominees?

A. It is important to declare nominees to ensure that in the unfortunate event of death, insurance company will pay out the claim to the nominee selected by you. The amount will go unclaimed, and your family will not receive any benefit if no nominee is selected.

Q. What is the % allocation for nominees?

A. You can declare multiple nominees separately for both GPA & GTL policies by allocating percentage share against each of the nominee. Maximum number of nominees can be 5. The percentage allocated to each nominee should add up to 100% for each policy.

Q. How do I add/change my nominee?

A. You can visit TPA portal and under the online enrolment tab, you can update the nominees in the last section called Nominee Details.

Q. What is the process for declaring the legal guardianship for a minor?

A. Legal guardian's details can be added on the nominee page of the portal and the same will be considered in case of claim settlement to a minor.

Section E – Portability

Portability Policy

Q. What is Policy portability?

A. Portability is a benefit which allows you to transfer the number of years of continuous coverage from group insurance to retail health insurance with waiver on time bound waiting periods. With this benefit, it helps in reducing the waiting period so that the policy can be utilized immediately. This option is available only for exiting, retiring employees or employee who are undergoing payroll transfer from one country to another in Optum. Our Broker, Marsh India has a tie up with retail insurance companies to extend continuous coverage benefit for the employees and/or their dependents. The premium rates of the corporate policy will be different from rates of the policy that is undergoing the portability option. The dependents who are enrolled to the corporate policy will be ported to the policy under the portability clause. No other new dependent additions are not possible.

Q. What is the process to port the corporate policy?

A. Employees need to reach out to groupinsurance@marsh.com 30 days prior to their date of leaving / transfer/retirement. Post providing basic details, Marsh team will share premium details. Once employees choose the plan & make a payment, policy will be issued.

Q. What are the various touch points during portability of policy?

A. Employee can reach out to groupinsurance@marsh.com

Q. What are the changes you could expect if your policy is ported?

A. Employee will no longer be part of corporate policy instead have retail policy. All policy terms & conditions would be applicable as per retail policy.

Section F – Medical insurance policy inclusions and exclusions

<table>
<tr><td>Room Rent Limit</td><td>No amount capping on room rent. Category of room applies as listed below.
Normal Room – Single standard AC
ICU Room – As per actuals

In case employee is opting for higher category of room, proportionate charges of treatment would be applicable. Example: Within a suite room, the charges of doctor consultation, nurse services, etc. are higher than single standard room.
Single standard room – INR 2000 per night (doctor consultation charge – INR 1500 per visit)
Suite Room – INR 10,000 per night (doctor consultation charge – INR 3000 per visit)

In case employee opts for the suite room, claim will be processed basis the charges related to Single Standard AC room. (All numbers in the example are for illustration only).</td></tr>
<tr><td>Ambulance Charges</td><td>Limited to INR 10,000 Per family per policy period</td></tr>
<tr><td>Maternity</td><td><table><tr><td>Category</td><td>Sum insured (Sublimit)</td><td>Co-pay</td><td>Coverage details</td></tr><tr><td>Normal/ Caesarean</td><td>INR 75,000</td><td>10%</td><td>Maternity event covered for first 2 living children</td></tr></table>
Life threatening situations will be covered over and above the maternity limit up to the remaining balance of sum insured.</td></tr>
<tr><td>Baby/ Child Cover</td><td>Baby cover from day 1 for illness and treatment of child up to available sum insured.</td></tr>
<tr><td>Pre and Post Natal</td><td>Covered up to INR 5,000 within the maternity limit on both OPD as well IPD (This can only be claimed once main procedure is done)</td></tr>
<tr><td>Infertility Treatment</td><td>Infertility treatment is covered up to maternity limit. All expenses related to IVF like ICSI (Intracytoplasmic sperm injection), ZIFT (Zygote intrafallopian transfer), GIFT (Gamete intrafallopian transfer) Ovum pickup, Egg fertilization, Embryo transfer are covered on day care or IPD (hospitalization) basis. All investigation done for the diagnosis of Infertility will be covered on pre-post basis of main Infertility claim covered within maternity limit.
Exclusion: Embryo freezing will not be covered as it is not a part of IVF treatment.
Co-pay as per maternity applicable in IVF cases</td></tr>
<tr><td>Internal Congenital diseases</td><td>Covered
Examples: Absence and agenesis of lacrimal apparatus, Absence of Eustachian tube, Absence of iris, Accessory kidney, etc.</td></tr>
<tr><td>External congenital diseases</td><td>As per policy congenital external diseases are covered only when it is life threatening.
Some exclusions are: Cleft Lip & Palate, club foot (CTEV), Spina Bifida, Congenital Umbilical Hernia</td></tr>
<tr><td>Day Care</td><td>Defined day care procedures are covered that have an active line of treatment.
Day care procedure list</td></tr>
<tr><td>Ayurveda treatments</td><td>Expenses incurred for Ayurveda / Homeopathic / Unani Treatment are admissible up to 25% of the sum insured provided the treatment for Illness and accidental injuries, is taken in at NABH accredited/ govt. authorized AYUSH Hospitals, on IPD basis (i.e., hospitalization).</td></tr>
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<table>
<tr><td>Psychiatric treatment</td><td>In-hospitalization treatment is covered.</td></tr>
<tr><td rowspan="4">Special Coverage</td><td>Cyber knife treatment /Stem cell transplant Surgery: Payable with 50 % co pay</td></tr>
<tr><td>Oral /Subcutaneous Chemotherapy (Even if there is no hospitalization): Covered</td></tr>
<tr><td>Septoplasty (For medical Reason): Payable</td></tr>
<tr><td>Continuous Ambulatory Peritoneal Dialysis (CAPD): Covered</td></tr>
<tr><td>Gender reassignment surgery</td><td>Gender reassignment surgery covered up to sum insured.
Coverage is only for employee.
Hormone replacement therapy not covered.
Only 5 cases allowed in one policy period.
Only surgery is covered, medical management like hormonal therapy is not covered</td></tr>
<tr><td>Cochlear implant</td><td>Covered up to 50 % of sum insured.

<table><tr><th colspan="3">Co-pay % to be paid by employee</th></tr><tr><td>Surgery cost</td><td>Implant</td><td>Surgery</td></tr><tr><td>Co-pay applicable</td><td>50%</td><td>10%</td></tr></table></td></tr>
<tr><td>Autism</td><td>Covered up to INR 200,000 per family. Maximum of INR 5,000 per session</td></tr>
<tr><td>Claim Submission</td><td>Within 30 days from date of discharge</td></tr>
<tr><td>Cataract</td><td>Cataract surgery is covered in daycare with replacement of “Standard lens” through phacoemulsification or MICS techniques.

Techniques coverage includes: -
1) Phacoemulsification (also called as small incision cataract surgery) Cataract Surgery with Standard Monofocal Lens
2) Micro incision cataract surgery (MICS) with standard confocal Lens

Exclusions (Not Covered): -
1) Toric Lens (any cost)
2) Multifocal Lens (any cost)
3) Laser cataract surgery
4) Femto/smile laser assisted cataract surgery
5) Robotic cataract surgery

Please note:
• Reasonable and customary charges will be applicable.
• Cataract surgery is a day care procedure which does not require room for admission.</td></tr>
<tr><td>Lasik Surgery</td><td>Payable for a deficit of +/-7.5 dioptre or more in vision irrespective of the type of surgery i.e., LASIK or ICL surgery.

Formula for calculation of refractive error: spherical power + half of cylindrical power

Example: Spherical power = 5.00

Cylindrical power = 2.50</td></tr>
</table>

<table>
<tr><td></td><td>So Refractive error will be 5 + (2.5/2) = 6.25</td></tr>
<tr><td>Genetic disorder</td><td>Treatment for genetic disorder is covered on hospitalization basis up to 25% of total SI</td></tr>
<tr><td>Advanced & modern treatment</td><td>
<table>
<tr><th>Treatment</th><th>Sub-limits</th></tr>
<tr><td>Uterine Artery Embolization and HIFU</td><td>Up to 20% of sum insured subject to maximum of INR 200,000</td></tr>
<tr><td>Balloon Sinuplasty.</td><td>Up to 20% of sum insured subject to maximum of INR 200,000</td></tr>
<tr><td>Deep Brain stimulation.</td><td>Up to 50% of sum insured subject to maximum of INR 500,000</td></tr>
<tr><td>Oral chemotherapy.</td><td>Up to 10% of sum insured subject to maximum of INR 100,000</td></tr>
<tr><td>Immunotherapy- Monoclonal Antibody to be given as injection.</td><td>Up to 25% of sum insured subject to maximum of INR 2,00,000</td></tr>
<tr><td>Intravitreal injections.</td><td>Up to 10% of sum insured subject to maximum of INR 75,000</td></tr>
<tr><td>Robotic surgeries.</td><td>Up to 50% of sum insured subject to maximum of INR 500,000</td></tr>
<tr><td>Stereotactic radio surgeries.</td><td>Up to 50% of sum insured subject to maximum of INR 300,000</td></tr>
<tr><td>Bronchial Thermoplastic.</td><td>Up to 50% of sum insured subject to maximum of INR 250,000</td></tr>
<tr><td>Vaporization of the prostrate (Green laser treatment or holmium laser treatment).</td><td>Up to 50% of sum insured subject to maximum of INR 250,000</td></tr>
<tr><td>IONM - (Intra Operative Neuro Monitoring).</td><td>Up to 10% of sum insured subject to maximum of INR 50,000</td></tr>
<tr><td>Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered.</td><td>Up to 50% of sum insured subject to maximum of INR 250,000</td></tr>
</table>

Except for the above-mentioned treatments, no other advanced treatment can be covered as per policy.
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