



FREQUENTLY ASKED QUESTIONS

GROUP MEDICLAIM
INSURANCE BENEFITS

2025-2026

For more information, please contact: hexaware@prudentbrokers.com





Q1. What is medical insurance?

Medical insurance is a hospitalization policy where it is mandatory for 24 hours of hospitalization with active line of treatment.

Medical insurance provides coverage to you as an employee and also covers your family members enrolled by you under the policy towards treatment in case of a medical emergency, as per policy terms and conditions.

Q2. Is the 24-hour rule applicable for all ailments?

Yes, 24-hour hospitalization is a must. However, this time limit is not applied to specific treatments that do not necessarily require 24 hours due to technological advancement in treatment. Some of these treatments known as daycare procedures include dialysis, chemotherapy, radiotherapy, eye surgery, tonsillectomy, etc. taken in the hospital/nursing home.

Q3. What is family floater?

Family floater means that the eligible sum insured can be utilized by any one or all family members put together during the policy year. i.e. employee, spouse, and first 2 dependent children, can avail separate mediclaim benefit. Whereas there is a separate voluntary parental coverage as shared below:

Grade	Family Sum Insured for Employee + Spouse + Child	Separate Floater Sum Insured for Parents + Parents- In Law
TRN-G6	INR 4,00,000	INR 2,00,000
G7-G10	INR 5,00,000	INR 2,50,000
G11 - G13	INR 7,00,000	INR 3,50,000
G14 AND ABOVE	INR 1,000,000	INR 5,00,000





Q4. Can employees change their Demography?

Yes. At the time of renewal:

Employees in E (Employee) plan can move to ESC (Employee + Spouse + Children).

Employees in ESC can also move to E in case they do not wish to cover their spouse and children in Hexaware policy.

Q5. Can employees increase their Sum Insured (SI)?

Yes. Employees are allowed to upgrade their Sum Insured by up to 2 levels from their default plan.

Example:

If the default plan is ₹4 Lakhs, the employee can choose to upgrade to:

₹5 Lakhs (1 level up)

₹7 Lakhs (2 levels up)

Q6. Is there a limit to how much the Sum Insured can be increased?

Yes. The increase is restricted to 2 levels only from the default plan. Employees cannot move more than two levels.

Q7. Is the Parental Sum Insured (SI) included in the ESC plan?

No. The Parental SI is separate from the ESC (Employee + Spouse + Children) Sum Insured.

This means the Claim paid for parents does not reduce the SI available for employee, spouse, or children.

Q8. Will parental enrollment from last year be carried forward?

Yes. If parents were enrolled in the previous policy year, their enrollment will be carried forward into the current year.

Q9. Can I opt for Simple topup and Flex Upgrade both?

No. Either employee can opt for simple topup or he/she can opt for Flex upgrade option.





Q10. Can employees increase the Parental Sum Insured?

Yes. Employees can upgrade the Parental SI by 2 levels from the voluntary base plan (as per employee grade).

Example:

Employee covered in TRN to G6 opts for voluntary Parental cover. Base Parental SI is ₹2 Lakhs, it can be upgraded to:

₹2.5 Lakhs (1 level up)

₹3.5 Lakhs (2 levels up)

Q11. Is there a limit to how much the Parental SI can be increased?

Yes. The upgrade is restricted to 2 levels only from the base plan. Higher upgrades are not permitted.

Q12. Do we have any waiting period on Parental addition?

Employees with DOJ before July 1, 2025:

Can cover parents with 1-year waiting period for pre-existing conditions

Waiting period can be waived off by enrolling in Advance Care Plan (under additional modules)

Q13. Can employee delete parents/ Inlaws?

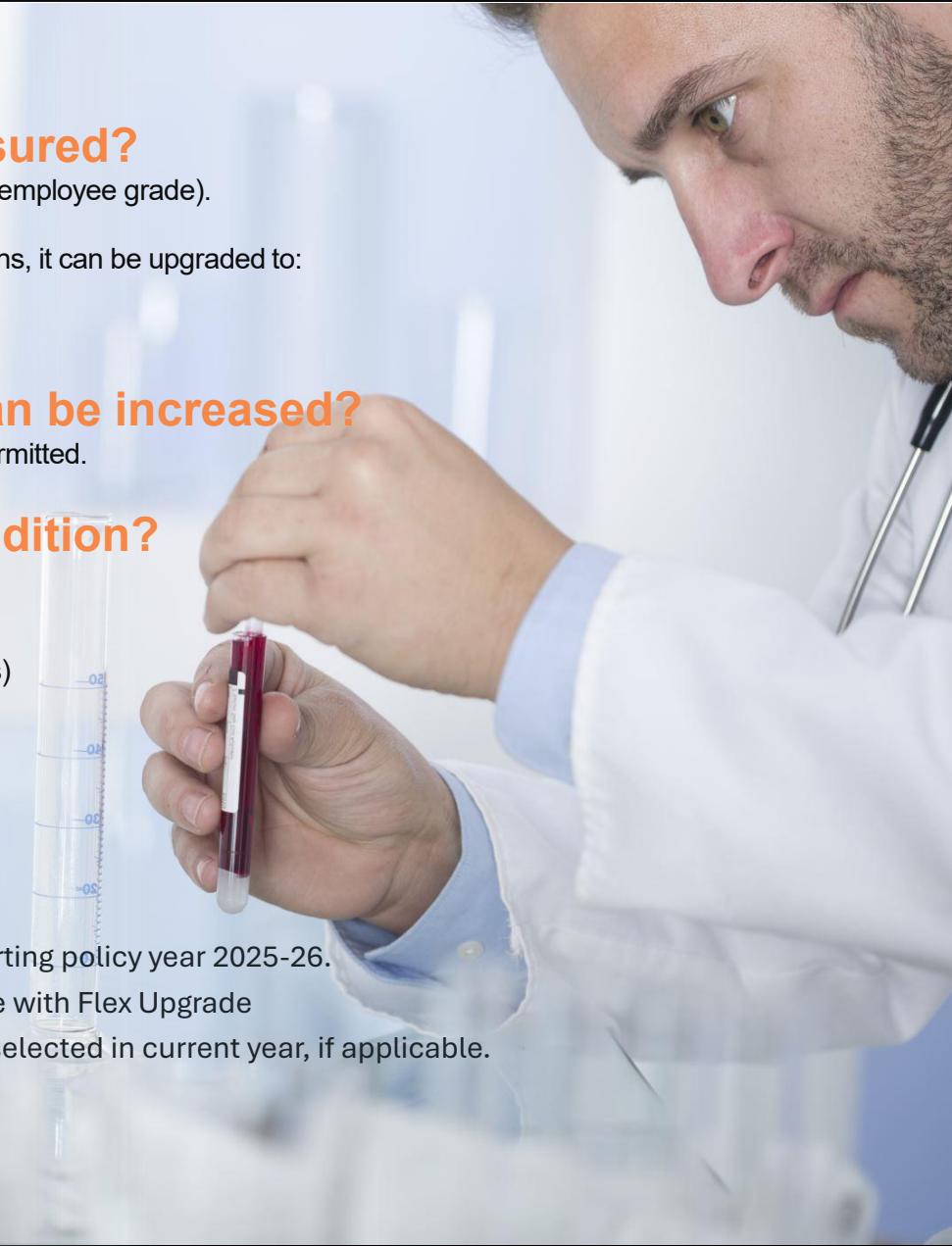
Deletion of parents is not permitted, except in case of demise

Q14. Can I change the plan next year again?

Employees that move to the Flex Upgrade will be locked-in for a period of 2 years starting policy year 2025-26.

After 2 policy years, employee will be able to move back to simple top-up or continue with Flex Upgrade

Employee can upgrade within the plan(simple top up or flex upgrade) that has been selected in current year, if applicable.





Q15. What is the difference between Flex Upgrade or Simple Top up ?

Benefits	Flex Upgrade	Simple Top up
Base Sum Insured	Base sum insured changes	Base Sum Insured remains same. Top-up triggers when Base SI is exhausted
Copay	10% copay reduces for employee claims only	10% copay reduces for employee, spouse and child claims
Room rent	Room rent increases with increase in Sum insured	Room rent is applicable as per Base SI only

Q16. Is child coverage available under GPA?

Yes. Employees can also opt to cover their children after they opt for voluntary GPA top up. The coverage amount for children will be 10% of the total Sum Insured (Base + Top-up) chosen by the employee.

Example:

If an employee opts for ₹20 Lakhs (Base + Top-up), each child will be covered for ₹2 Lakhs.

Q17. Can spouse/Child coverage for GPA be opted without employee top-up?

No. Employee need to opt for Top up if employee wish to cover spouse and child for GPA coverage.





Q18. Can employees enhance their GPA coverage?

Yes. Employees can choose from the following top-up options:

₹10 Lakhs

₹20 Lakhs

₹30 Lakhs

₹40 Lakhs

These are optional and can be selected based on individual needs.

Q19. What happens to the current company-sponsored GPA plan?

The existing company-sponsored GPA plan remains unchanged. All employees will continue to be covered under this base plan.

Q20. Is spouse coverage available under GPA?

Yes. Employees can opt to cover their spouse under GPA.

The coverage amount for the spouse will be 50% of the total Sum Insured (Base + Top-up) chosen by the employee.

Example:

If an employee opts for ₹20 Lakhs (Base + Top-up), the spouse will be covered for ₹10 Lakhs.

Q21. Is Nominee declaration mandatory?

Yes. Nominee declaration is mandatory for GPA and GTL topup plan

Q22. Can employees enhance their GTL coverage?

Yes. Employees can choose from the following top-up Sum insured options under FLEXCARE:

₹50 Lakhs

₹1 Crore

These top-ups are optional and can be selected based on individual needs on Insurer portal only.

Q23. What happens to the current company-sponsored GTL plan?

The existing company-sponsored GTL plan remains unchanged. All employees will continue to be covered under this base plan.



Q24. Will the premium for the GTL top-up change over time?

No. The premium for the selected top-up option will remain fixed for a tenure of 10 years.

This means employees will pay the same premium amount every year for the next 10 years, regardless of age or health changes.

Q25. Will GPA and GTL topup continue after exiting the organization?

GPA top up will continue only till you are a part of Hexaware. Once you enroll in GPA topup, you will not be able to opt out until you retire or resign the organization.

GTL top up will continue even after you exit the organization as the premium will be paid by you and the policy will be issued on individual basis.

Q26. What is GPA and GTL topup Policy period?

GPA and GTL policy will start from 1st Oct 2025 till 31st Aug 2026.

Q27. How will the premium be deducted for all voluntary policies?

Premium will be deducted from salary starting 1st Oct,2025.

Q28. Do we have any benefits under Flexcare?

Yes . FlexCare offers you below 4 Additional modules which are on voluntary basis.

1. Pregnancy care plan
2. Basic care plan
3. Advanced care plan(offers waiver of 1 year waiting period on parents Pre-existing disease)
4. Elder care plan.



Q29. Do I need to pay any premium?

The premium for Employee + Spouse + first 02 children is borne by the company up to default Base Sum insured as per grade. The employees who would like to cover their parents & parents-in-law, 3rd child and increasing their sum insured by opting for simple top-up or flex upgrade have to bear the premium. This will be deducted from the salary. Employee who wish to increase there sub limits can opt for Additional modules and GPA top up by payment on additional premium.

Q30. What if I have my 3rd child?

For 3rd child coverage, the employee has to bear the premium and coverage will be considered under base sum insured of the family coverage .

Q31. How can I add my newborn baby/newly wedded spouse?

Navigation for D-HR: StationH >> Webapps >> DHR >> Family and Emergency Contacts >> edit your dependent details and update

- 1.Update new-born baby/newly wedded spouse as dependent in D-HR within 10- 15 days from date of birth/date of marriage.
- 2.If new-born baby name is not decided yet, then please write as B/O MOTHER NAME
- 3.For GMI (Group Mediclaim Insurance) coverage, please share details with 10-15 days in below format to hexaware@prudentbrokers.com

Emp No	Name of Employee	Name of Dependent	DOB	Relation	Gender

Note- If dependents are not declared within the timelines ,they will not be covered for current policy year and can be added only at time of next renewal.



Q32. Are there any special criteria for seeking admission/treatment in the hospitals/nursing homes?

A hospital/nursing home means any institution in India established for indoor care and treatment of sickness and injuries and which has been registered as a hospital or nursing home with the local authorities and is under the supervision of a registered and qualified medical practitioner and should comply with following criteria :

1. It should have at least 15 in-patient beds
2. Fully equipped operation theatre of its own, wherever surgical operations are carried out
3. Fully qualified nursing staff under its employment round the clock
4. Fully qualified doctor(s) should be in-charge round the clock
5. Maintains daily record of each patients

Note: In class 'C' towns, condition of number of beds to be reduced to 10. Further, it necessarily should not be blacklisted with the TPA.

Q33. Will my stay be covered under Mediclaim if I have been admitted under doctor's instructions but there has been no proper line of treatment?

Any hospitalization without any active line of treatment will not be covered under Mediclaim insurance.





Q34. What are pre-existing diseases? Are they covered in the policy?

Pre-existing diseases refer to conditions or ailments that may have been contracted before the start of the policy. The policy covers pre-existing diseases from day 1.

Examples of pre-existing conditions/diseases are blood pressure (hypertension), diabetes, cancer, heart ailment, hernia, cataract and this list can be long, as it means any and every ailment, for which medication or treatment is on or found to be manifested (without treatment) on the date of the policy inception.

NOTE - There is a waiting period of one year for pre-existing diseases/conditions for parental claims

The waiting period shall not be applicable for employees with DOJ July 1, 2025 onwards.

Waiting period shall be applicable for employees with DOJ prior to July 1, 2025. However, employee can opt for Advance care plan under additional module to waive of waiting period.





Q35. What if the cost exceeds the sum insured?

In such a situation, you will be liable to pay the incremental amount, over and above the sum insured limit, as per policy terms and conditions. The TPA will inform the hospital about your balance sum insured and the hospital will recover the amount over and above the balance sum insured, from you.

Hence, it is recommended that employees should look at the top-up/flex upgrade available to increase/enhance their sum insured for themselves and their dependents at time of enrolment drive.

Q36. Is there any limit for reimbursement of expenses incurred in a laboratory or a diagnostic centre as part of hospitalization?

No, if the expenses form a part of the hospitalization process and if the amount is approved and payable as per the terms and conditions of the policy, then they are reimbursable up to the sum insured amount. Tests related to the ailment for which the patient is hospitalized are only considered.

Q37. What expenditures will generally be covered under the pre-hospitalization clause?

Medical expenses incurred for laboratory test, pathological test and such similar expenses which are usually incurred for the same ailment prior to hospitalization, will be covered under the pre-hospitalization clause.

Pre-hospitalization expenses are payable only if it is followed by at least 24- hour hospitalization within 30 days of expense and there should be an active line of treatment given based on the investigation.



Q38. What is the room rent eligibility criteria and how does it impact claim settlement?

1. Room rent limits per day are as under –

Family floater Base Sum Insured (INR)	Normal Room Rent Limit Per Day for ESC (INR)	ICU Per Day Limit for ESC (INR)	Base Sum Insured for Parents & PIL	Normal Room Rent Limit Per Day for Parents / PIL (INR)	ICU Per Day Limit for Parents / PIL (INR)
4,00,000	4,500	9,000	2,00,000	3,000	6,000
5,00,000	5,250	10,500	2,50,000	3,750	7,500
7,00,000	7,500	15,000	3,50,000	5,250	10,500
10,00,000	15,000	30,000	5,00,000	7,500	15,000
12,50,000	15,000	30,000	6,25,000	9,375	18,750
15,00,000	15,000	30,000	7,50,000	11,250	22,500

•Room Rent = Room Rent + Nursing Charges + RMO charges

Room rent= Room rent + Nursing charges + RMO charges

1. **Illustration:** For TRN to G6 Company provided family sum insured is INR 4,00,000, INR 4,500 is the limit for normal room per day & INR 9,000 is the limit for ICU per day.
2. For base policy for this grade, the sum insured of parents is capped at INR 2,00,000, INR 3,000 is the limit for normal room per day & INR 6,000 is the limit for ICU per day
3. Proportionate deductions are applicable i.e., if patient is admitted to a room category with per day rent more than your eligibility, then the entire bill will be settled on a proportionate basis. For proportionate deduction, pharmacy expenses are not included

Q39. Co-payment clause for Employee under Base policy

10% Copay for Employee, Spouse and Child
20% Copay for Parents and Parents In Law





Q40. Covered under post-hospitalization clause?

Medical expenses incurred for the treatment subsequent to release from hospitalization and other such similar overheads will be covered under post-hospitalization clause. Post-hospitalization expenses are covered up to 60 days from the date of discharge.

Q41. Is AYUSH treatment covered?

AYUSH treatment (ayurvedic, unani, siddhai, and homoeopathic) taken in a government hospital/hospital recognized by government of India is covered up to 25% of base sum insured on IPD basis only.

Q42. Is dental treatment covered?

Dental treatment or surgery is covered only in case of accidental injuries requiring dental treatment as a part of hospitalization and not otherwise.

Q43. Are all pregnancy-related expenses covered?

Voluntary medical termination of pregnancy is not covered under Mediclaim.

Only medical termination of pregnancy advised by the treating doctor is covered subject to approval from the insurer on submission of case details and same will be covered in base sum insured only.



Q44. What about pre & post-natal expenses with respect to delivery?

Pre 30 days and post 60 days natal expenses are covered within maternity sublimit.

Q45. Is infertility-related treatment covered?

Expenses for male and female fertility-related treatment are covered up to INR 50,000 on IPD/OPD basis only from base policy.

Q46. Are congenital diseases covered under the policy?

Congenital diseases means the abnormalities of structure or function which are present at birth. They may or may not be inherited.

Yes, internal congenital is covered up to sum insured.

Congenital External covered in case of life threatening and for all non-cosmetic treatment upto base Sum insured only





Q47. What happens if my marital status changes during the policy?

If the marital status changes (by reason of marriage), the employee needs to update the details on D-HR portal within 10 days and also write to hexaware@prudentbrokers.com within 10 days of event (date of marriage)

Navigation for D-HR: StationH >> Webapps >> DHR >> Family and Emergency Contacts >> edit your dependent details and update

Q48. What happens if my spouse and I are working in the same organization?

1. The insured can be covered only once in the policy
2. Maternity to be allowed once only for Hexaware in case of both husband and spouse are employees of Hexaware



Q49. Is the baby covered from Day 1?

On delivery of a child, the child is prone to many health disorders like jaundice or expenses incurred for incubator for pre-mature births or any other complications. Please note that for such complications, the baby will be covered from day 1 in the overall family floater sum insured & not just the maternity sub-limit subject to sharing the data of new-born child to hexaware@prudentbrokers.com within 10 days of event

Navigation for D-HR: StationH >> Webapps >> DHR >> Family and Emergency Contacts >> edit your dependent details and update

Q50. What are healthy baby expenses?

Expenses incurred for a normal baby after the birth till discharge which includes NICU/doctor's charges/routine vaccination charges, etc. is covered within maternity limit up to INR 5,000 till 60 days from DOB.

Q51. What is bereavement cover?

If the employee passes away in the hospital during treatment, no co-pay of any deductibles on the claimed amount is applicable, entire claimed amount is to be paid up to the sum insured

This shall be applicable only for the employee.





Q52. What is the definition on medical management

1. Capping on medical management cases: INR 20,000
2. Definition of medical management: All types of fevers of unknown origin, malaria, viral fever, respiratory tract infection, gastroenteritis, and vomiting

Note: Above condition will not apply in case of:

1. Administration of any IV drug
2. Or a temperature reading on admission/any time during the hospital stay found to be above 100 F
3. Or low BP (hypotension) reading/inability to accept an oral feed-in case of gastroenteritis
4. Or low oxygen saturation in case of respiratory ailments



Q53. Do I have critical illness cover?

For the employee only, the below critical illness benefits are:

1. Enhancement of sum insured to double the current sum-insured
2. Room rent applicable on enhanced limits
3. One time lump sum benefit of INR 20,000 in addition to hospitalization expenses
4. List of critical illnesses are:
 - Renal failure requiring kidney transplantation & dialysis
 - Cerebral vascular strokes
 - Open and closed heart surgery (inclusive of C.A.B.G.)
 - Malignancy diseases confirmed on histopathological report
 - Encephalitis (Viral)
 - Neurosurgery
 - Total replacement of joints
 - Liver disorder associated with complication of cirrhosis of liver
 - Grievous injury which includes:
 1. Multiple fracture of long bone
 2. Head-injury leading to unconsciousness, burns of more than 40%
 3. Injury requiring artificial ventilator support plus vertebral column injury





Q54. What are the Covid care benefits?

Covid hospitalization: All treatments including plasma therapy given at hospital or any government defined Covid facility

Covid coverage: RT-PCR or any other approved test for 'Covid-19' will be allowed for non-Covid-19 hospitalization & expenses incurred for room sanitisation

Covid home care cover up to INR 15,000 per Insured:

To cover the costs of treatment of Covid incurred by the insured person on availing treatment at home, maximum up to 14 days per incident provided that:

1. Positive RT-PCR test report for patient advised home care is available
2. The medical practitioner advises the insured person to undergo treatment at home
3. There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment
4. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained
5. The insured shall be permitted to avail the services as prescribed by the medical practitioner. Cashless or reimbursement facility are offered under homecare expenses subject to claim settlement policy disclosed in the website of the insurer
6. In case the insured intends to avail the services of non-network provider, claim shall be subject to reimbursement
7. Non-medical expenses like PPE kits, masks and gloves covered under Covid and non-Covid hospitalization is covered subject to reasonable and customary clause
8. No co-pay i.e. "20% co-pay is waived" in the base policy for "pandemic hospitalization"





Q55. What are the key reasons for deduction in Covid-19 claims?

1. If a hospital has not followed the government circular, then the claim will get processed as per the government circular only, and over & above excess package amount will be borne by the employee
2. If you are going to get hospitalized for Covid-19 treatment, then please check with your insurance SPOC for room rent limit of the particular hospital, and please opt for a room within the limit decided by the government guideline. If you opt for a higher room rent, then over & above excess package amount will be borne by the employee
3. Excess bed/ICU charges over & above Covid-19 package will get deducted as per government circular
4. Excess Covid-19 test charges will get deducted as per government circular
5. Visit charges included in per day package as per government circular
6. Excess PPE kit charges not payable as per government circular
7. Excess dengue charges will get deducted as per government circular
8. Post-hospitalization Covid-19 test not payable
9. Investigation charges deducted as unauthorized reports
10. Medicine charges will get deducted as already included in package as per government circular
11. Over & above package as per government circular
12. Apart from the above, state government guidelines affect claims in respect of selective package charges of room, ICU, medicine, lab expenses, etc.





Q56. Any quick solutions to avoid deductions in Covid-19 claims?

KNOW YOUR STATE COVID CEILING: All major states in India like Mumbai, Karnataka, West Bengal, Tamil Nadu, and Delhi have issued guidelines to both providers & government hospitals ceiling the rates that the provider can charge for treatment as per the national protocol for Covid-19 care & standard care for co-morbidities. It is observed that the hospitals are not following the ceiling limit. You are requested to check the amount and be in touch with the insurance SPOC for the right guidance

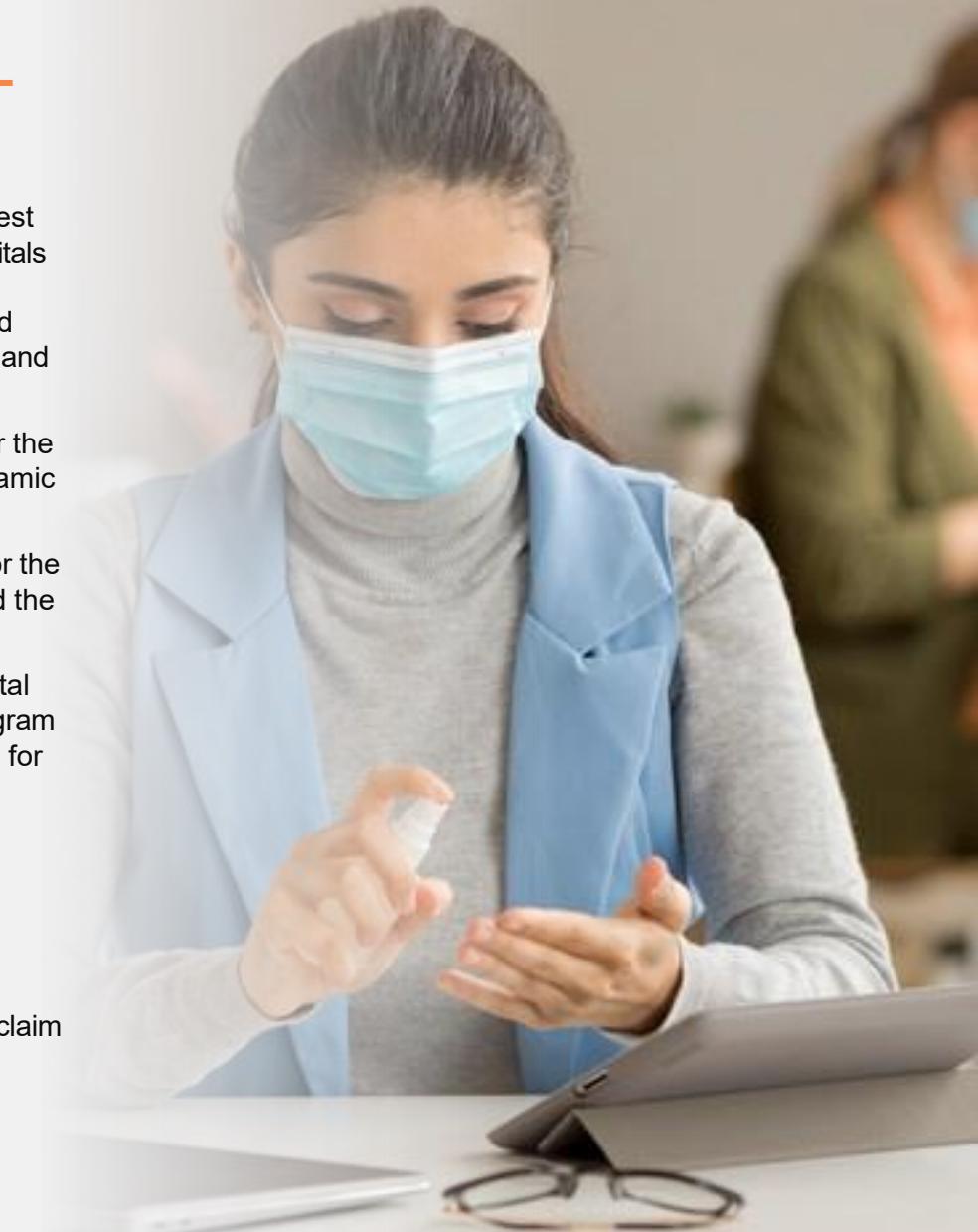
PREFERRED HOSPITALS: Do remember to speak with your insurance SPOC and inquire for the preferred provider network following the right billing mechanism. The TPA maintains a dynamic list of providers giving the right treatment with the right amounts

ROOM RENT LIMIT: Majority of rejections are seen in the bills because of patient opting for the higher room rent category. It is advisable that you talk to the insurance SPOC & understand the room rent limit of hospital as per government or state guidelines

CHECK YOUR BILL CHARGES: It is also observed that hospitals are charging for experimental drugs not related to Covid-19. All these charges are outside the scope of the insurance program and are not payable. Please engage in a dialogue with the doctor/hospital from time to time for clarification

Q57. Can I opt for reimbursement claim even if the hospital is covered in the network list?

MOU discount will get deducted as per IRDAI rules & regulation. If employee is submitting claim file for reimbursement from network hospitals, then MOU discount will be borne by the employee. Hence it is advisable to avail cashless facility if the hospital is tied up with the MediAssist and New India





Q58. In how many days will I get my Mediclaim (medical insurance) card?

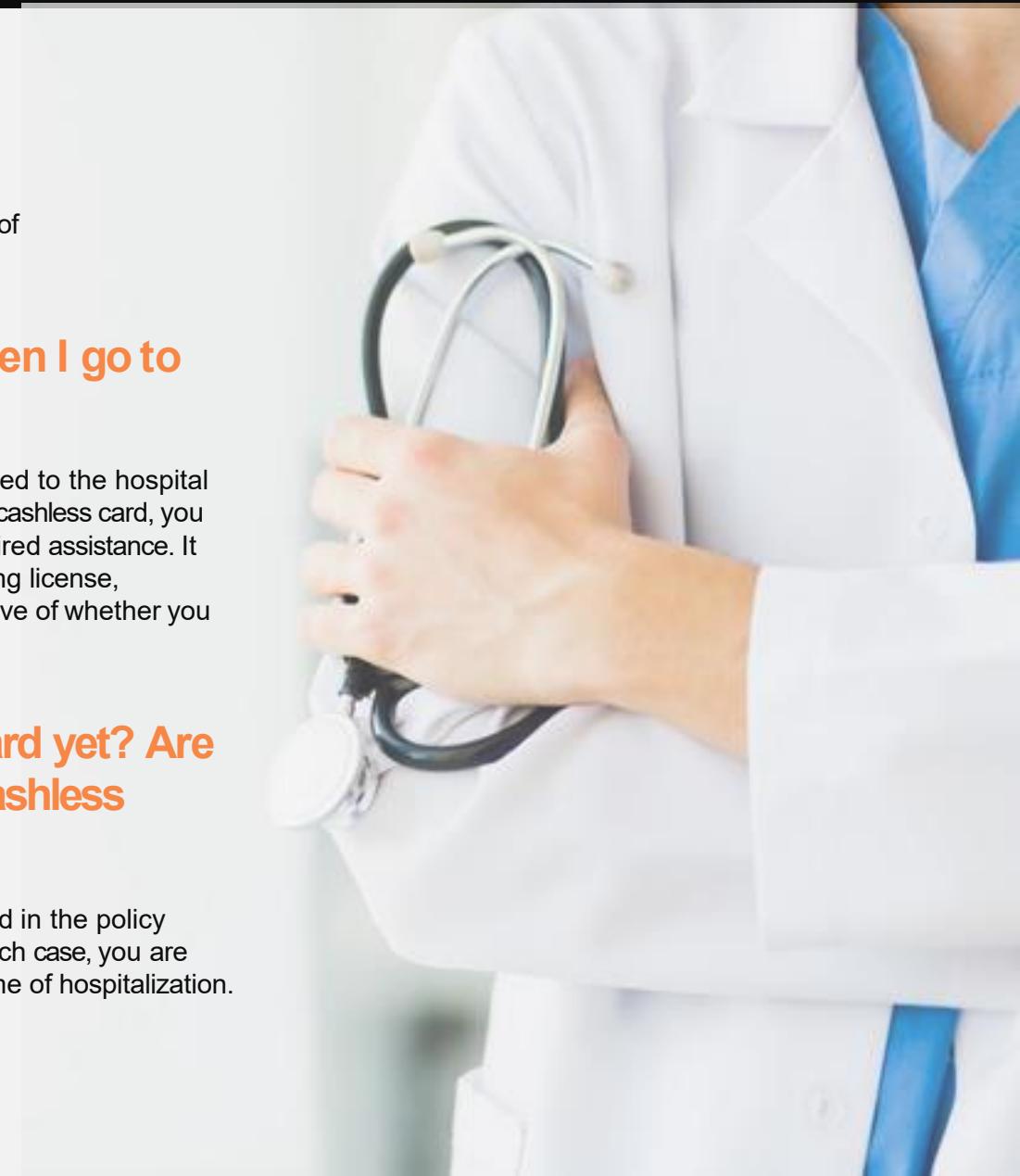
Mediclaim cards will be available within 45 working days from the date of closure of enrollment drive.

Q59. Do I need to carry my Mediclaim e-card when I go to the hospital?

Ideally, you should always carry a print of the e-card with you, when getting admitted to the hospital from the available list of network hospitals with the TPA. But, if you do not have a cashless card, you should get in touch with Prudent's claims representative who will provide the required assistance. It is advisable to carry a valid photo ID proof (employee ID card, Aadhaar card, driving license, election card or any card which is approved by the government of India), irrespective of whether you are carrying the cashless card or not.

Q60. What if you have not got your e-cashless card yet? Are you covered? What do you need to do to get a cashless treatment?

The claim would be processed without the cards, provided the claimant is declared in the policy within specified timelines. You would be entitled to a cashless treatment but in such case, you are requested to get in touch with Prudent's claims representative, before or at the time of hospitalization.





Q61. The information on my e-card is incorrect. What should I do now?

Please update your internal DHR system and also write to hexaware@prudentbrokers.com with a copy of Aadhaar card which is approved by the government of India for the error correction.

Q62. Post my marriage, my surname has been changed; however, my e-card has my maiden name written on it. How do I get the name changed on my e-card?

Please update your internal DHR system and also write to hexaware@prudentbrokers.com with a copy of Aadhar card.



Q63. If I avail cashless facility or file a reimbursement claim, will the insurer pay the entire amount or will I be required to bear part of the bill at the hospital?

All expenses that are covered under the insurance policy will be paid for by the insurer. However, you will be required to pay for non-admissible expenses, if any, such as registration charges, charges incurred on account of person accompanying you, non-medical consumables, etc.

Further, you will also bear the amount deducted on account of any restriction in the policy like room rent, maternity limit, co-payment etc.

Q64. What if I undergo major hospitalization in two different hospitals? Will the policy reimburse expenses incurred?

Yes. The expenses are reimbursed up to the limit of the sum insured and they must satisfy the terms and conditions of the policy. Proper documents, such as discharge summary from both the hospitals are a must.

Please reach out to Prudent's claims team to understand the documentation for such scenarios.





Q65. What is meant by a network/empaneled hospital?

Hospitals which have a tie-up with the TPA servicing the health policy is called a network/empaneled hospital.

For network hospital details please find the below link, please select your location & the insurer name as “The New India Assurance Co. Ltd.”

<https://www.medibuddy.in/networkHospitals>

Q66. Do I need to get treatment at a network hospital only?

- You can get treated in any registered hospital, which meets the hospital criteria, within the country but the cashless facility will be available only at the network hospitals
- It is recommended that cashless treatment is taken in the network hospital and it is mandatory for cashless to be availed in the network hospital
- If cashless facility is not availed in the network hospital, then in reimbursement, the applicable hospital discount will be deducted, and claim will be settled
- Expenses incurred in non-network hospitals will be reimbursed to you, after following the applicable reimbursement process and as per the terms and conditions of the policy



Q67. What if we get admitted in a hospital outside the network list?

If you get admitted to a hospital outside the network list, you will not get the cashless facility. You can always file the claim under the reimbursement mode.

Also, you need to check if the hospital is not blacklisted.

Q68. What is cashless request form?

The cashless request form is a document which has to be duly filled up, signed, and stamped by the treating doctor. Thereafter, the hospital will mail it to the TPA on the e-mail ID given on the cashless request claim form (pre-auth, request letter).

Q69. How to fill the cashless request form?

Part A: To be filled in by the insured/patient

Part A: To be filled in by the treating doctor/hospital.

Information required: ID no. as mentioned on e-card, signs and symptoms of the present ailment, duration of the ailment, diagnosis, pre-existing conditions, if any, proposed line of treatment, approximate date of admission/discharge, approximate duration of stay, and approximate cost of hospitalization, estimated expenditure, etc.





Q70. How do I know whether my claim has been admitted for cashless reimbursement or not?

Authorization letter or denial letter shall be e-mailed directly to the hospital with a copy to the e-mail ID mentioned on the claim form and the hospital will intimate you about the same. You can also do the necessary follow up with Prudent's representative to check the status.

Q71. What is an authorization letter?

An authorization letter is the communication authorizing extension of cashless hospitalization to the insured. The same is issued by the TPA, subject to admissibility of the claim and availability of balance sum insured for the member.

Q72. Is it possible to have cashless approval for pre- and post-hospitalization?

Cashless will not be possible for pre- and post-hospitalization claims. Reimbursement of the same is possible on submission of complete bills & documents relating to the claim within specified timelines.

Q73. Are there any restrictions on the number of claims I can file for maternity expense?

Maternity benefit can be claimed for the first 2 children and/or operation associated therewith.





Q74. Is there a time limit within which I am expected to submit the pre- and post- hospitalization bills?

Yes, you are advised to submit the bills with respect to pre- hospitalization, within 30 days of discharge from the hospital. Post- hospitalization bills must be submitted within 7 days of completion of treatment or completion of 60 days post-discharge, whichever is earlier.

However, in case of expenses related to maternity, the same must be submitted within 30 days of discharge from hospital.

Q75. Do I have to intimate claim?

Intimation of reimbursement claim is mandatory, if missed 10% copay on delay intimation will be deducted from admissible claim amount.

Mail intimation on @mumbaiclaims@prudentbrokers.com

Q76. What is the document submission timeline in case of reimbursement claims?

After completion of treatment, when the patient has been discharged from the hospital, you must submit the final claim within 20 days from the date of discharge from the hospital.

Q77. Will I get my claim papers back?

No, you will not get the claim papers back after settlement of the claim. You are expected & advised to keep a photocopy of the same for your future reference before submitting the papers. However, rejected claim documents will be available on request.





Q78. What is top-up policy?

A top-up policy is a plan to enhance your current health insurance sum insured, providing you with better coverage at low premium rates.

The top-up sum insured is over and above the base policy, which includes all the members covered in the base policy.

Q79. Why should I take a top-up?

You must opt for a top-up for the below benefits so that your family members and you are covered for sufficient sum insured

- Increase your sum insured by paying nominal premium
Illustration: For TRN to G6, the company provided family sum insured is INR 400,000 and you take top-up sum insured of INR 3,00,000, then the total sum insured is INR 700,000 for E-S-C, and INR 5,00,000 for the 1st set of parents/parent-in-law (considering that the base policy sum insured for parents is INR 2,00,000)
- Top-up policy is just sum insured addition.
- Co-pay will reduce by 10% on Employee Spouse and Children claims
- 20% Co-pay on Parents claims will remain same
- Next year (2025-26), you can increase the sum insured but not reduce the sum insured
- Topup policy triggers only when base policy SI is exhausted.
- Room rent will be as per base SI only





Q80. What is the premium applicable for the top-up policy?

Below is the premium chart excl GST for top-up (2025-26)

Family composition/ Sum Insured	2 Lacs	3 Lacs	5 Lacs
E	6,206	7,567	10,344
E1P / E2P	10,295	12,516	17,110
ESC	8,057	9,826	13,391
ESC1P / ESC2P	10,561	12,848	17,529

Q81. What is the sum insured available for parents/parents-in-law?

Parents/parents-in-law covered under the voluntary base policy as per employee grade.

Note- Parental SI will be separate then ESC SI.

Illustration: An employee in grade TRN to G6 have INR 4,00,000 as the family floater sum insured so parents will have separate voluntary base SI INR 2,00,000.





Q82. What are the rules for the enrollment of the parents and parents-in-law that I should be aware of?

1. Parents/parents-in-law not covered under the base policy in last year's (2024-25) policy by the existing employees with DOJ prior to July 1, 2025 will have option of adding parents/parents-in-law here, subject to 1-year waiting period for pre-existing ailments/ conditions
2. For employees with DOJ later than July 1, 2025, this waiting period for pre-existing ailments/conditions will not be applicable

Q83. What is the premium payable for the 1st and 2nd set of parents?

Premium will differ accordingly to parental Plans and No. of Parents added.

Premiums will be available on portal at time of enrolment .





Q84. Is there any lock-in period?

Yes. Once you opt for voluntary parental ,3rd child or a top-up policy, or Sum insured enhancement then you cannot exit till you retire or exit the organisation.

Q85. Can I add only one parent?

One parent can be added if he/she is the only surviving parent. You need to share death certificate to hexaware@prudentbrokers.com copy leelas@hexaware.com and only single parent details must be reflected in the internal D-HR system.

Q86. Can I cover my parents/parents-in- law any Month?

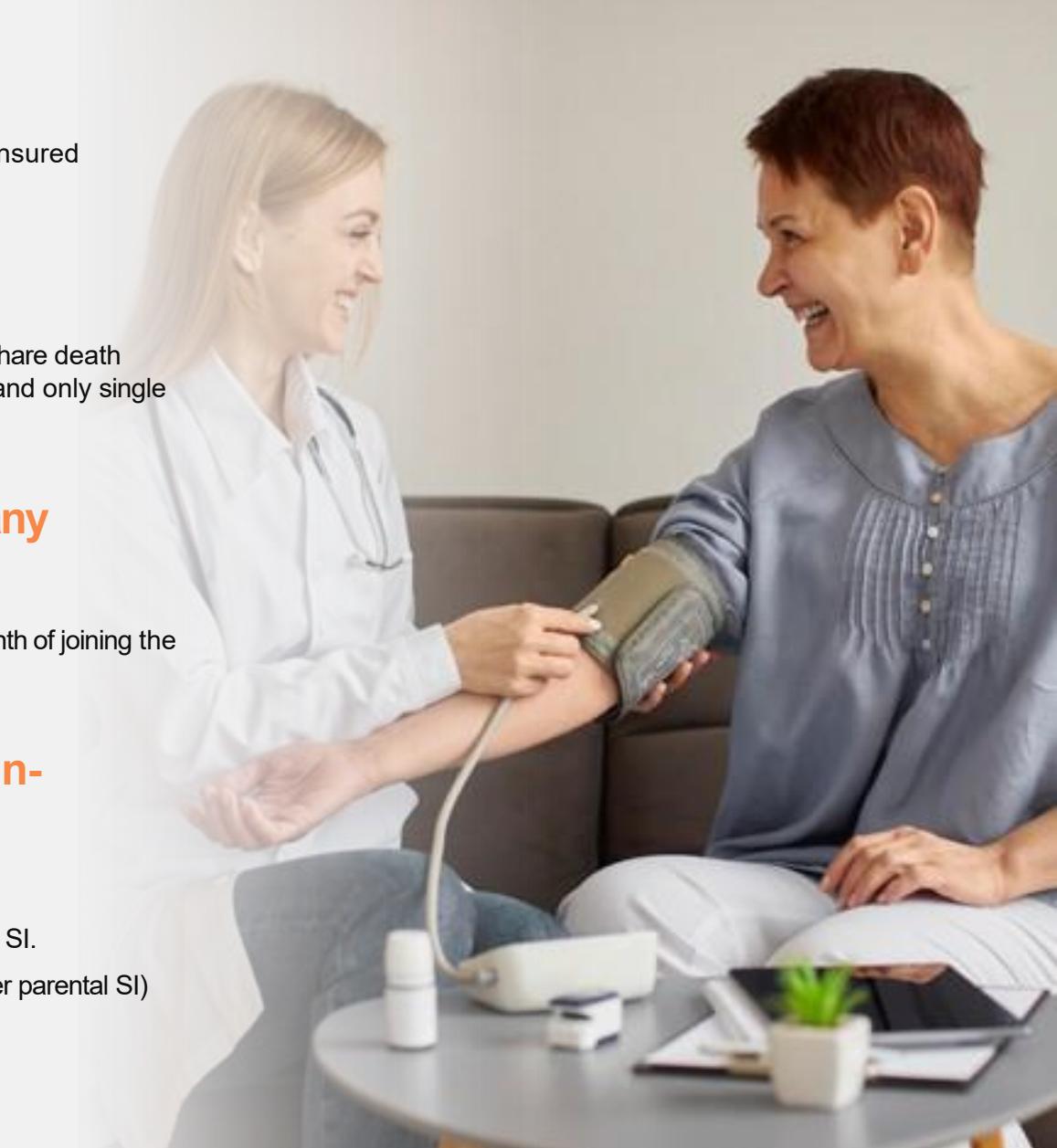
No. for existing employee only at policy renewal drive,or next month from month of joining the enrollment drive will be open for new joiners only.

Q87. Can I add my Parents as well as Parents-In-Law?

Yes. You can add both set of parents.

Parents/parents-in-law will be covered in the separate voluntary base policy SI.

All added parents will be covered in separate voluntary Parental base plan (floater parental SI)





Q88. Is premium the same for 1st and 2nd set of parents?

Yes.

Q89. What are non-admissible expenses?

These include the following:

1. Vaccination & inoculation
2. Cost of braces, equipment or external prosthetic devices, non-durable implants, eyeglasses, cost of spectacles and contact lenses, bi-focal lenses, multifocal lenses, toric lenses, hearing aids including cochlear implants and durable medical equipment
3. Vitamins and tonics unless forming part of treatment for injury or disease as certified by the attending physician
4. Voluntary medical termination of pregnancy during the first 12 weeks from the date of conception
5. The instrument used in the treatment of sleep apnea syndrome (C.P.A.P.) and continuous peritoneal ambulatory dialysis (C.P.A.D.) and oxygen concentrator for bronchial asthmatic condition
6. All non-medical expenses including convenience items for personal comfort such as telephone, television, governess, private nursing/barber or beauty services, diet charges, baby food, cosmetics, tissue paper, diapers, sanitary pads, toiletry items, and similar incidental expense
7. Service charges or any other charges levied by hospital, e.g. registration/admission charges, RMO charges, etc.
8. Monitor charges not payable
9. As per insurance company's guidelines, surgeon, anaesthetist, medical practitioner, consultant, and specialists fees must form part of the final hospital bill. In case not, the charges paid directly will not be admissible under our policy
10. Advance technology is not covered





Q90. What is Hexaware's parental policy?

Hexaware's parental policy is part of the Base plan where sum insured for parents and parents-in-law is Separate as per below table. This ensures that the sum insured is available for all family members if an unfortunate event happens when more than 1 family member is hospitalized.

Grade	Base SI for Employee spouse and children	Separate voluntary base SI for Parents and Parents-In-Law
TRN- G6	INR 4,00,000	INR 2,00,000
G7-G10	INR 5,00,000	INR 2,50,000
G11 - G13	INR 7,00,000	INR 3,50,000
G14	INR 10,00,000	INR 5,00,000

Q91. Why can't we remove or add our parents every year?

Currently, only 20% of the employees have opted for parental policy. If every employee only covers their parents, who have a very high probability of making a claim, then claim ratio will be higher, thus making the premium unaffordable to all of us. Hence, anyone enrolling must enrol all surviving parents and must cover their parents till they continue to be Hexaware employees.





Q92. Why is parental cover important?

As your parents' age, it becomes difficult to get a retail policy. If they get one, they have to go through a medical check-up after which premium is decided with/without additional waiting periods and/or premium loading as per medical reports. Additionally, there is a 3 or 4 years of waiting period for pre-existing ailments. Covering parents in Hexaware's policy does not require a medical check-up. It includes existing ailments from day 1.

Adding your parents in GMI by paying nominal premium.

Illustration: For TRN to G6 company provided family sum insured is INR 4,00,000 and for voluntary parents sum insured INR 200,000 separate.

In case of hospitalization for total knee replacement: Cost of surgery: INR 3,50,000 (approx. for both knees) GMI Sum Insured: INR 2,00,000

Premium paid for single parent: INR 16,035

Medically approved amount: INR 3,00,000 (approx)

Medically payable after deducting 20% co-pay: INR 2,40,000

Claim Paid: INR 2,00,000 (as parents sum insured is 2 lac)

Note: If you haven't enrolled your parents then the total surgery cost INR 3,50,000 would have to be borne by you.

However, since the employee has enrolled the parents, he has saved the INR 2,00,000.





Q93. How is the premium compared to the retail policy?

Our survey indicates that Hexaware's parental policy premiums are at discounted rates compared to retail policy, and offers superior coverages like no waiting periods and Covid-related coverages.

Q94. Is the sum insured sufficient for my parents?

It is better to take top-up policy/flex upgrade that ensures increased sum insured for your parents + family members. The most common procedures due to age are cardiac , costing over INR 5 lac & cancer treatment costing over INR 10 lac, so employees must take informed decision on having adequate coverage.





Q95. Why is there a waiting period for an existing employee with DOJ: July 1, 2025?

We would like to have a sustainable policy for all employees in the future as well, hence, an employee cannot add parents whenever their parents are hospitalized. If an employee does not cover his/her parents, then the employee has taken his/her personal decision of not doing so and in such a scenario, he/she cannot come back next year asking to be covered just because there is a change in health status. This will also mean unfair loading of claim costs on employees who have enrolled earlier. Also, the 1 year waiting period for existing illness ensures that the claims for existing disease (cancer, heart disease, dialysis, cataract, etc.) do not hit the 1st year, however, any other procedures like Covid, malaria, dengue, pneumonia, etc. will be covered.

Q99. Why should I enroll my parents/parents-in-law this time without fail?

We have made our GMI policy wider by adding parents-in-law last year. This year, we are adding both, i.e., the 1st and 2nd set of parents in base policy. In coming years, all existing employees will not have the opportunity of adding their parents/parents-in-law.

The most common procedures due to age are cardiac arrest costing + INR 5 lac & cancer treatment costing + INR 10 lac, so the employees must exercise appropriate assessment.





Q100. What are the general exclusions applicable?

1. Hospitalization due to war, invasion, act of foreign enemy, war like operations, nuclear weapons, ionising radiation, contamination by radioactive material nuclear fuel or nuclear waste
2. Circumcision, cosmetic, or aesthetic treatment, plastic surgery unless required to treat any injury or illness
3. Vaccination & inoculation
4. Cost of braces, equipment or external prosthetic devices, non-durable implants, eyeglasses, cost of spectacles and contact lenses, bi-focal lenses, multifocal lenses, toric lenses, hearing aids including cochlear implants, and durable medical equipment
5. Convalescence, general debility 'run-down' condition or rest cure, obesity treatment and its complications, congenital external disease or defects or anomalies (except in case of life-threatening circumstances with sub limit of INR 1,00,000 per incidence, treatment relating to venereal disease, intentional self-injury, accident due to misuse of drugs/alcohol or use of intoxicating substance, use of tobacco leading to cancer)
6. Bodily injury or sickness due to wilful or deliberate exposure to danger (except in an attempt to save a human life), intentional self-inflicted injury attempted suicide and arising out of non-adherence to any medical advice
7. Treatment of any bodily injury sustained whilst or as a result of active participation in hazardous sports of any kind
8. Diagnostic, X-ray, or laboratory examination not consistent with or incidental to the diagnosis of positive existence and treatment of any ailment, sickness or injury, for which confinement is required at a hospital/nursing home
9. Vitamins and tonics unless forming part of treatment for injury or disease as certified by the attending physician
10. Voluntary medical termination of pregnancy during the first 12 weeks from date of conception
11. Any naturopathy treatment
12. Instrument used in the treatment of sleep apnea syndrome (C.P.A.P.) and continuous peritoneal ambulatory dialysis (C.P.A.D.) and oxygen concentrator for bronchial asthmatic condition
13. Genetical disorders and stem cell implantation/surgery
14. Any domiciliary hospitalization/treatment except in case of Covid or any pandemic where the treatment at home is recommended by the treating doctor
15. Treatment taken outside India



16. Experimental and unproven treatment
17. Change of treatment from one system of medicine to another unless recommended by the consultant/hospital under whom the treatment is taken
18. All non-medical expenses including convenience items for personal comfort such as telephone, television, governess, private nursing/barber or beauty services, diet charges, baby food, cosmetics, tissue paper, diapers, sanitary pads, toiletry items, and similar incidental expenses
19. Service charges or any other charges levied by hospital, e.g., registration/admission charges, RMO charges, etc.

20. Treatment of any bodily injury sustained whilst or as a result of participating in any criminal act
21. Monitor charges not payable
22. As per insurance company's guidelines, surgeon, anaesthetist, medical practitioner, consultant, specialists fees must form part of the final hospital bill. In case not, the charges paid directly will not be admissible under our policy
23. Procedure/treatment usually done in outpatient department is not payable under the policy even if converted as an inpatient in the hospital for more than 24 hours
24. Advance technology is not covered





Q101. Where can I check for network hospitals?

Network Hospital Link:

<https://www.medibuddy.in/networkHospitals>

Please select your location & insurer name:

The New India Assurance Co. Ltd.

It is recommended to check if the hospital is in network or not every time before you get hospitalized as the network list of hospitals is a dynamic list where hospitals are added and removed from the list almost daily.

Q102. Do I have to do claims intimation?

Yes, claim intimation is mandatory within 02-03 days from the date of admission on mumbaiclaims@prudentbrokers.com. Non receipt of claim intimation within 2 to 3 days from date of admission will result in extra 10 % co-pay on admissible claim amount.

- | | |
|-------------------------|----------------------------|
| 1. Employee no. | 6. Email ID |
| 2. Employee name | 7. Reason for admission |
| 3. Patient name | 8. Hospital/nursing home |
| 4. Patient relationship | 9. Date of hospitalization |
| 5. Mobile number | 10. Doctor's name |

Q103. What is the TAT for reimbursement?

After submission of all documents and when there are no pendencies including the declaration on claims settlement on the basis of scan, the TPA will settle the claim within 15 to 20 working days.





Q104. Who all can be covered in the policy?

The members of the family who could be covered in the policy are:

1. Employee
2. Spouse
3. First 2 children up to the age of 30 years
4. 3rd child (voluntary)
5. Parents (voluntary) – No age limit
6. Parents-in-law (voluntary) – No age limit

Q105. What happens when I have to undergo a treatment like dialysis when I am discharged on the same day?

When treatment such as dialysis, chemotherapy, radiotherapy, etc., are taken in the hospital/nursing home and the insured person-patient is discharged on the same day, the treatment will be considered to be taken under hospitalization benefit scheme.





Q106. Why is health insurance important?

All of us should buy health insurance and for all members of our family, according to our needs. Buying a health insurance protects us from the sudden, unexpected costs of hospitalization (or other covered health events, like critical illnesses) which would otherwise make a major dent into household savings or even lead to indebtedness. Each of us is exposed to various health hazards and a medical emergency can strike any of us without any prior warning. Healthcare is increasingly expensive, with technological advances, new procedures and more effective medicines that have also driven up the costs of healthcare. While these high treatment expenses may be beyond the reach of many, taking the security of health insurance is more affordable.





Q107. What are the key points I must remember when using benefits under this policy?

- Please ensure that all your dependents are covered and have a valid card at the outset itself as it will not be possible to add dependents at a later stage
- Check if policy summary/mail confirmation is received on email post completing enrolment.
- Submit your reimbursement claims within timelines from the hospital. Please do not postpone this till later as it may mean that your claim gets rejected due to late submission

Q108. What is daycare treatment?

Daycare treatment refers to medical treatment and or surgical procedure which is:

1. Undertaken under general or local anaesthesia in a hospital/daycare centre in less than 24 hours because of technological advancement
2. Which would have otherwise required a hospitalization of more than 24 hours. Treatment normally taken on an outpatient basis is not included in the scope of this definition

Q109. Who is the insurer and TPA (third-party administrator) for this policy?

Insurer: The New India Insurance Company Ltd.

TPA: Medi Assist Insurance TPA Pvt. Ltd.



Q110. Is pre-acceptance medical check-up required?

Medical check-up for opting the policy is not required.

Q111. Is there any time limit to submit the reimbursement claim?

Once you get hospitalized, claims needs to be intimated to mumbaiclaims@prudentbrokers.com within 2 to 3 days from the date of admission. Claims to be submitted within 20 days from the date of discharge.

Note: If intimation of claims is made after 07 days, co-pay of 10% will be applicable. This co-pay will be over and above all other conditions of policy.

Q112. Can I add my dependents anytime during the year?

No, mid-term addition is not allowed in the policy. Once the drive is closed, no additions will be considered.

except new-born baby and newly married spouse. And same details need to be received within 10 to 15 days from the date of event.





Q113. Can I get treated anywhere in India?

Yes. Treatment taken in India is only covered under GMI policy.

Q114 . Does policy cover treatment overall India?

Yes, the policy covers treatment and/or services rendered only in India.

Q115 . Will I be able to cover newborn baby or newly married spouse in top-up policy mid-year?

Newborn baby or newly married spouse additions are not covered in top-up policy mid-year.





Q116. What is the MediBuddy credential for login?

Please find below log in credential for your ready reference. You can check network hospital, download e-card, policy number, and check claim status.

Link: <https://portal.medibuddy.in/Home.aspx>

User ID: employeeid@Hexaware

Password: Date of Birth (DDMMYYYY)

Q117. What procedures must I follow for reimbursement, home care, and cashless claim?

Mail at below email id for reimbursement and cashless process.

Reimbursement – mumbaiclaims@prudentbrokers.com

Cashless- Cashless@prudentbrokers.com

Please find below login credential for your ready reference. You can check network hospital, download e-card, policy number, and check claim status.

Link: <https://portal.medibuddy.in/Home.aspx>

User ID: employeeid@Hexaware

Password: Date of Birth (DDMMYYYY)



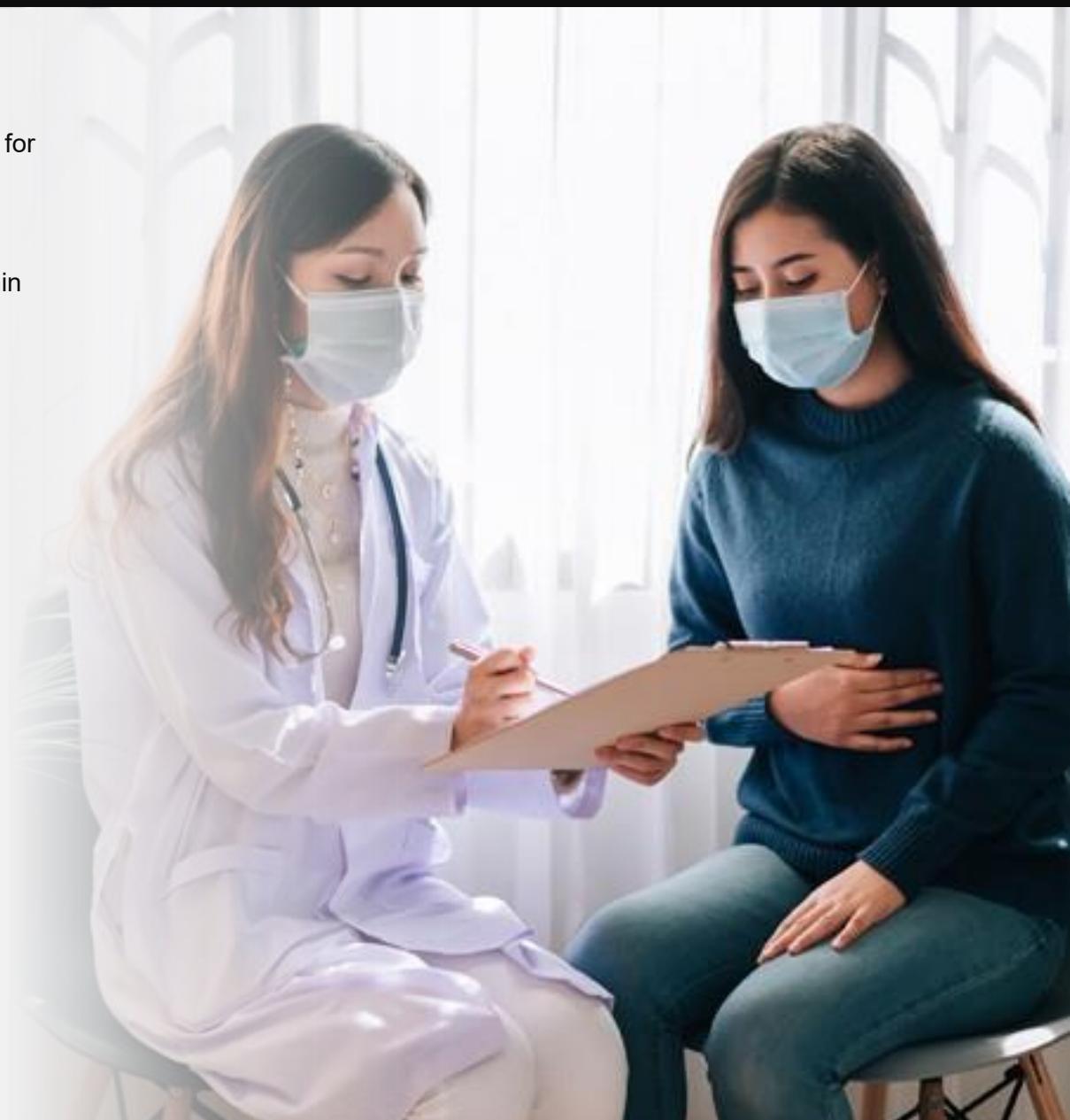


Q118. CLAIM INTIMATION:

1. In case the insured member gets admitted to a non-network hospital for treatment, then he/she can opt for mediclaim reimbursement
2. For planned admission, intimation must be sent 48 hours prior to the admission
3. In case of an emergency, admission intimation needs to be sent within 2-3 days from the date of the admission
4. Intimations can be electronically sent to mumbaiclaims@prudentbrokers.com and hexaware@mediassist.in
5. Original discharge card, attending doctors' bills and receipts, and certificates should be hand

INTIMATION DETAILS:

- Policy number
- Employee name
- Employee no.
- Employee mobile no.
- Patient name
- Relation
- Hospital name & address
- Date of admission
- Diagnosis





- Claim forms part A and B are mandatory, and part B of the claim form has to be filled by the hospital authority (signed and stamped).
- Also, provide a copy of the PAN card & Aadhar card,
- Cancelled cheque
- Original documents related to hospitalisation.

Please courier the original claim documents within 20 days from the date of discharge to us at the mentioned address.



Reimbursement
Claim Checklist



Reimbursement
Claim Form

Courier Address :

Mr. Arnab Bose
Medi Assist Insurance TPA Pvt. Ltd.
4th floor, Aarpee Chamber, Off Andheri Kurla Road,
Behind Times Square Building,
Sagbaug, Andheri (East), Mumbai – 400059



HOME QUARANTINE CLAIM PROCESS:

- Complete form A, duly filled by the insured, with signed, PAN card & aadhaar card copy
- Cancelled cheque (with account holder's name printed on the same)
- Covid positive report, bills, prescriptions, consultation reports, and Covid-related documents (originals)
- Please courier claim documents within 20 days post-home quarantine



Reimbursement
claim Form Part A



Home Isolation
checklist



Courier Address :

Mr. Arnab Bose
Medi Assist Insurance TPA Pvt. Ltd.
4th floor, Aarpee Chamber, Off Andheri Kurla Road,
Behind Times Square Building,
Sagbaug, Andheri (East), Mumbai – 400059



PRE AND POST CLAIM PROCESS:

- Complete form A, duly filled by the insured (signed), for pre- and post- hospitalisation
- PAN card & aadhaar card copy
- Cancelled cheque, and original hospitalization documents
- Pre- and post-hospitalization claim file needs to be couriered within 60 days from date of discharge



Reimbursement
claim Form A



Pre and Post
Checklist

Courier Address :

Mr. Arnab Bose
Medi Assist Insurance TPA Pvt. Ltd.
4th floor, Aarpee Chamber, Off
Andheri Kurla Road, Behind
Times Square Building,
Sagbaug, Andheri (East), Mumbai – 400059





Q119. CASHLESS HOSPITALIZATION PROCESS:

- Select network hospital from website
- **Web site link:** <https://www.medibuddy.in/networkHospitals>
- **Select Insurance Company:** The New India Assurance Co. Ltd.
- Inform hospital's insurance department about cashless facility
- **Provide Photo ID:** PAN card/aadhaar card & e-card of the patient
- Once submitting documents to hospital, they will send cashless request
- (Pre-authorization form along with all supporting documents) to Medi Assist TPA for further processing
- Post submitting all documents to Medi Assist TPA, medical team will check all received documents and gives approval to the hospital

Q120. Why you should go for Cashless?

Covers both planned and unplanned hospitalisation expenses in network hospital.

Minimum paperwork.

No need to pay hospital bill up to the extent of cashless approval as per policy terms and conditions.

Fast and efficient way to claim medical expenses on 24-hour hospitalisation.

Saves your sum insured from getting exhausted (due to lower utilization of sum insured) through pre-negotiated rates.

If you do not apply for cashless from a network hospital having a tie up with TPA, the discount offered by the hospital at the time of cashless will be deducted at the time of settlement of claim through the reimbursement mode



Points to remember:

- Please retain copies of all the documents submitted to us for future reference
- Please retain a POD copy of the courier for tracking your consignment in case of any delay
- The above list of documents is indicative. Should there be any other document requirement as specified by the insurance company, our document recovery team will contact you on receipt of your claim documents
- For implants used in cataract, heart valve surgeries, CABG, abdominal surgeries, knee replacement surgeries, please submit the bill from the vendor for the prosthetic device used along with sticker
- PPN declaration form must be filled by hospital authority with signed and stamped in case insured hospitalized in network hospital and not utilized cashless facility
- Non receipt of claim intimation within 2 to 3 days from date of admission 10% co-pay will be applicable on medical admissible claim amount
- Please refer to the state guidelines on Covid hospitalization before discharge and final bill generation by the hospital
- **If claim amount is incorrectly written in the claim form, claim will be processed on the lower of the 2 amounts – claim amount or actual bills**
- **Cancelled cheque with your name printed is mandatory for reimbursement claim.**



Q121. Who should I contact for assistance?

For all reimbursement claim assistance, please write to us at:

mumbaiclaims@prudentbrokers.com

For all cashless claim assistance, please write to us at:

cashless@prudentbrokers.com

For all general queries, please write to us at:

hexaware@prudentbrokers.com

CLAIMS SUPPORT (PRUDENT BROKERS)

Cashless Assistance:

Mr. Vaibhav Nikam | 08069225408

cashless@prudentbrokers.com

Reimbursement Assistance:

Ms. Vrishali Bansode | 080 6922 5470

mumbaiclaims@prudentbrokers.com

Cashless Claims Escalation Point :

Dr. Saman Sayed | +91 86574 91774

Saman.sayed@prudentbrokers.com

Reimbursement Escalation point

Dr Pooja Vejre | +91 7304045685

pooja.vejre@prudentbrokers.com

POLICY SUPPORT (PRUDENT BROKERS)

First Level Contact (General Queries):

Ms. Prasiddhi Sawant | +91 92891 38284

hexaware@prudentbrokers.com

Escalation Point 1:

Mr. Amit Durgakar

amit.durgakar@prudentbrokers.com

Escalation Point 2:

Ms. Ashita Lotia

ashita.lotia@prudentbrokers.com



Disclaimer: This FAQ will serve as a guide to the benefits provided by HEXAWARE. The information contained herein is only a summary of the terms and conditions agreed with the insurer. If there is a conflict in interpretation, then the terms and conditions of the policy will prevail.