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Group Medical Insurance Guide 2016

People matter, results count.

About the Employee Benefits Guide

This Employee Benefits Guide is a reference guide to the benefits provided by Capgemini. For complete information on the benefit terms & conditions you please refer to the policy documents/wordings provided by the respective insurers. This Benefits Guide covers Group Medical Plan

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Note: Confidential Document

The information contained here is only a summary of the employee benefit insurance policy documents which are kept by the employer. If there is a conflict in interpretation then the terms & conditions of the applicable policy document will prevail.

Group Medical Policy

Group Medical Policy

- A. Program Details
  - Plan Information
  - Benefit Details
  - Enrollment Procedure
  - General Exclusion
  - Claims Process

The Group Medical policy covers expenses by the insured persons (employee & family members covered) on account of hospitalization due to sickness or accident. The policy covers expenses incurred on room rent, medicines, surgery etc. Expenses for hospitalization are payable only if a 24 hour hospitalization has been taken. Under a scheme such as this typical expense heads covered are of the following: room/boarding expenses as provided by the hospital or nursing home; nursing expenses; surgeon, anesthetist , medical practitioner, consultant , specialist fees; anesthesia, blood, oxygen, operation theater charges, surgical appliance, medicines and drugs; dialysis, chemotherapy, radiotherapy, and similar expenses.

Plan Information - Group Medical Policy

Plan Name	Group Medical Plan
Policy Holder	IGATE Global Solutions Ltd.
Insurance Company	United India Insurance Company Limited
Period of the Cover	12 months
Inception Date	01st July 2016
Sum Insured Limits	Age 18 to 30 years - INR 200,000 Age 31 to 40 years - INR 300,000 Age 41 and above - INR 400,000 (Age as of 1st July 2016 or for new joiners as on DOJ will be considered for entire duration of this year policy)
Members Covered	➢ Employee ➢ Spouse ➢ Dependent Children (Upto the age 25)
Geographical Limits	Within India
Mid-Term Enrollment	Only allowed for new born baby and newly wed spouse

Benefit Details - Group Medical Policy

Policy Benefits	
Standard Hospitalization	Covered
Pre & Post Hospitalization Expenses	Covered
Maternity Benefits	Covered
Pre & Post Natal Expenses	Covered
New Born Baby cover day 1*	Yes
Pre-existing Diseases	Covered
First 30-days Waiting Period	Waived Off
First Year Waiting Period	Waived Off
Room Rent Capping	1% sum insured sub to min of INR 3,000 for Normal room & no limit for ICU
Infertility Treatment	Coverage upto INR 10,000 per employee with a policy cap of INR 100,000 subject to 24 hrs hospitalisation

Policy Benefits	
Homeopathic and Ayurvedic Treatments	Covered subject to hospitalisation in Govt. Registered hospitals
Abortion	Covered within and upto Maternity sublimit, if performed legally & under medical advice within first 20 weeks on confirmation of substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped. 20 weeks to be extended as per amendment in MTP Act, 1971 in due course of time.
Ambulance Services	Maximum upto INR 2,500 per hospitalisation
Treatment like Cyber Knife/ Stem Cell Treatment, Robotic Surgery, Psychiatric Treatment, Age related Macula Disorder, Cochlear Implant, Eye sight correction beyond +/- 7, Morbid Obesity Treatment , Functional Endoscopic Sinus Surgery, Internal and External Congenital Disease are covered.	

The above are only snapshots of the benefits provided under your group medical plan. Please refer Policy document for complete information on Coverage & Exclusions.

Submission of claim - TPA must receive the claim documents for all reimbursements within 60 days of discharge from hospital.

Standard Hospitalization - Group Medical Policy

If any Insured Person suffers an Illness or Accident during the Policy Period that requires that Insured Person's hospitalization as an inpatient, then the insurer will reimburse reasonable and customary expenses towards the below mentioned hospitalization under your group medical plan.

- Inpatient Treatment
- Room rent and boarding expenses
- Doctors fees (who needs to be a medical practitioner)
- Intensive Care Unit
- Nursing expenses, Anesthesia, blood, oxygen, operation theatre charges, surgical appliances
- Medicines, drugs and consumables (Dressing, ordinary splints and plaster casts)
- Diagnostic procedures (such as laboratory, x-ray, diagnostic tests)
- Costs of prosthetic devices if implanted internally during a surgical procedure
- Organ transplantation including the treatment costs of the donor but excluding the costs of the organ

The expenses shall be reimbursed provided they are incurred in India and are within the policy period. Expenses will be reimbursed to the covered member depending on the level of cover that he/she is entitled to. Expenses that are of a diagnostic nature only or are incurred from a preventive perspective with no active line of treatment and do not warrant a hospitalisation admission are not covered under the plan.

Pre & Post Hospitalization Expenses- Group Medical Policy

The pre & post hospitalization expenses are covered under your group medical plan.	
Pre-hospitalization Expenses	If the Insured member is diagnosed with an Illness which results in his / her hospitalization and for which the Insurer accepts a claim, the Insurer will also reimburse the Insured Member's Pre-hospitalisation Expenses for up to 30 days prior to his / her Hospitalization.
Duration	30 days
Restrictions	Such Medical Expenses must be incurred for the same condition for which the Insured Person's subsequent Hospitalization was required.
Post-hospitalization Expenses	If the Insurer accepts a claim under Hospitalization and immediately following the Insured Member's discharge, further medical treatment directly related to the same condition for which the Insured Member was Hospitalized is required, the Insurer will reimburse the Insured member's Post-hospitalisation Expenses for up to 60 day period.
Duration	60 days
Restrictions	Such costs are incurred in respect of the same condition for which the Insured Person's earlier Hospitalization was required

Please note that although you are covered for post hospitalization claims for 60 days after discharge, you are expected to file a reimbursement claim with the TPA within 30 days of incurring the expense.

Maternity Benefits - Group Medical Policy

The maximum benefit allowable is INR 50,000 per delivery for Normal and for Caesarian within the Sum Insured,. There are special conditions applicable to the Maternity Expenses Benefits as below.

These benefits are admissible only if the expenses are incurred in Hospital/Nursing Home as in-patients in India. Claim in respect of delivery for only first two children and/or operations associated therewith will be considered in respect of any one Insured Person covered under the Policy or any renewal thereof. Those Insured Persons who already have two or more living children will not be eligible for this benefit. Expenses incurred in connection with voluntary medical termination of pregnancy during the first 12 weeks from the date of conception are not covered. Sterilization expenses excluded.

The maternity benefit is provided under your group medical plan	
Maximum Benefit	INR 50,000 for Normal & C – Section
9-months waiting period	Waived Off
Pre-Post Natal expenses	OPD cover upto INR 5,000 & IPD within Maternity limit.
New born baby covered from day 1	Yes
No. of maternity claims	Not restricted

IMPORTANT:
FOR MATERNITY REIMBURSEMENTS AND EMPLOYEES ON SUBSEQUENT MATERNITY LEAVE , PLEASE DO NOT WAIT TILL YOU RETUR BACK TO OFFICE TO SUBMIT A CLAIM AS IT WILL CROSS THE CLAIM SUBMISSION TIMEFRAMES AND CLAIM MAY BE DENIED. PLEASE ALSO IMMEDIATELY INFORM HR ABOUT THE NEW BABY COVERAGE AS YOUR DEPENDENT AS SUBSEQUENT COMPLICATION MAY BE A POSSIBILITY AND INTIMATION IS MANDATORY PRIOR TO COVERAGE.

Other Benefits - Group Medical Policy

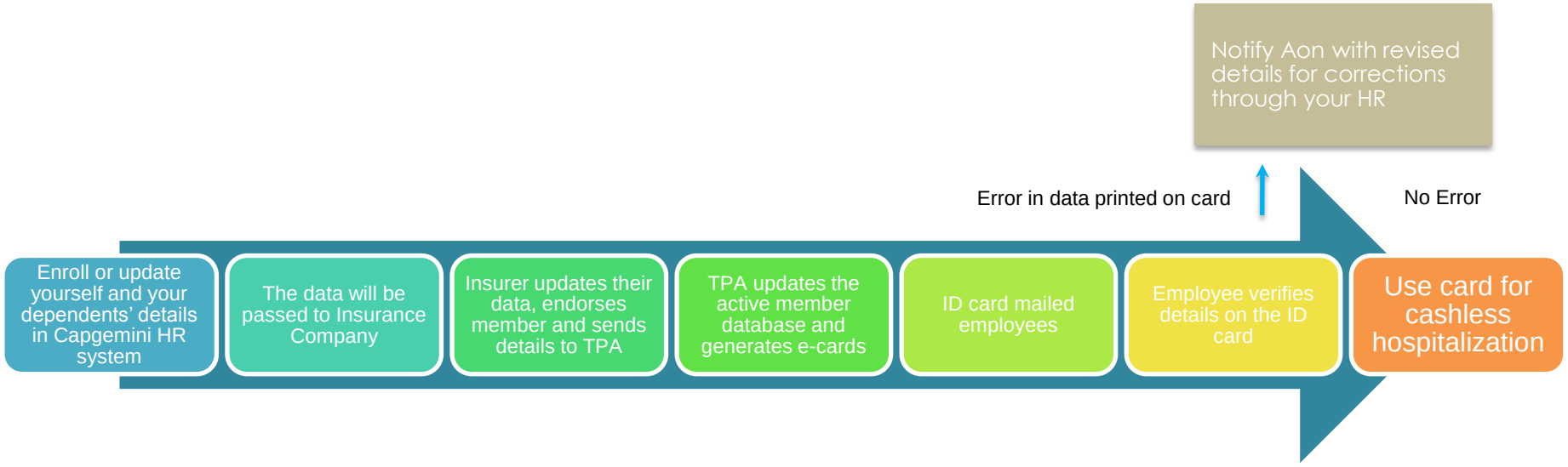
Policy Benefit	Definition	Covered/Not Covered
Pre-existing Diseases	Any Pre-Existing Condition or related condition for which care, treatment or advice was recommended by or received from a Doctor or which was first manifested prior to the commencement date of the Insured Person's first Health Insurance policy with the Insurer.	Covered
First 30 day waiting period	Any disease contracted by the Insured Person (except for the "First Year diseases" listed below) during the first 30 days from commencement date of the Policy is not covered. This exclusion shall not apply if in the opinion of Panel of Medical Practitioners constituted by the Company for the purpose, the Insured person could not have known of the existence of the Disease or any symptoms or complaints thereof at the timer of making the proposal for insurance to the Company.	Waived
First year Waiting Period	During the first year of the operation of the policy, the expenses on treatment of diseases such as Cataract, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Congenital Internal Diseases, Fistula in anus, Piles, Sinusitis and related disorders are not payable. If these diseases are pre- existing at the time of proposal, they will not be covered even during subsequent period or renewal.	Waived
Dental & Vision	Any expenses related to treatment for eye and ear will be covered only if it is resultant of accident. If otherwise the same will not be covered under the policy. The accident has to incur in the current policy year.	Not Covered
Diagnostic Expenses	Standalone diagnostic expenses are not payable under the policy. If the diagnosis is followed by treatment the diagnositc expenses can be claimed as pre hospitalisation expense.	Not Covered

Enrollment Procedure - Group Medical Policy

• You must enroll in order to obtain coverage for yourself and your eligible dependents. Please ensure you enroll your dependents' information to HR by providing relevant enrollment data (viz. name, date of birth, gender) as per the identified process. Your enrollment data must reach the Insurer within 30 days of your joining the company for all new joining employees.

• Please update your HR each time you acquire a new dependent i.e. when your family status changes because of marriage, birth of a child. New spouse must be declared within 30 days of marriage. New-born child has to be declared immediately after first discharge following child-birth.

• If you fail to enroll within the defined timelines, enrollment may only be done at the next annual renewal.



General Exclusions - Group Medical Policy

- Injury or disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, War like operations (whether war be declared or not) or by nuclear weapons / materials.
- Circumcision (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident), vaccination, inoculation or change of life or cosmetic or of aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.
- Cost of spectacles, contact lenses, hearing aids etc., Surgery for correction of eye sight, covered only of eye sight power is + / - 7,
- Any dental treatment or surgery which is corrective, cosmetic or of aesthetic procedure, filling of cavity, root canal including wear and tear etc unless arising from disease or injury and which requires hospitalisation for treatment.
- Convalescence, general debility, “run down” condition or rest cure, congenital external diseases or defects or anomalies, sterility, any fertility, sub-fertility or assisted conception procedure, venereal diseases, intentional self-injury/suicide and diseases / accident due to and or use, misuse or abuse of drugs / alcohol or use of intoxicating substances or such abuse or addiction etc.
- All expenses arising out of any condition directly or indirectly caused by, or associated with Human T-cell Lymphotropic Virus Type III (HTLD - III) or Lymohadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of similar kind commonly referred to as AIDS, HIV and its complications including sexually transmitted diseases.
- Expenses incurred at Hospital or Nursing Home primarily for evaluation / diagnostic purposes which is not followed by active treatment for the ailment during the hospitalised period.
- Expenses on vitamins and tonics etc unless forming part of treatment for injury or disease as certified by the attending physician.
- Any Treatment arising from or traceable to pregnancy, miscarriage, or complications of any of these including changes in chronic condition as a result of pregnancy except where covered under the maternity section of benefits
- Naturopathy treatment, unproven procedure or treatment, experimental or alternative medicine and related treatment including acupressure, acupuncture, magnetic and such other therapies etc.

General Exclusions - Group Medical Policy

- Expenses incurred for investigation or treatment irrelevant to the diseases diagnosed during hospitalisation or primary reasons for admission. Private nursing charges, Referral fee to family doctors, Out station consultants / Surgeons fees etc,.
- Genetical disorders.
- External and or durable Medical / Non medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Infusion pump etc., Ambulatory devices i.e. walker , Crutches, Belts ,Collars ,Caps , splints, slings, braces ,Stockings etc of any kind, Diabetic foot wear, Glucometer / Thermometer and similar related items etc and also any medical equipment which is subsequently used at home etc..
- All non medical expenses including Personal comfort and convenience items or services such as telephone, television, Aya / barber or beauty services, diet charges, baby food, cosmetics, napkins , toiletry items etc, guest services and similar incidental expenses or services etc..
- Change of treatment from one path to other path unless being agreed / allowed and recommended by the consultant under whom the treatment is taken.
- Treatment of obesity or condition arising therefrom (excluding morbid obesity and life threatening) and any other weight control programme, services or supplies etc..
- Any treatment required arising from Insured's participation in any hazardous activity including but not limited to scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing etc unless specifically agreed by the Insurance Company.
- Any treatment received in convalescent home, convalescent hospital, health hydro, nature care clinic or similar establishments.
- Any stay in the hospital for any domestic reason or where no active regular treatment is given by the specialist.
- Out patient Diagnostic, Medical or Surgical procedures or treatments, non-prescribed drugs and medical supplies, Hormone replacement therapy, Sex change or treatment which results from or is in any way related to sex change.
- Massages, Steam bathing, Shirodhara and alike treatment.
- Any kind of Service charges, Surcharges, Admission fees / Registration charges etc levied by the hospital.
- Doctor's home visit charges, Attendant / Nursing charges during pre and post hospitalisation period.
- Treatment which is continued before hospitalization and continued even after discharge for an ailment / disease / injury different from the one for which hospitalization was necessary.

Hospitalization Procedure - Group Medical Policy

You can avail either the cashless facility or submit the claim for reimbursement.

Definition of Cashless

• Cashless hospitalization means the TPA may authorize (upon an Insured person's request) for direct settlement of eligible services and corresponding charges between a Standard Network / PPN Network Hospital and the TPA. In such case, the TPA will directly settle all eligible amounts with the Network Hospital and the Insured Person may not have to pay any deposit at the commencement of treatment or bills after the end of treatment, to the extent these services are covered under the Policy. Denial of cashless does not mean that the treatment is not covered by the policy.

Definition of Reimbursement

• In case you choose a non-network hospital, you will have to liaise directly with the hospital for admission. However, you are advised to follow the pre authorization procedure and intimate the TPA about the claim to ensure eligibility for reimbursement of hospitalization expenses from the insurer.

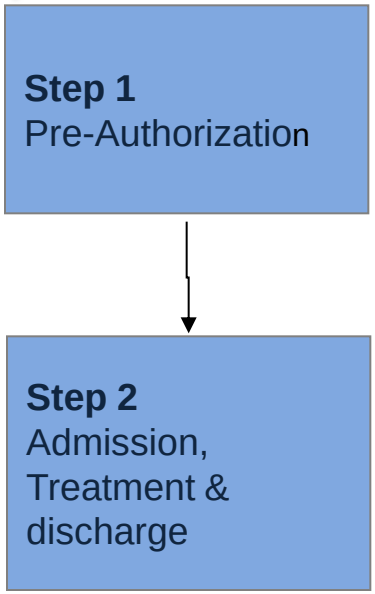
• To learn more about cashless or reimbursement, please click the desired section mentioned below.

Cashless Hospitalization - Group Medical Policy

Cashless hospitalization means the Administrator may authorize (upon an Insured person's request) for direct settlement of eligible services and the corresponding charges between a Network Hospital and the Administrator. In such case, the Administrator will directly settle all eligible amounts with the Network Hospital and the Insured Person may not have to pay any deposits at the commencement of the treatment or bills after the end of treatment to the extent these services are covered under the Policy.

List of hospitals in the TPA's network eligible for cashless hospitalization	
Customer Service Line: Toll Free: General Queries – 1800 209 8884 Cashless Emergency – 1800 209 8444 **Capgemini Dedicated Landline (chargeable):** 022- 30657366 **List of network hospitals:** https://www.uhcpindia.com/	**Relationship Manager:** Mr. Sanojkumar Pal **(UHC TPA)** Mobile: 9167770474 E-mail id – sanojkumar.pal@uhcpindia.com Mr Pradeep Jaiswal **(Aon Global)** Mobile: 7676846885 E-mail id - capgemini.bangalore@globalinsurance.co.in

Planned Cashless Hospitalization - Group Medical Policy



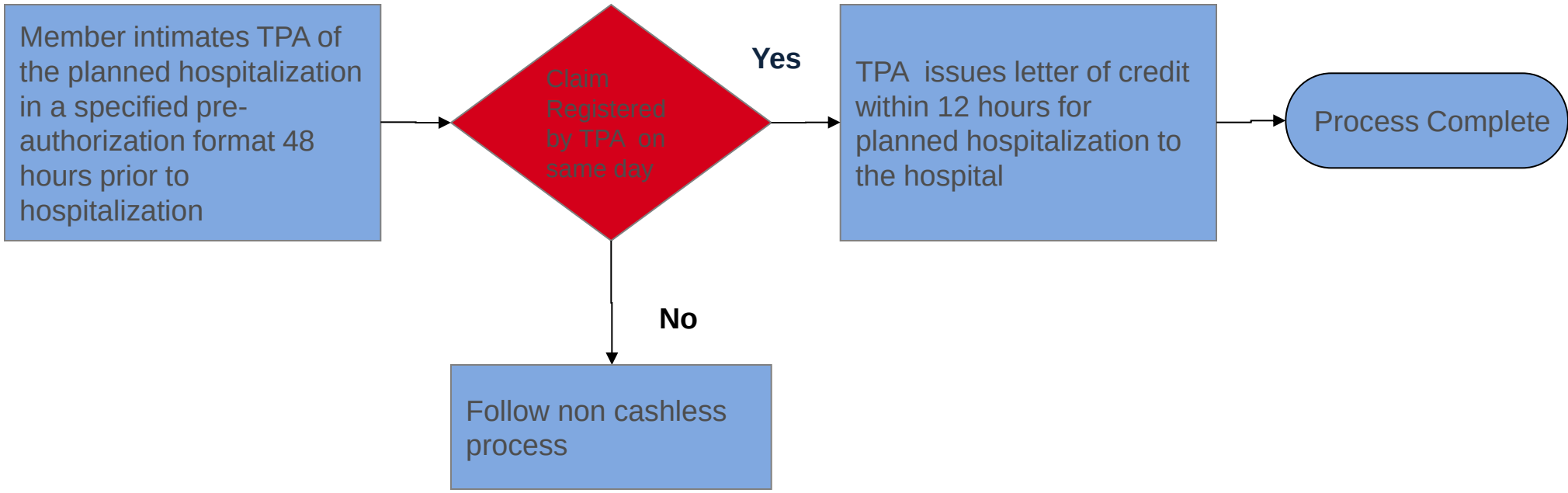
All non-emergency hospitalization instances must be pre-authorized by Help Desk, as per the procedure detailed below. This is done to ensure the best healthcare possible is obtained, and the Insured Member is not inconvenienced when taking admission into a Network Hospital.

After your hospitalization has been pre-authorized, you need to secure admission to a hospital. A letter of credit will be issued by TPA to the hospital. Kindly present your ID card at the Hospital admission desk. The Insured Member is not required to pay the hospitalization bill in case of a network hospital. The bill will be sent directly to, and settled by TPA

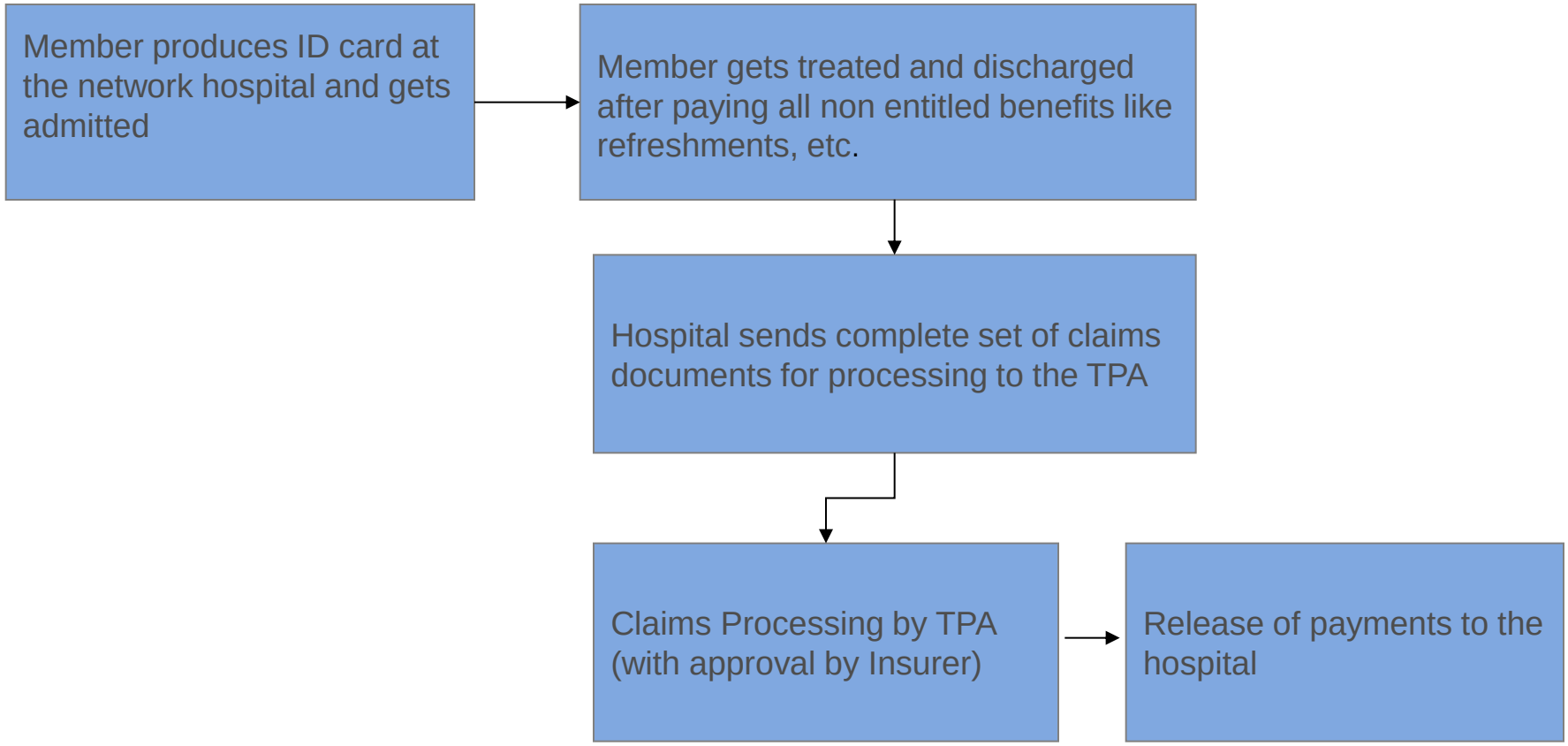
Note: -

Patients seeking treatment under cashless hospitalization are eligible to make claims under pre and post hospitalization expenses. For all such expenses, the bills and other required documents must be submitted separately as part of non-cashless claims.

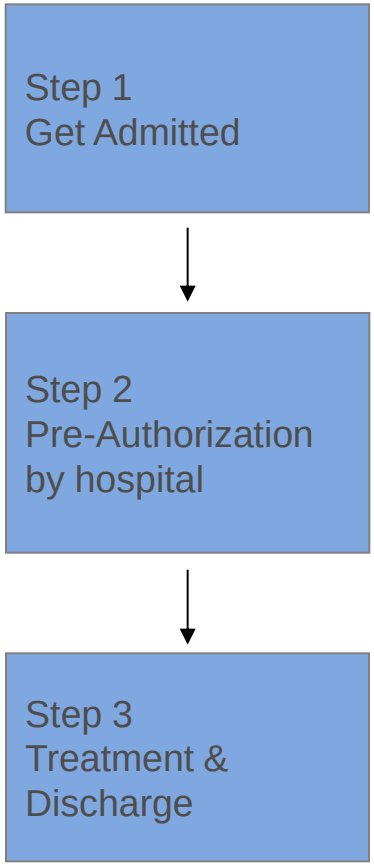
Cashless Pre-authorization - Group Medical Policy



Admission, Treatment and Discharge - Group Medical Policy



Emergency Hospitalisation - Group Medical Policy

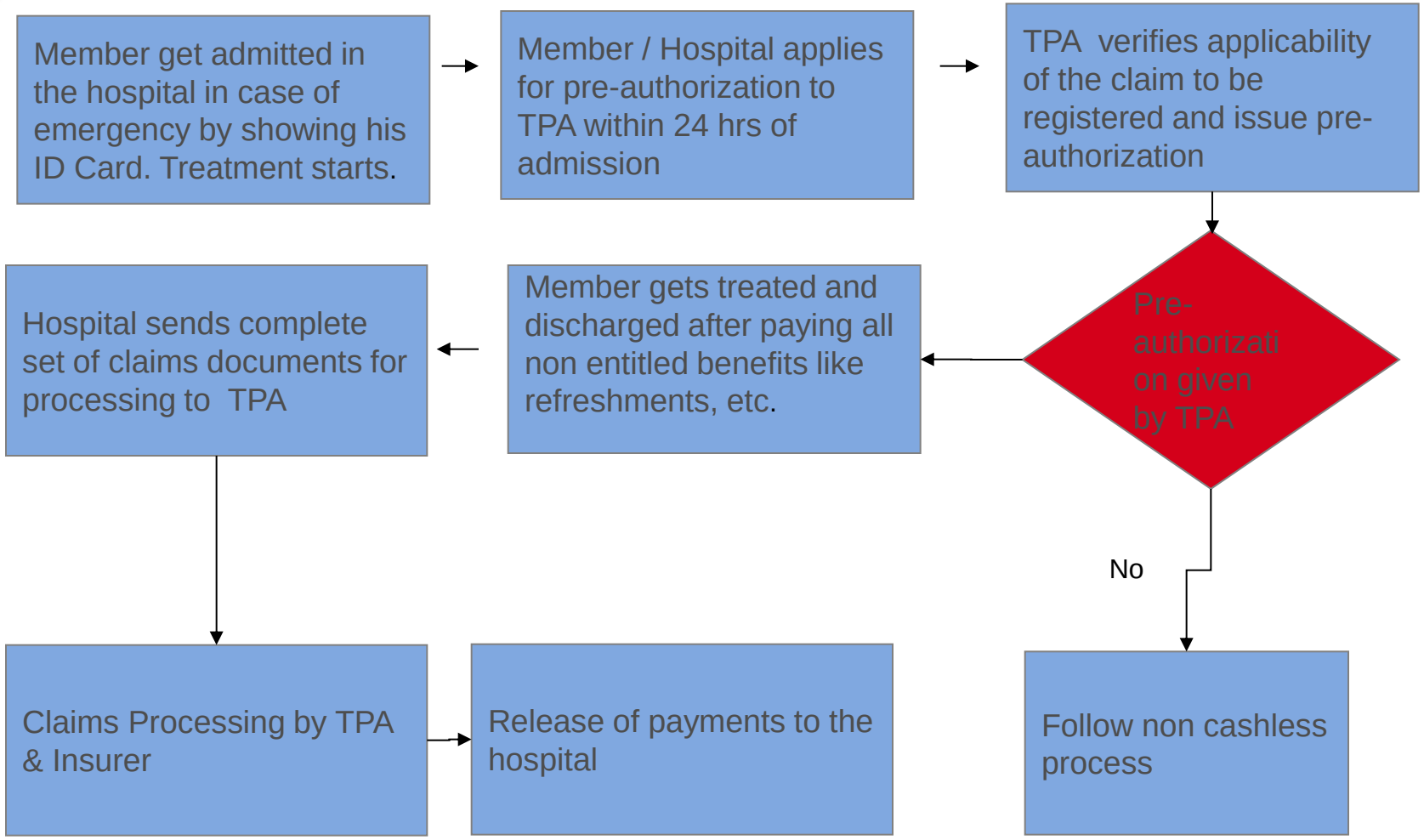


In cases of emergency, the member should get admitted in the nearest network hospital by showing their ID card. The treatment should not be put on hold irrespective of the time of receipt of pre-authorization.

Relatives of admitted member should inform the call centre within 24 hours about the hospitalization & seek pre authorization. The pre authorization letter would be directly given to the hospital. In case of denial, member would be informed directly.

After your hospitalization has been pre-authorized, the employee is not required to pay the hospitalization bill in case of a network hospital. The bill will be sent directly to, and settled by TPA.

Emergency Hospitalization Process - Group Medical Policy



Non Cashless Hospitalization - Group Medical Policy

Admission procedure

In case you choose a non-network hospital, you will have to liaise directly for admission.

You are advised to follow the pre-authorization procedure to ensure eligibility for reimbursement of hospitalization expenses from the insurer.

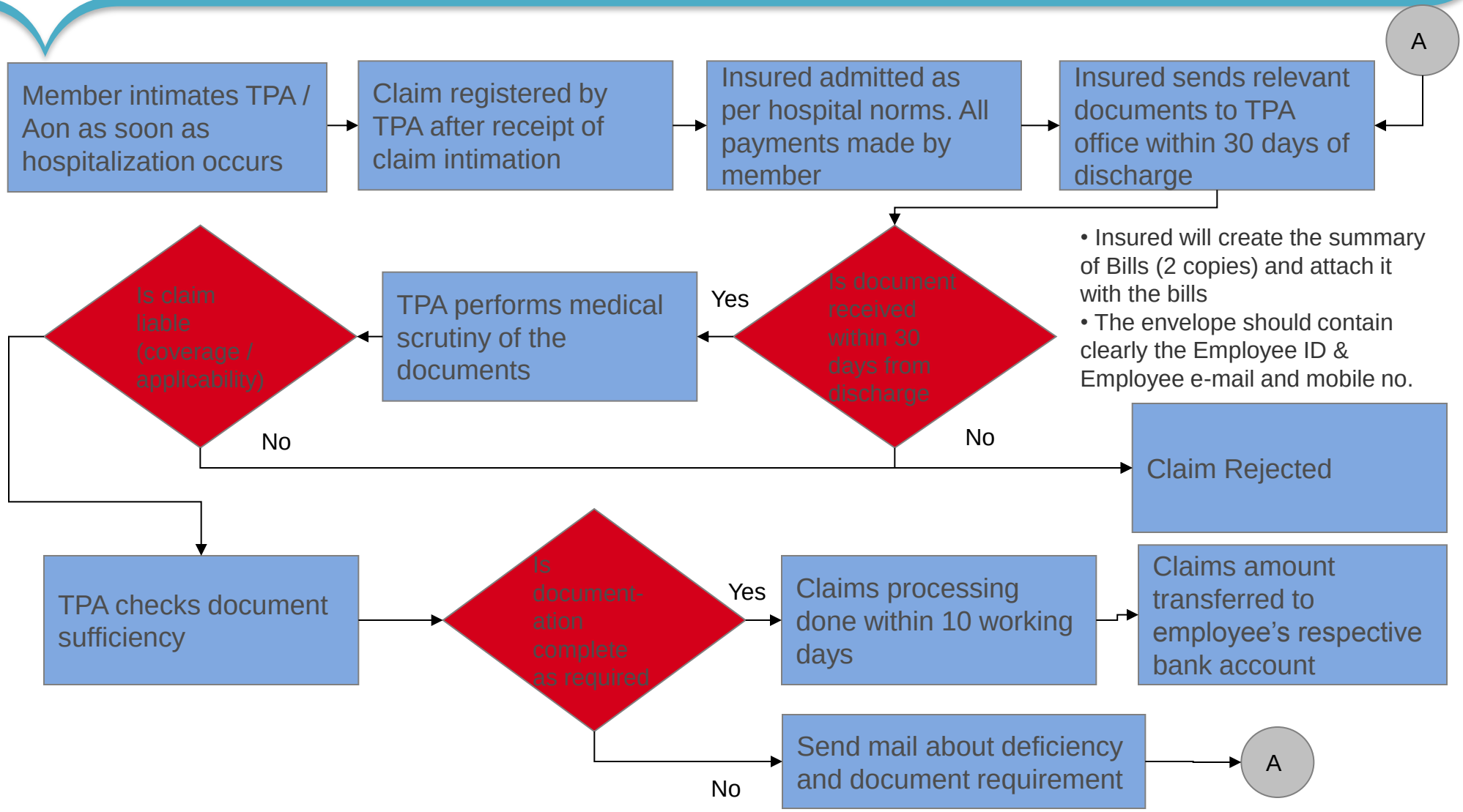
Discharge procedure

In case of non-network hospital, you will be required to clear the bill and submit the claim to TPA for reimbursement from the insurer. Please ensure that you collect all necessary documents such as discharge summary, investigation reports etc. for submitting your claim.

Submission of hospitalization claim

1. After hospitalization is complete and the patient has been discharged from hospital, you must submit the final claim within 30 days from date of discharge from hospital (applicable in case of Non-Network hospital).
2. Under hospitalization claims, you are also permitted to claim for treatment expenses 30 days prior to hospitalization and 60 days after date of discharge. This is applicable for both network and non-network hospitalization.

Non Cashless Hospitalization Process - Group Medical Policy



Claims Document List - Group Medical Policy

No.	Document Required
1	Signed claim form
2	Main hospital bills in original (with bill no; signed and stamped by the hospital) with all charges itemized and the original receipts
3	Discharge card (original)
4	Attending doctors' bills and receipts and certificate regarding diagnosis (if separate from hospital bill)
5	Original reports or attested copies of bills and receipts for medicines, investigations along with doctors prescription in original and laboratory
6	Follow-up advice or letter for line of treatment after discharge from hospital, from doctor.
7	Break up with details of pharmacy items, materials, investigations even though it is there in the main bill
8	In case the hospital is not registered, please get a letter on the hospital letterhead mentioning the number of beds and availability of doctors and nurses round the clock.
9	In case of non-network hospitalization, please get the hospital and doctor's registration number in hospital letterhead and get the same signed and stamped by the hospital.
10	Cancelled cheque

Important FAQs - Group Medical Policy

- **What other expenses are excluded apart from those mentioned under general exclusion?**
  Expenses like Registration Fees, File opening fees, Telephone, Internet charges , Food and refreshments supplied to visitors and attendants, Television charges, service fees , Any expenses not related to treatment of illness are non medical expenses and not covered under the plan.

- **How do I cover my spouse or my new born child?**
  You will have to enroll your spouse / new born baby within 30 days of the life event via HR.

- **What is a TPA ID card?**
  It is an identification card issued by TPA. Once validated by TPA, it will entitle you to credit towards hospitalization and any other negotiated benefits at hospitals on the TPA panel upon pre-authorization. Information on this is available with the TPA customer service helpline. Please remember the ID card is not a credit card. The card does not entitle you to credit. To avoid any misuse of your card, the hospitals may ask you to furnish some photo identification card for the member (eg. Voter ID, Photo Credit card).

  Once your details have been forwarded by HR to the Insurer, the Insurer will make additional endorsements and give details of the same to TPA. TPA will issue the card on the basis of complete information received on the employee and dependents. It normally takes 14 working days to issue the ID card. In case you lose your ID card, please inform HR immediately.

- **What if the hospital does not accept my TPA ID card?**
  Please make sure that the hospital is on the TPA network or PPN network list. This can be verified by accessing the website of the TPA or call the TPA customer service helpline for assistance. If it is a network hospital and you are not accepted, please report the refusal to TPA making note of the name of the hospital staff.

Important FAQs - Group Medical Policy

- **What are network hospitals? What should I do when I reach the hospital?**
  These are hospitals where TPA has a tie up for cashless hospitalization. Once you reach the hospital, please show your ID card for identification. Please complete the pre-authorization procedure listed earlier. TPA will send a letter of credit (upon pre-authorization) to the hospital making sure they extend the credit facility to you.

  If pre-authorization is not done, you must collect all reports and discharge card when you get discharged. Please make sure you sign the hospital bill before leaving the hospital. You will then submit the claim along with all necessary supporting documents to TPA for reimbursement . Please complete the Claim Form, attach all relevant documents and send them to the TPA for reimbursement through your HR.

- **What are claim reimbursements?**
  In the event where cashless hospitalization is not availed, you will need to submit all original bills along with the Claim Form to the insurance company/TPA. Upon approval, the hospitalization expenses will be reimbursed to you.

- **How can I claim my pre & post hospitalization expenses?**
  The group policy covers pre-hospitalization expenses made prior to 30 days of hospitalization and incurred towards the same illness/ disease due to which hospitalization happens. It also covers all medical expenses up to 60 days post discharge as advised by the Medical Practitioner. All bills with summary to be sent to TPA for reimbursement.

- **How can I make a claim if a claim is made partly under my name and my spouse's insurance plans?**
  Claims can be settled under multiple policies on reimbursement basis. First, submit the claim to the first insurer / TPA. Request for the original documents to be returned by the TPA. This will only be done if a part claim is submitted and the TPA will mark the claim as settled up to the limit. The balance of expenses can be submitted to the second insurer / TPA for settlement

Important FAQs - Group Medical Policy

What are the key reasons why a claim under the medical policy could be completely rejected under the plan?

The following are some common reasons for rejection, though NOT the only reasons for which a claim could be rejected.

1) Treatment taken after leaving the organization.

2) Treatment that should have been taken on outpatient basis (unnecessary inpatient admission and /or no active line of treatment in the hospital) or where hospitalization has been done primarily for preventive reasons.

3) Treatment taken that is not covered as per policy conditions or excluded under the policy. Please go through the list of standard exclusions listed earlier.

e.g. Ailment because of alcohol abuse is a standard exclusion. Cosmetic treatments or treatments for external conditions such as squint correction etc are not covered. Hospitalization taken in a hospital which is not covered as per policy conditions (eg. less than 10 bed hospitals). Admission before/after the policy period or details of member not updated on the insurer's list of covered members.

4) In case original documents are not submitted as per the claim submission protocol, the claim may stand rejected.

Escalation Matrix

Escalation Matrix for Group Top up Medi-claim

Overall Escalation/Contact Point for Group Medi-claim, Personal Accident and Group Term Life Policy					
Name	**Agency**	**Email ID**	**Contact No**	**Designation**	**Level**
Pradeep Jaiswal	AON Global	capgemini.bangalore@aon.com	7676846885	Executive	Level 1
Gautam Gokhale	AON Global	gautam.gokhale@aon.com	9967981281	Manager	Level 2