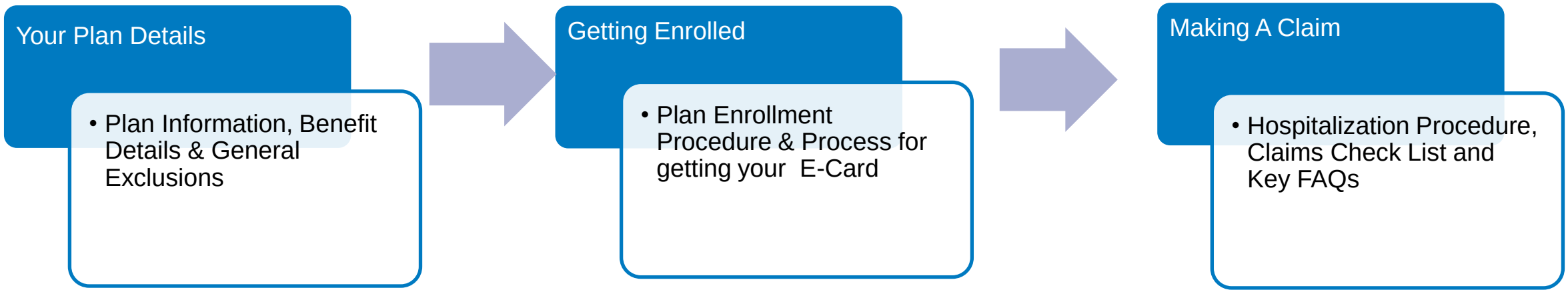
Legato Health Technologies LLP

Benefit Manual 2022-23

Prepared By
Aon India Insurance Brokers Pvt. Ltd.
Registered Office - Unit 102, 1st Floor, The Estate, #121, Dickenson Road, Bengaluru - 560042
Composite Insurance Broker | IRDAI License No.624
License Validity - 16/10/2020 to 15/10/2023

Make the best use of your Benefits



Group Medical Benefits

Know Your Benefits

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 the typical expense heads covered are 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.

Confidential Document

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

Your GMC Plan Details

Plan Name	Group Medical Plan
Policy Holder	Legato Health Technologies LLP
Period of the Cover	Annual
Inception Date	25-January-2022
Expiry Date	24-January-2023
Insurer	Aditya Birla Health Insurance Co. Ltd.
TPA	Paramount Health Services & Insurance TPA Pvt. Ltd (New)
Floater Sum Insured Limits	INR 300,000 per Family (Up to Manager) INR 500,000 per Family (Sr Manager) INR 800,000 per family (Director and above) Additional Enhanced Sum Insured Policy :Floater Sum Insured INR 300,000 per Family(Policy terms remain same as per base policy)
Members Covered	• Employee • Spouse • Dependent children (first 2 living dependent children up to 25 yrs of age) • Dependent Parents/Parents-in-law up to 90 years of age. • Employees have option to cover additional parents by paying additional premium **INR 4,350 + GST Per parent.**
Geographical Limits	Covered for expenses incurred in India only
Mid-Term Enrollment	Allowed, only for new joiners, & New dependents - New marriage employee's Spouse & Newborn child within 30 days
Age-Limit	01 days to 90 years

Your Plan Details

Family Definition

Particular	Description	Special Condition, if any
Total Members Covered per Family	Employee, spouse, dependent children, Dependent Parents/parents-in-law	Additional parents/parents-in-law can be covered by paying an additional premium of INR 4,350 + Tax per parent
Employee	Yes	-
Spouse	Yes	-
Child	Yes	2 dependent children only
Parent	Yes	-
Parent-in-Laws	Yes	-
Sibling	No	-
Other	No	-

Is Mid Term Enrollment Allowed?

Particular	Description	Special Condition, if any
Mid-Term Enrollment of Existing employees' Dependents(as on plan start date)	Not Allowed	-
Mid-Term Enrollment of New Joinees (New Employees +Their Dependents)	Allowed *	-
Mid-Term Enrollment of New Dependents (Spouse/Children)	Allowed *	Newly married employees' spouses & newborn children within the policy year subject to 30 days intimation from DOJ / DOB / Date of marriage.

No Individual should be covered as dependent of more than one employee

Your Plan Details

Policy Benefits	
Standard Hospitalization	Covered
Pre-existing Diseases	Covered
First 30-days Waiting Period	Waived off
First Year Waiting Period	Waived off
Pre & Post Hospitalization Expenses	Covered, 60 days Pre and 90 Days post
Ambulance Services	INR 2,000 per person per event only in emergency
Restriction on Room-Rent	• For Employees up to Manager Level : Normal: INR 8,000 per day and Intensive Care Unit (ICU): On Actuals. • Senior Management (above I13 grade, Sr Manager and Above : Single A/c Private per day and Intensive Care Unit (ICU): On Actuals.
Deductible & Co pay	Nil Co-Pay
Domiciliary hospitalization	Not covered
Diagnostics Expenses	Standalone diagnostic not covered

Policy Benefits	
Ayurvedic claims (AYUSH)	Covered upto 25% of the SI, subjected to inpatient treatment being undertaken in a Govt registered hospitals or NABH accredited Hospitals only.
Day Care Procedures	Covered
Internal congenital	Covered
External Congenital	Covered, in case of life-threatening situation
Dental & Vision	Covered only in case of accident (hospitalization)
Oral Chemotherapy	Covered
Home Quarantine for Covid	Covered up to 20% of Sum Insured only if tested positive for COVID 19. (Medicine / Investigation / Doctor / Nurse -Consultation / PPE kit).
Cochlear implant	Covered, cochlear implant with 50% FSI
Cataract	Covered, INR 30,000 per eye
PTCA, Stents & Joint Replacement	Covered, cost of implant as per prices decided by National Pharmaceuticals Pricing Authority
Cyber knife/Robotic surgery/ Stem cell therapy	Covered with 50% co-payment
Lasik Surgery to correct eyesight	if refractive error of eye is beyond +/-7.5D

IMPORTANT:- Intimation and Submission Timeframes:
Intimation of claim:- TPA must receive Cashless request within 24 hours days from date of Admission.
Submission of claim :- TPA must receive the claim documents for all reimbursements within 30 days of discharge from hospital.
The above details are only snapshots of the benefits provided under your group medical plan. Please refer Policy document for complete information on Coverage & exclusions.

Your Plan Details

Maternity Benefits

- Maternity benefits are admissible only if the expenses are incurred in Hospital / Nursing Home as in-patients in India.
- 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. Infertility Treatment and sterilization are excluded from the policy.

The maternity benefit is provided under your group medical plan	
Maximum Benefit	INR 75,000 for both Normal and C-Section within Sum Insured Limit
Limit	Maximum up to 02 instances
9-months waiting period	Waived off
Pre-Post Natal expenses	Covered up to INR 5,000 with in maternity limit only on (OPD & In-patient)
New born baby covered from day 1	Covered from day 1
Well Baby expenses	Well baby charges covered up to 3,000 within Maternity Limit

IMPORTANT :
For maternity reimbursements and employees on subsequent maternity leave , please do not wait till you have returned back to office to submit a claim as it will cross the claim submission within 30 days to avoid denial of claim. Please also immediately inform your hr about the new baby coverage as your dependent as A subsequent complication may be A possibility and intimation is mandatory prior to coverage.

Your Plan Details

Other Benefit Features

Policy Benefit	Definition	Covered/Not Covered
Room Rent	• Normal INR 8,000 per day for Level up-to Managers and Single A/c Private per day for levels Sr Managers & above • Intensive Care Unit (ICU): On Actuals • Insured employees are requested to use prudence and proper negotiation with Hospital/ Nursing home in availing the eligible room category. • Please remember, higher the room category higher is the cost of treatment. This may result in faster exhaustion of your total available eligibility • Employee opting for a higher room catergory will have to bear the proportionate increase in cost on all categories / heads	Covered

Your Plan Details - Voluntary Employee Top-up policy

Plan Name	Group Medical Plan
Policy Holder	Legato Health Technologies LLP
Period of the Cover	Annual
Inception Date	25th of January 2022
Expiry Date	24th of January 2023
Insurer	Aditya Birla Health Insurance Co. Ltd.
TPA	Paramount Health Services & Insurance TPA Pvt. Ltd
Sum Insured Limits	INR 100,000, INR 200,000, INR 300,000, INR 400,000, INR 500,000, INR 700,000; INR 800,000 INR 10,00,000
Members Covered	As per the base cover
Geographical Limits	Covered for expenses incurred in India only
Mid-Term Enrollment	Allowed, only for new joiners
Age-Limit	90 Years
Benefits	Same as the base cover

Premium Rates – Voluntary Employee Top up policy

Independent Voluntary Top up policy premium chart	
Top up Sum Insured	**Net Premium (Incl Tax)**
INR 100,000	INR 7,493
INR 200,000	INR 8,555
INR 300,000	INR 9,263
INR 400,000	INR 10,030
INR 500,000	INR 10,974
INR 700,000	INR 12,626
INR 800,000	INR 15,930
INR 10,00,000	INR 18,526

Additional Multiply work fit for the employee only who are opting for Top-up as per below

- Active age score through online HRA
- 24*7 access to wellness experts- Doctor on call, counsellor on call, ask a dietician, ask a specialist
- Wellness tips
- Active day leader board
- Access to 6 fitness sessions every month- Yoga, Zumba, Cardio, Strength etc.
- Cashback and discount from various lifestyle partners

Deduction of premium towards "Top Up" Coverage: The amount towards the premium will be deducted from your next month's salary.

Your Plan Details

What Is Covered?

If any Insured Person suffers an Illness or Accident during the Policy Period that requires 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 hospitalization admission are not covered under the plan.

Your Plan Details

Group Medical – Pre & Post Hospitalization Expenses

The pre & post hospitalization expenses are covered under your group medical plan.	
Pre-hospitalization Expenses	If the Insured Person is diagnosed with an Illness which results in his or her Hospitalization and for which the Insurer accepts a claim, the Insurer will reimburse the Insured Person's Pre-hospitalization Expenses for up to 30 days prior to his Hospitalization as long as the 30 day period commences and ends within the Policy Period.
Duration	Within 30 days before hospitalization
Restrictions	No restriction
Post-hospitalization Expenses	If the Insurer accepts a claim above and, immediately following the Insured Person's discharge, he requires further medical treatment directly related to the same condition for which the Insured Person was Hospitalized, the Insurer will reimburse the Insured Person's Post-hospitalization Expenses
Duration	Within 60 days post discharge

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 7 days of incurring the expense after compiling 60 days.

Your Plan Details

Other Benefit Features

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-days waiting period	▪ Any Illness diagnosed or diagnosable within 30 days of the effective date of the Policy Period if this is the first Health Policy taken by the Policyholder with the Insurer.	▪ Covered
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 Menorrhegia or Fibromyoma, Hernia, Hydroceie, 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 too	▪Waived off
Day Care	▪Day Care Procedure means the course of medical treatment, or a surgical procedure listed in the Schedule which is undertaken under general or local anesthesia in a Hospital by a Doctor in not less than 2 hours and not more than 24 hours.	▪Covered
Diagnostic Expenses	▪All diagnostic tests and lab tests as part of hospitalization and pre-post hospitalization including OPD. Diagnostic tests without treatment or not related to treatment are not covered	▪Covered and Only incase of 24-hr hospitalization related to treatment

Your Plan Details

General Exclusions

- Injury or disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, War like operations (whether war be declared or not) or by nuclear weapons / materials.
- Circumcision (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident), vaccination, inoculation or change of life or cosmetic or of aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.
- Surgery for correction of eyesight, cost of spectacles, contact lenses, hearing aids etc.
- 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.
- Congenital external diseases or defects/anomalies
- 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, all psychiatric and psychosomatic disorders and diseases / accident due to and or use, misuse or abuse of drugs / alcohol or use of intoxicating substances or such abuse or addiction etc.
- Any cosmetic or plastic surgery except for correction of injury
- Expenses incurred at Hospital or Nursing Home primarily for evaluation / diagnostic purposes which is not followed by active treatment for the ailment during the 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, abortion 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.

Your Plan Details

General Exclusions

- 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.
- Naturopathy treatment, unproven procedure or treatment, experimental or alternative medicine and related treatment including acupressure, acupuncture, magnetic and such other therapies etc.
- Genetical disorders and stem cell implantation / surgery.
- 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 pathy to other pathy unless being agreed / allowed and recommended by the consultant under whom the treatment is taken.
- Treatment of obesity or condition arising therefrom (including morbid obesity) and any other weight control 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.
- Massages, Steam bathing, Shirodhara and alike treatment under Ayurvedic treatment.

Your Plan Details

General Exclusions

- Any kind of Service charges, Surcharges, Admission fees / Registration charges etc levied by the hospital.
- 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.
- 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,.
- Vitamins and tonics unless used for treatment of injury or disease
- Infertility treatment, Intentional self Injury, Outpatient treatment.
- Family planning Operations (Vasectomy or tubectomy) etc
- Genetical disorders / stem cell implantation / surgery
- 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.
- External and or durable Medical / Non medical equipment of any kind used for diagnosis and or treatment like Prosthetics etc.
- Lasik treatment or any other procedure for correction/enhancement of vision is not covered.
- Any device/instrument/machine that does not become part of the human anatomy/body but would contribute/replace the function of an organ is not covered.
- Warranted that treatments on trial/experimental basis are not covered under scope of the policy.

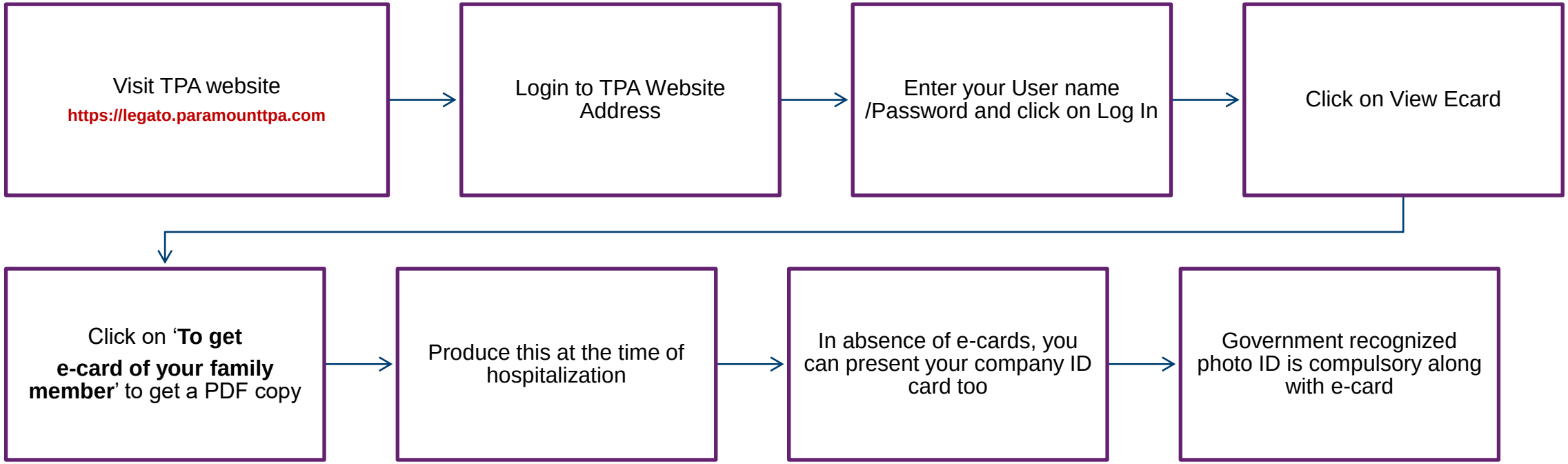
Getting Enrolled

The Procedure : What Must You Remember ?

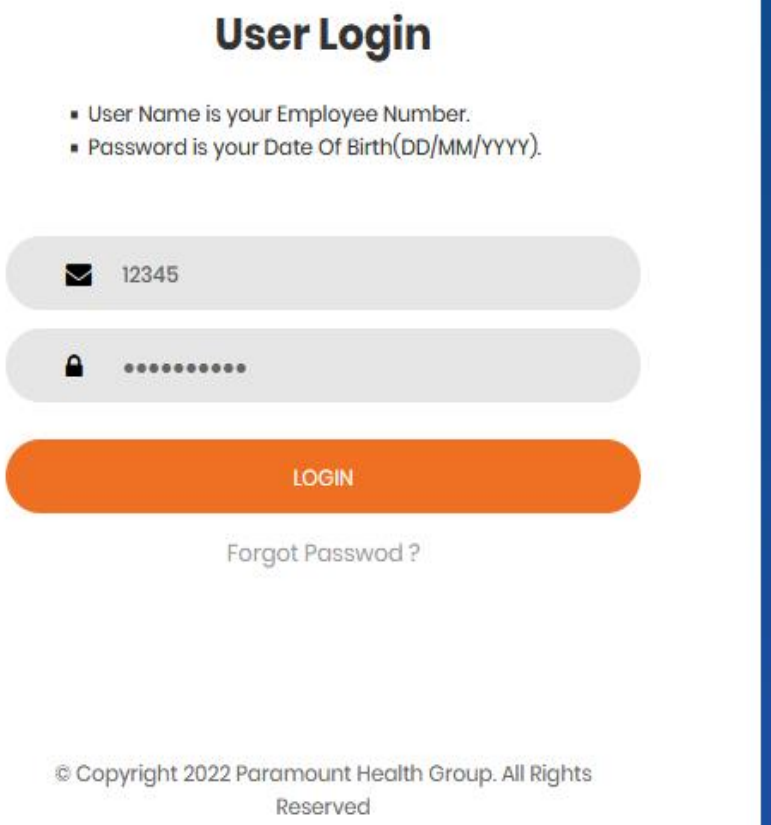
- Employees have to provide all the details of dependents in the prescribed format provided in the joining docket for Mediclaim coverage. Dependents once declared cannot be changed during the policy period.
- Existing Employees are covered as on date of policy commencement (or date of joining for new employees joining after 25 Jan 2022) along with their eligible dependents as per data provided by HR to Insurance Company.
- No midterm inclusion of dependents would be allowed except in case of spouse due to marriage of a employee and birth of child.
- Midterm enrollment of new dependents (Spouse / Children) is allowed for employees within 30 days from Date of Marriage/ Date of Birth. The details need to be updated by you on Family Health Plan (TPA) website.
- Eligible Dependent covered under the policy for existing employees can be viewed on the TPA website.

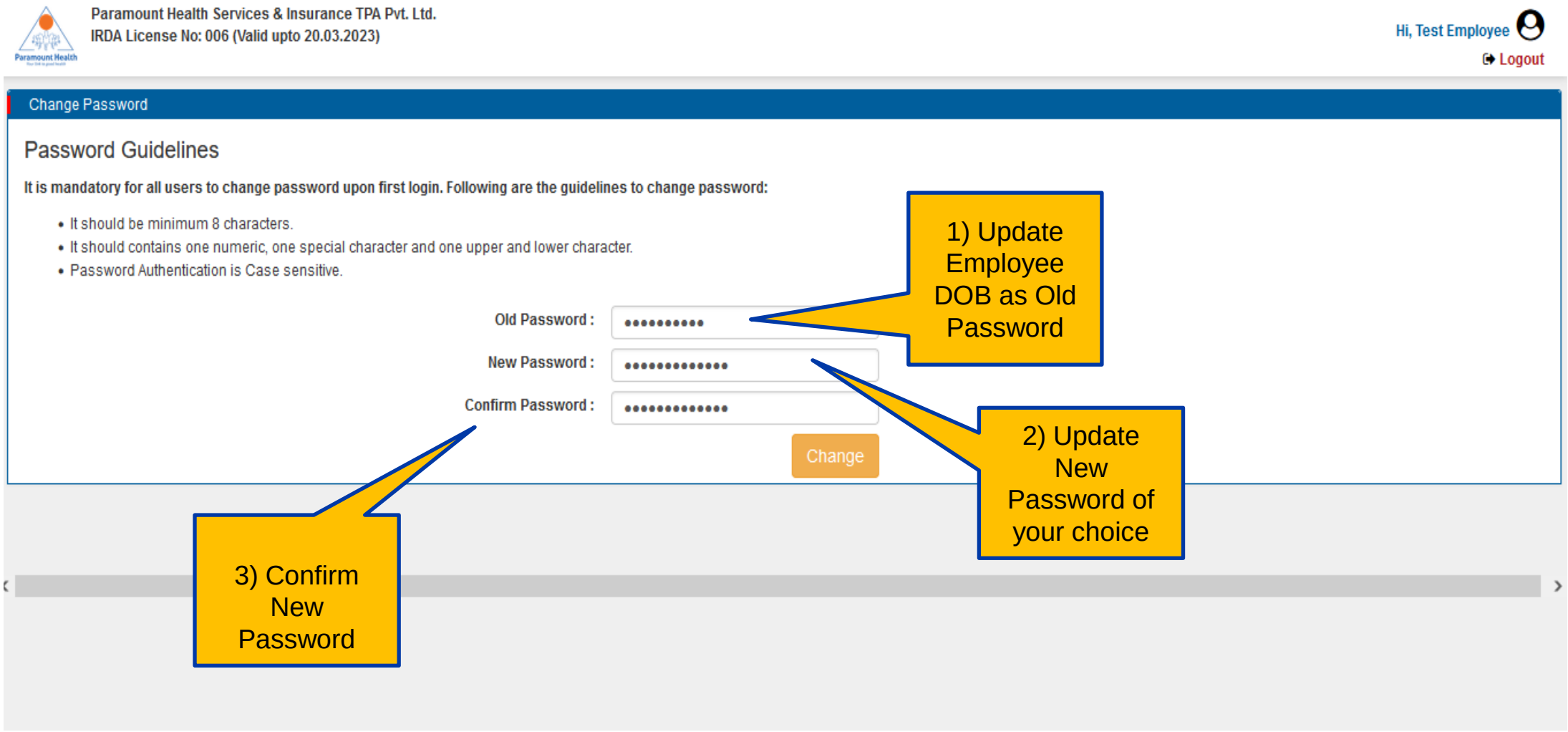
Getting Enrolled

The Process For E-Cards

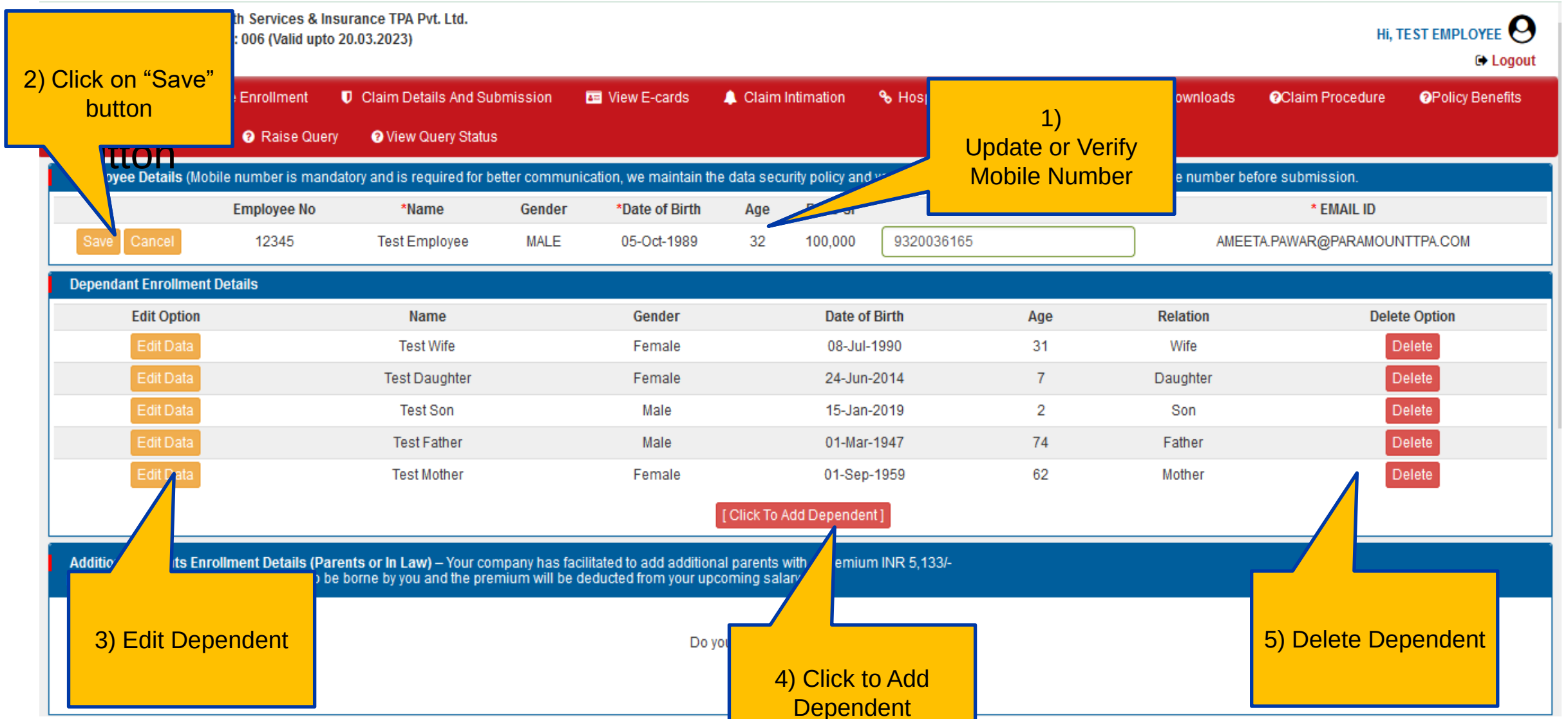


Log on to https://legato.paramounttpa.com

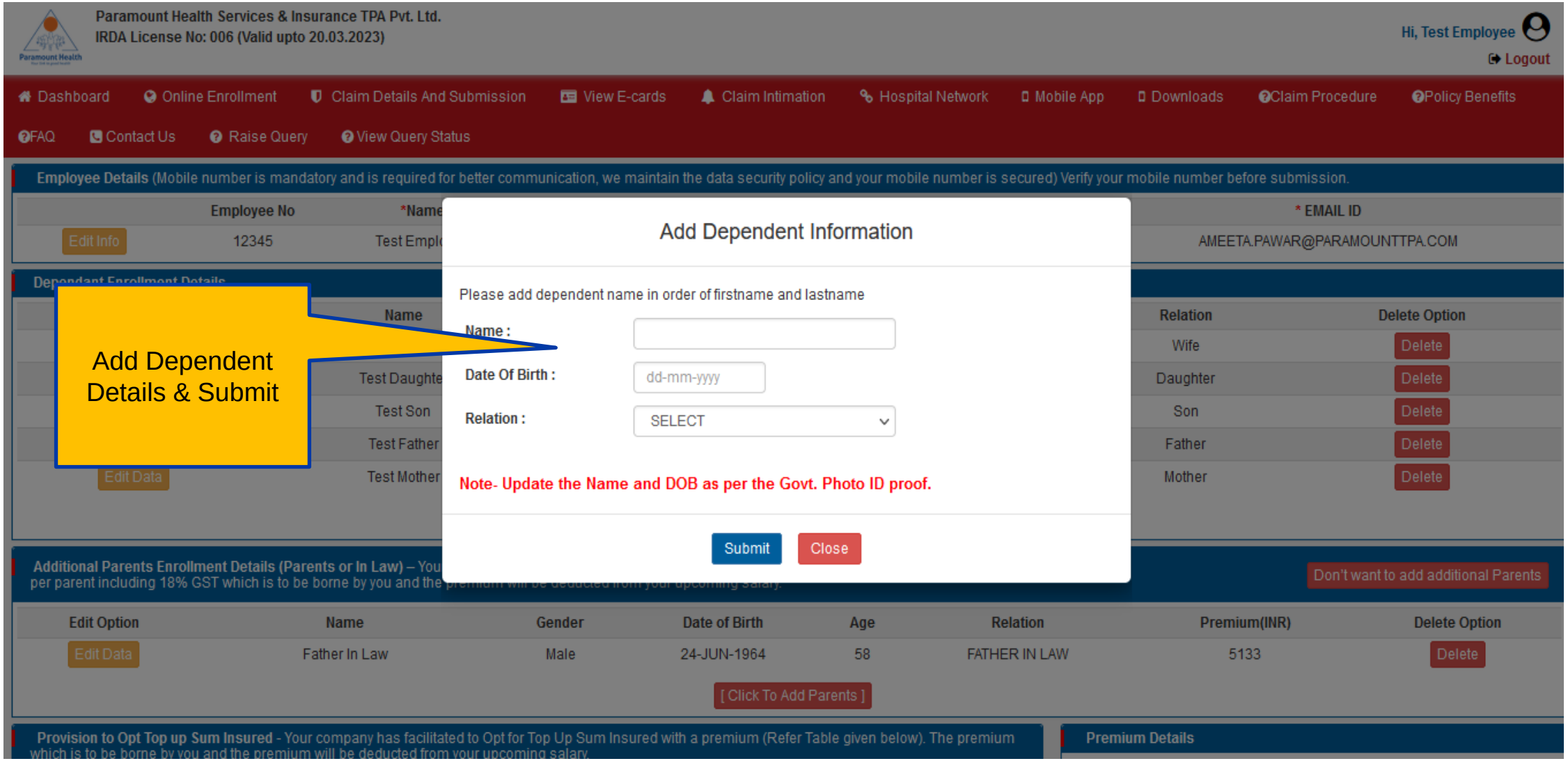



Paramount Health Services & Insurance TPA Pvt. Ltd.
IRDA License No: 006 (Valid upto 20.03.2023)
Hi, Test Employee
Logout
Change Password
Password Guidelines
It is mandatory for all users to change password upon first login. Following are the guidelines to change password:
It should be minimum 8 characters.
It should contains one numeric, one special character and one upper and lower character.
Password Authentication is Case sensitive.
Old Password :
New Password :
Confirm Password :
Change
1) Update Employee DOB as Old Password
2) Update New Password of your choice
3) Confirm New Password

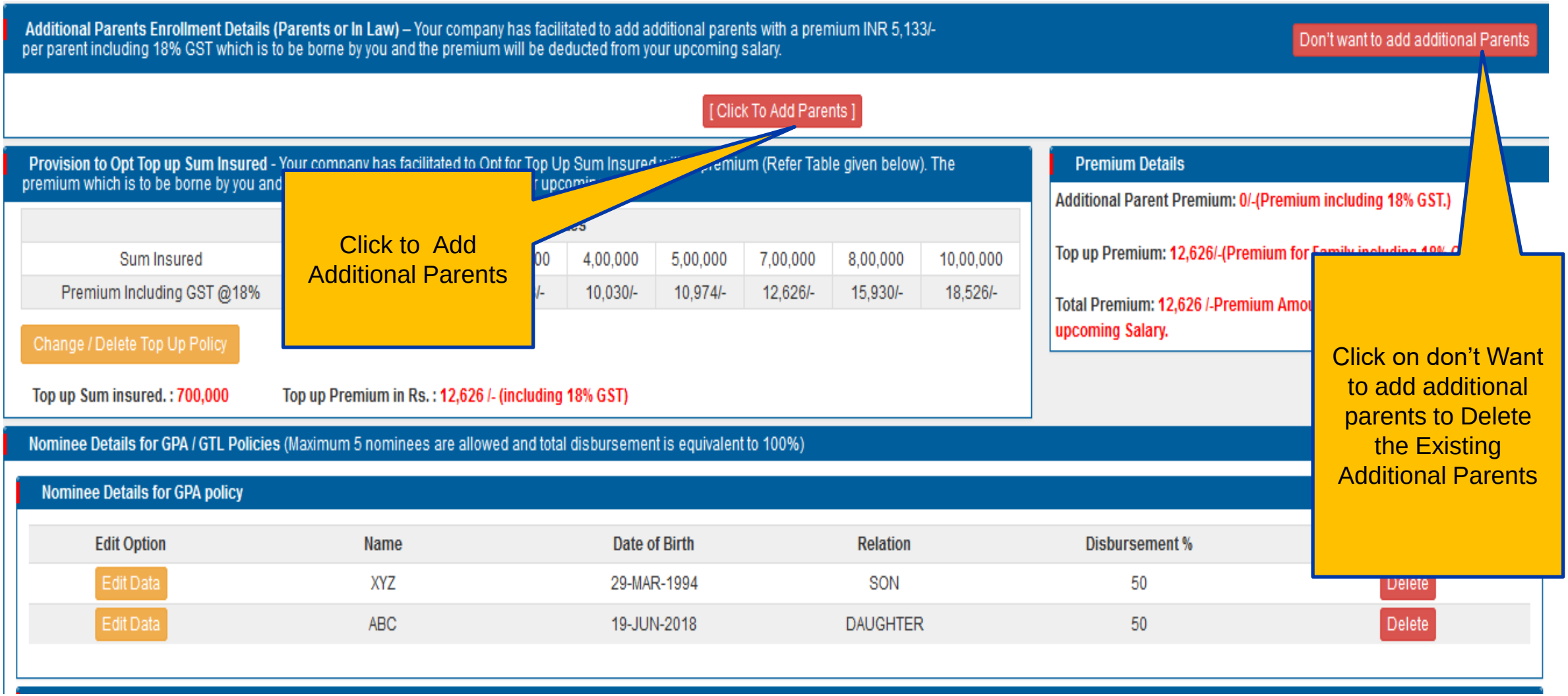
Update & Verify Mobile & Dependent details



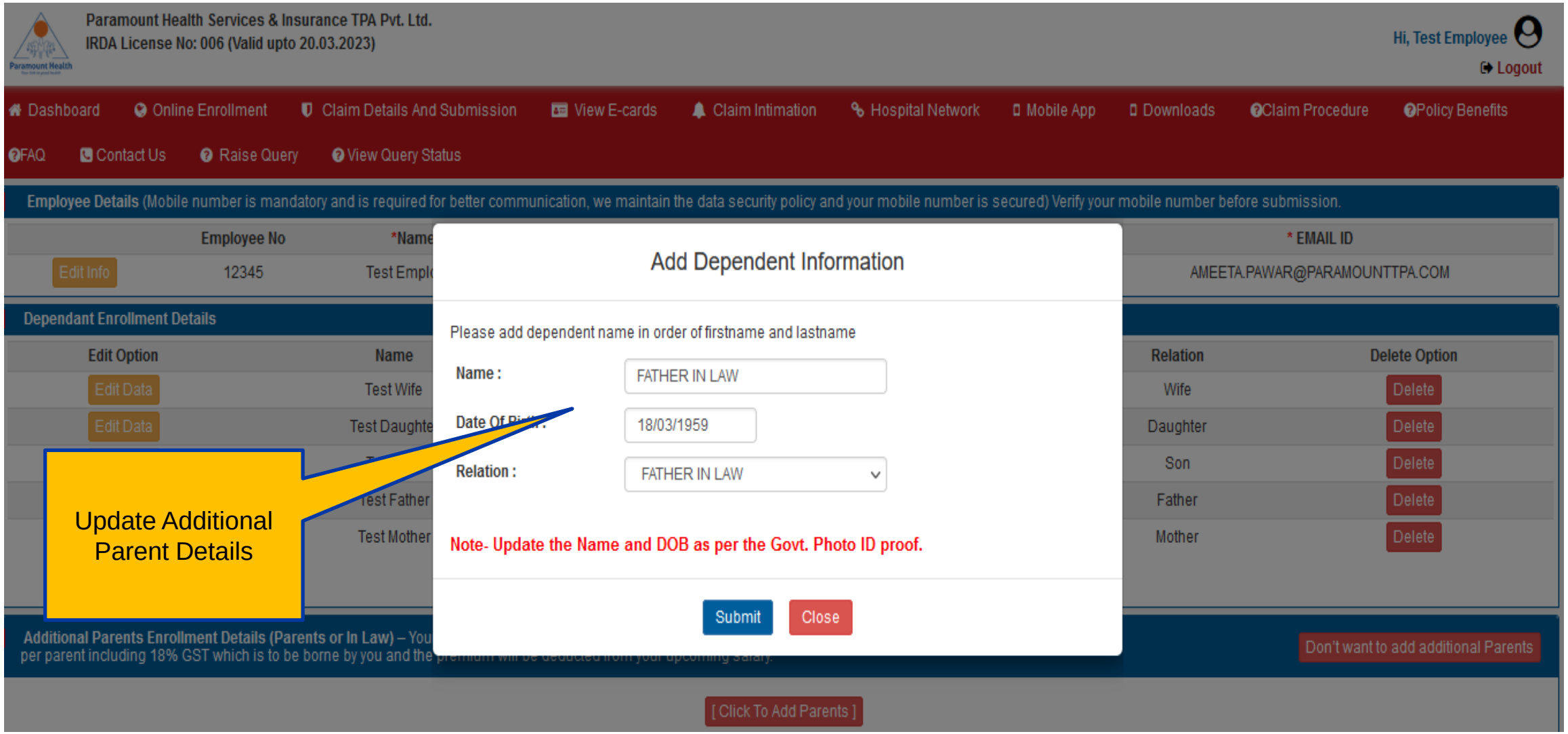
Add Dependent details



Add / Delete Additional Parents if Required



Add Additional Parents if Required



Option to Select / Delete Top Up Sum Insured

Provision to Opt Top up Sum Insured - Your company has facilitated to Opt for Top Up Sum Insured with a premium (Refer Table given below). The premium which is to be borne by you and the premium will be deducted from your upcoming salary.

Top-Up Policy Rates								
Sum Insured	1,00,000	2,00,000	3,00,000	4,00,000	5,00,000	7,00,000	8,00,000	10,00,000
Premium Including GST @18%	7,493/-	8,555/-	9,263/-	10,030/-	10,974/-	12,626/-	15,930/-	18,526/-

Do you want topup policy ? Yes No

Top up Sum insured 700,000 Top up Premium in Rs. : 12,626 /- (including 18% GST)

Premium Details

Additional Parent Premium: 5,133/-(Premium including 18% GST.)

Top up Premium: 12,626/-(Premium for Family including 18% GST.)

Total Premium: 17,759 /-Premium Amount will be deducted from your upcoming Salary.

Nominee Details for GPA / G ies (l disbursement is equivalent to 100%)

Click “Yes” to OPT or “No” to Delete the Existing Top Up

Nominee Details for GPA policy

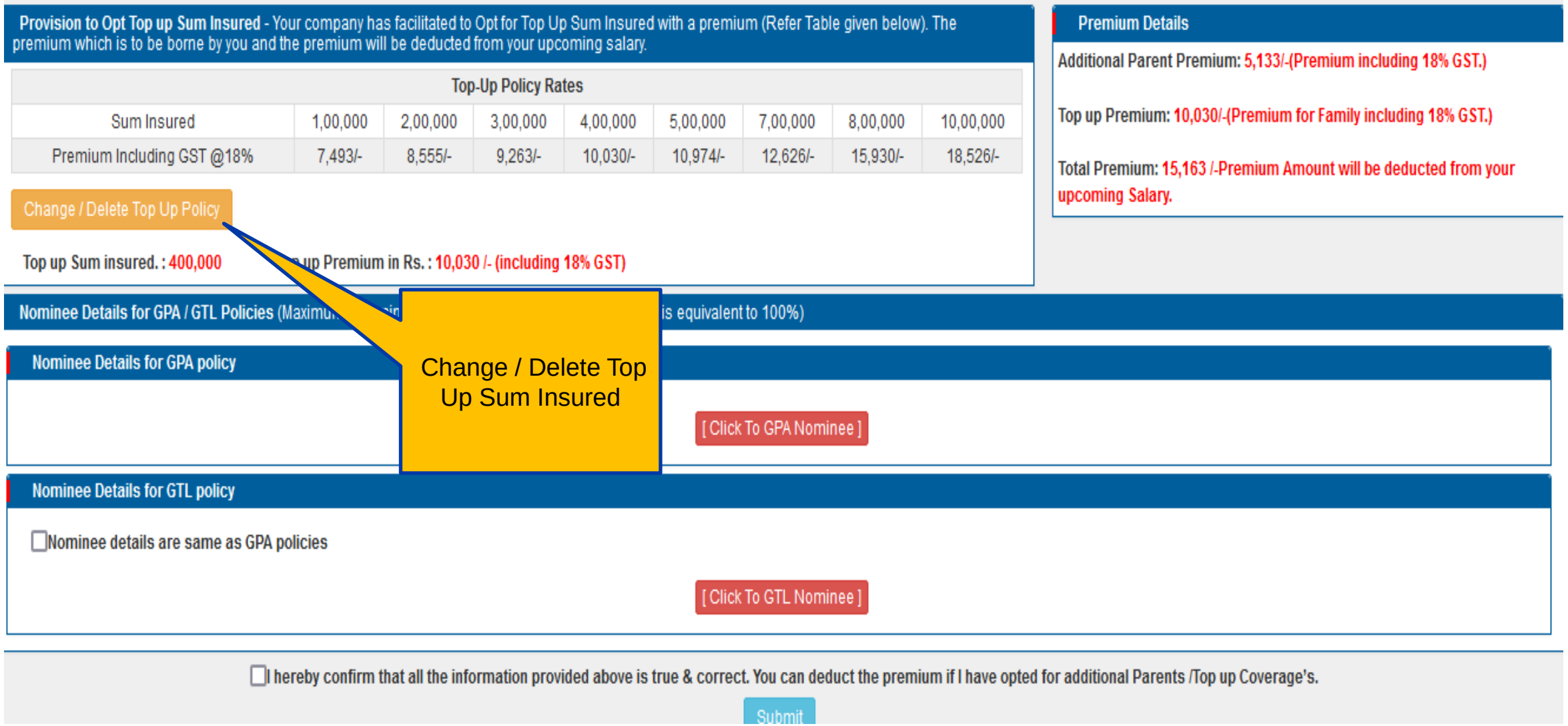
Edit Option	Date of Birth	Relation	Disbursement %	Delete Option
Edit Data	29-MAR-1994	SON	50	Delete
Edit Data	19-JUN-2018	DAUGHTER	50	Delete

Nominee Details for GTL policy

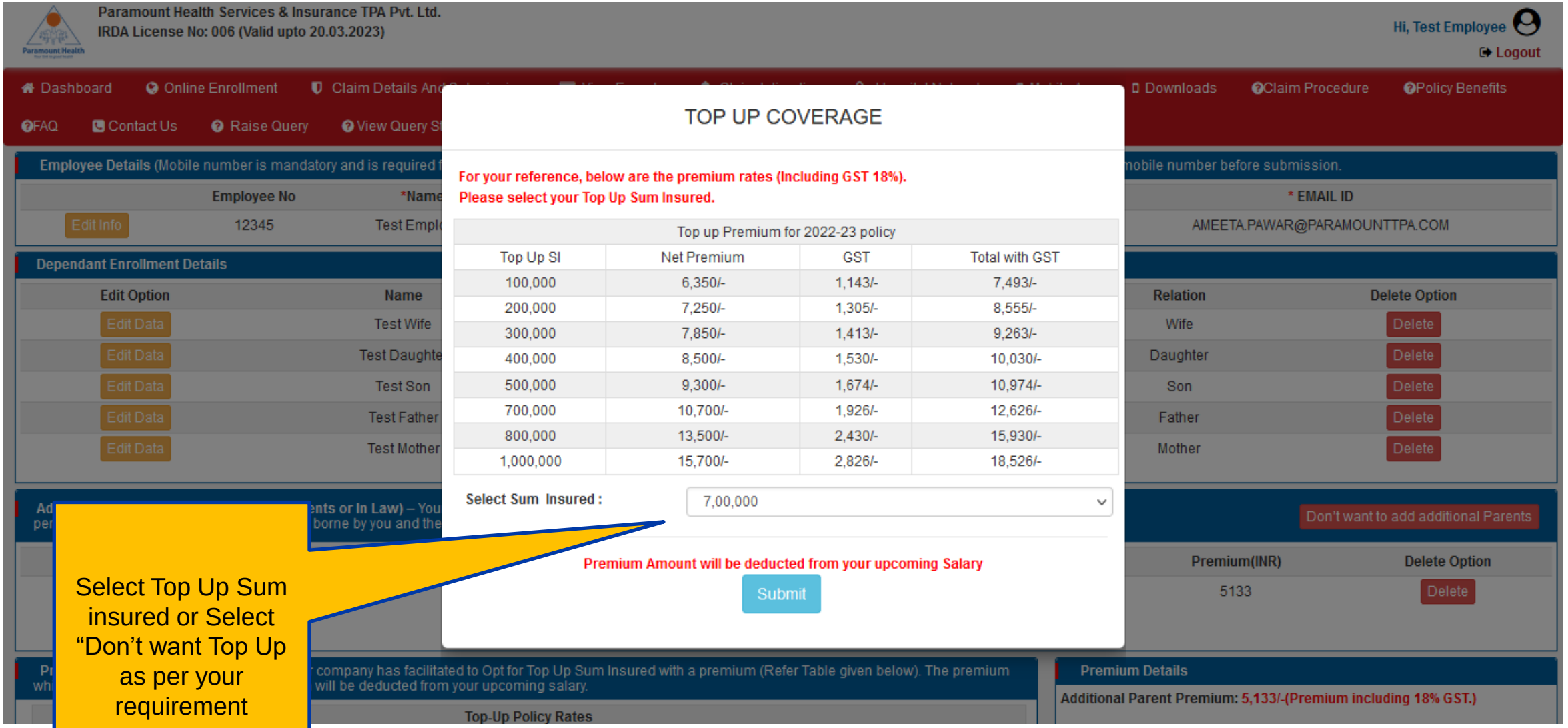
☐ Nominee details are same as GPA policies

Edit Option	Name	Date of Birth	Relation	Disbursement %	Delete Option

Change / Delete Top Up Sum Insured Option



Screen to Select / Delete Top Up Sum Insured



Select Top Up Sum insured or Select "Don't want Top Up as per your requirement

Update Nominee Details of GPA/GTL Policy

Provision to Opt Top up Sum Insured - Your company has facilitated to Opt for Top Up Sum Insured with a premium (Refer Table given below). The premium which is to be borne by you and the premium will be deducted from your upcoming salary.

Top-Up Policy Rates								
Sum Insured	1,00,000	2,00,000	3,00,000	4,00,000	5,00,000	7,00,000	8,00,000	10,00,000
Premium Including GST @18%	7,493/-	8,555/-	9,263/-	10,030/-	10,974/-	12,626/-	15,930/-	18,526/-

Change / Delete Top Up Policy

Top up Sum insured. : 400,000 Top up Premium in Rs. : 10,030 /- (including 18% GST)

Premium Details

Additional Parent Premium: 5,133/-(Premium including 18% GST.)

Top up Premium: 10,030/-(Premium for Family including 18% GST.)

Total Premium: 15,163 /-Premium Amount will be deducted from your upcoming Salary.

Nominee Details for GPA / GTL Policies (Maximum 5 nominees are allowed and total disbursement is equivalent to 100%)

Nominee Details for GPA policy

[Click To GPA Nominee]

Click to Add GPA Nominees

Nominee Details for GTL policy

Nominee details are same as GPA policies

If the GPA & GTL Nominee are Same then Click in the Drop Box

[Click To GTL Nominee]

Click to Add GTL Nominees

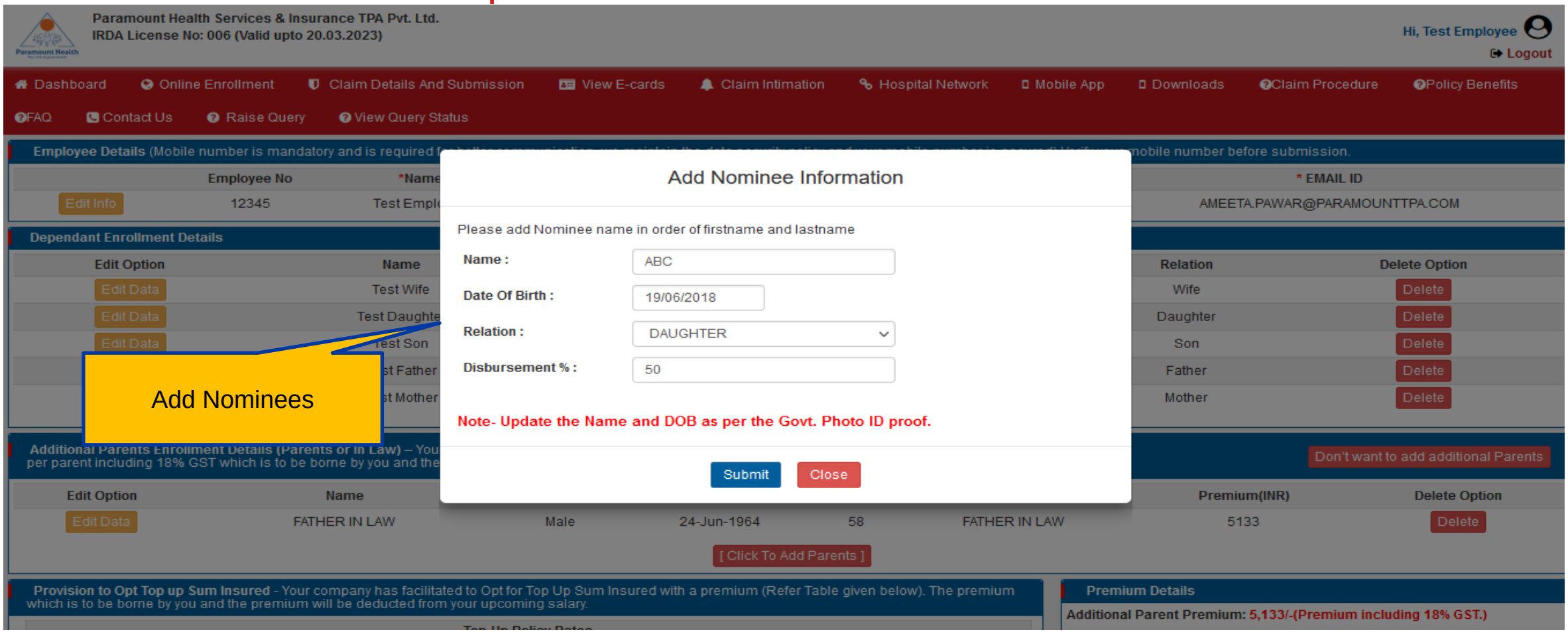
I hereby ve is true & correct. You can deduct the premium if I hav ge's.

Submit

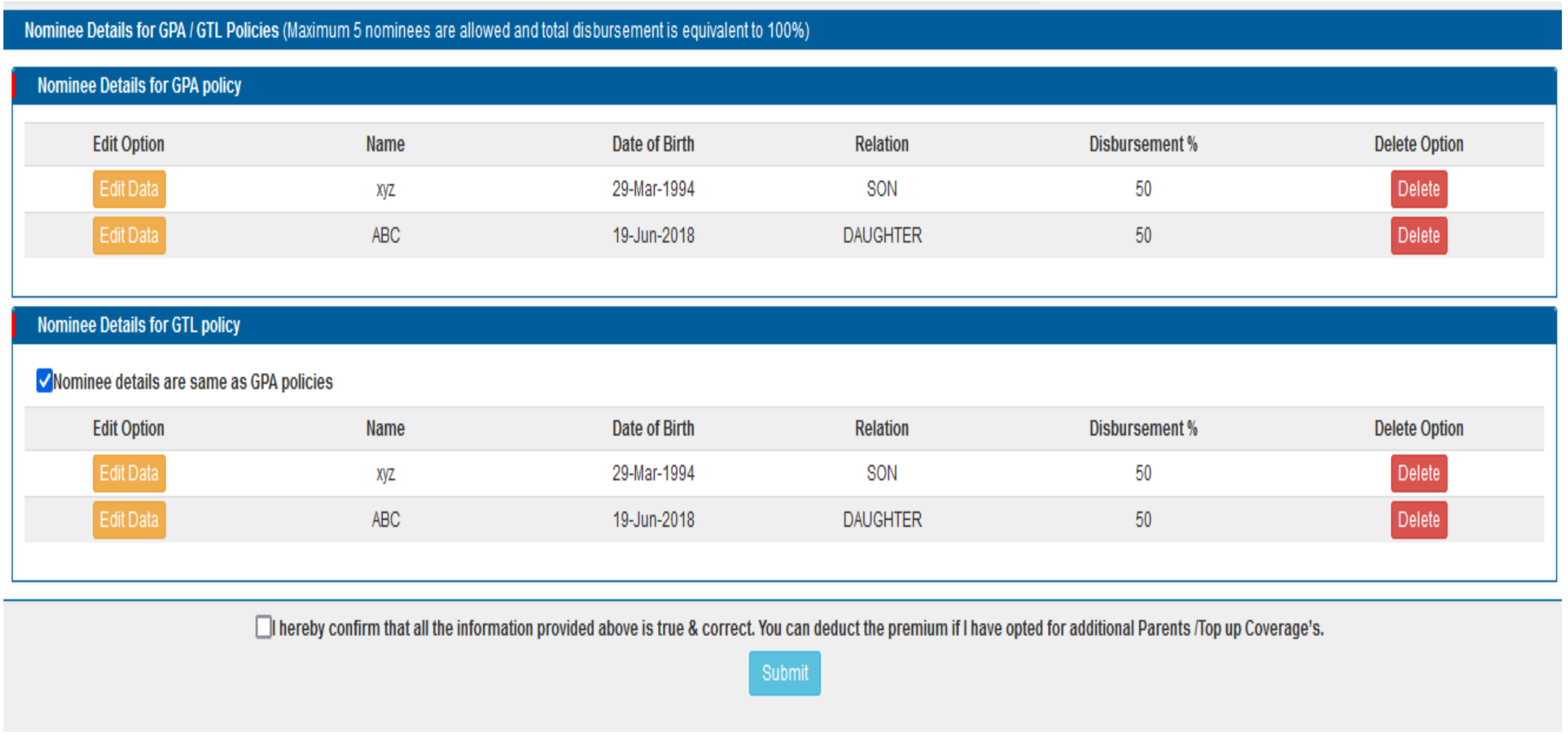
Screen to Add Nominee

You can add maximum 5 nominees

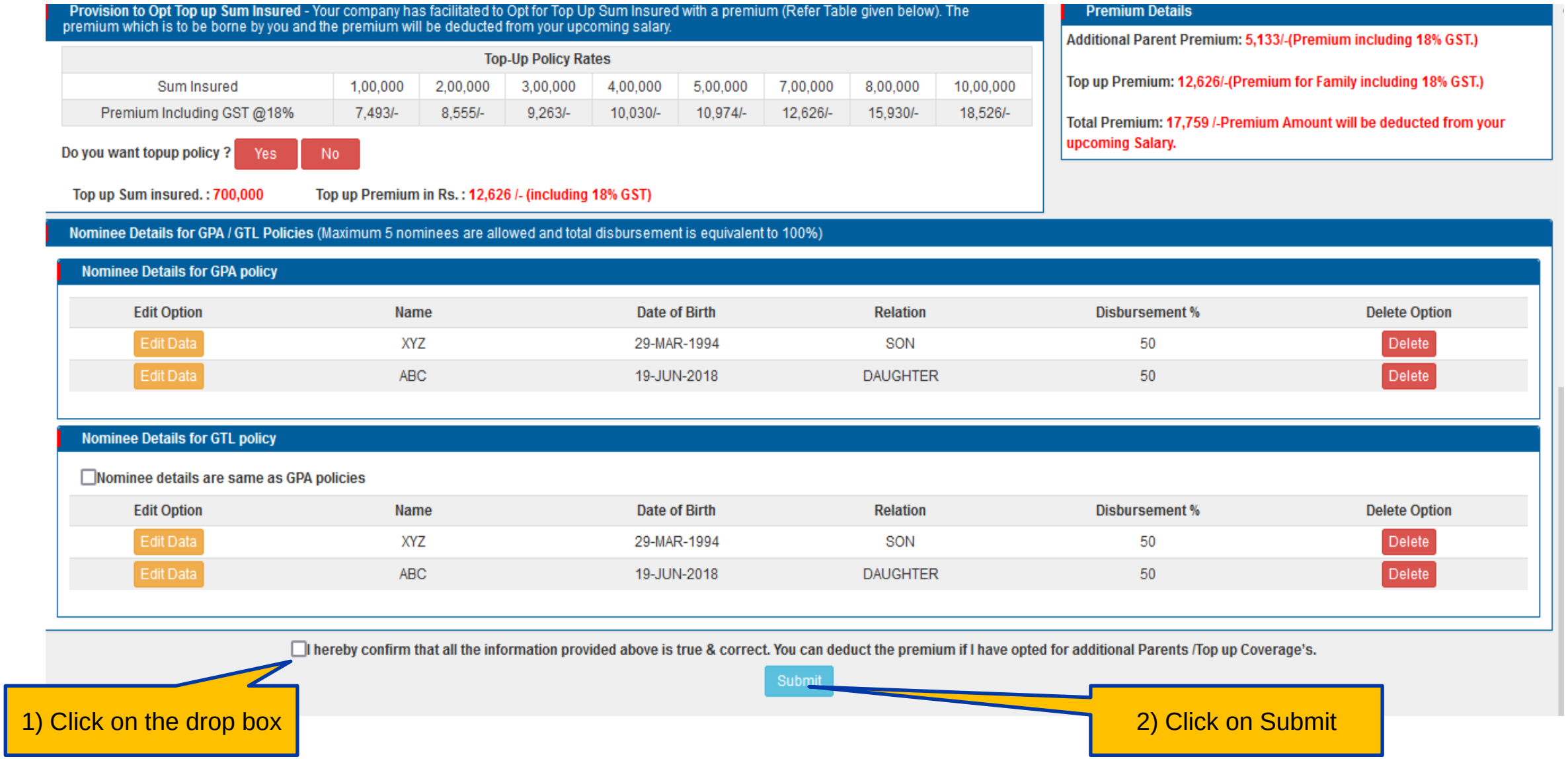
Total Disbursement is equivalent to 100%



Nominee Details Reflecting in the below screen

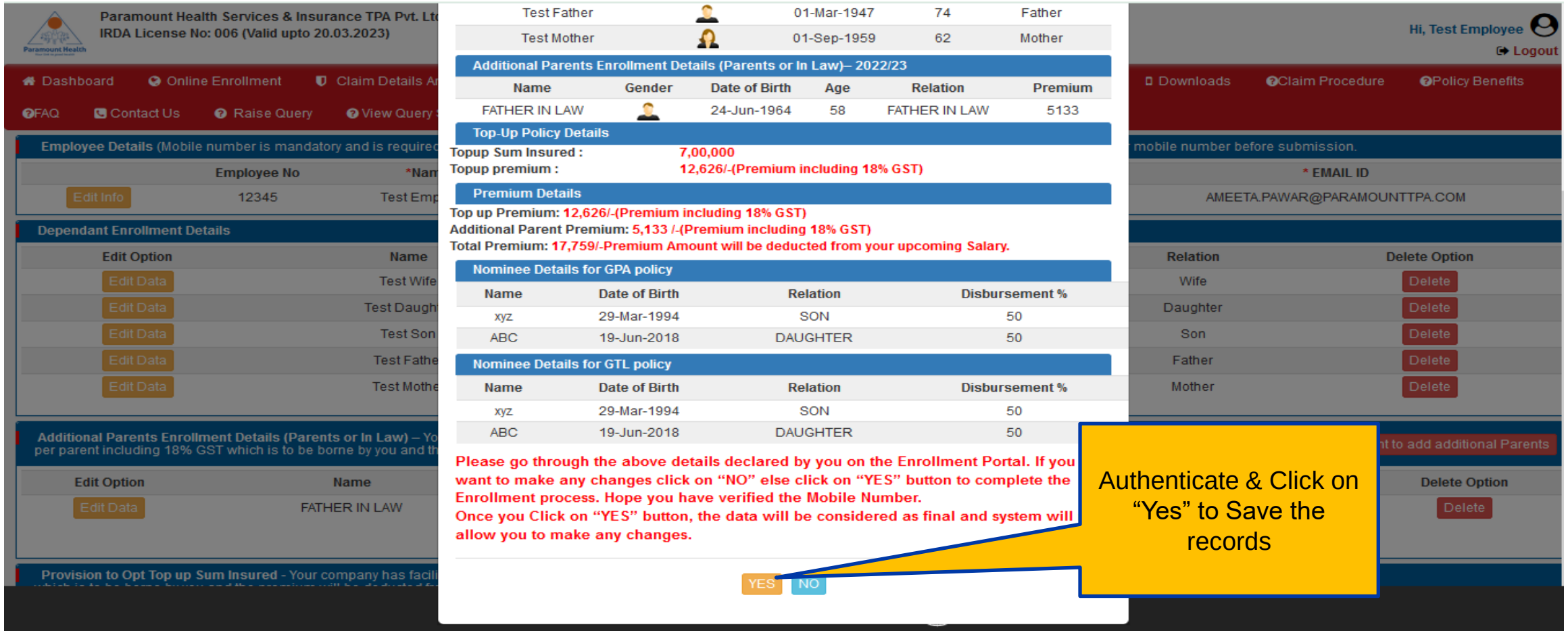


Click to Submit (Record will save on final Submission)

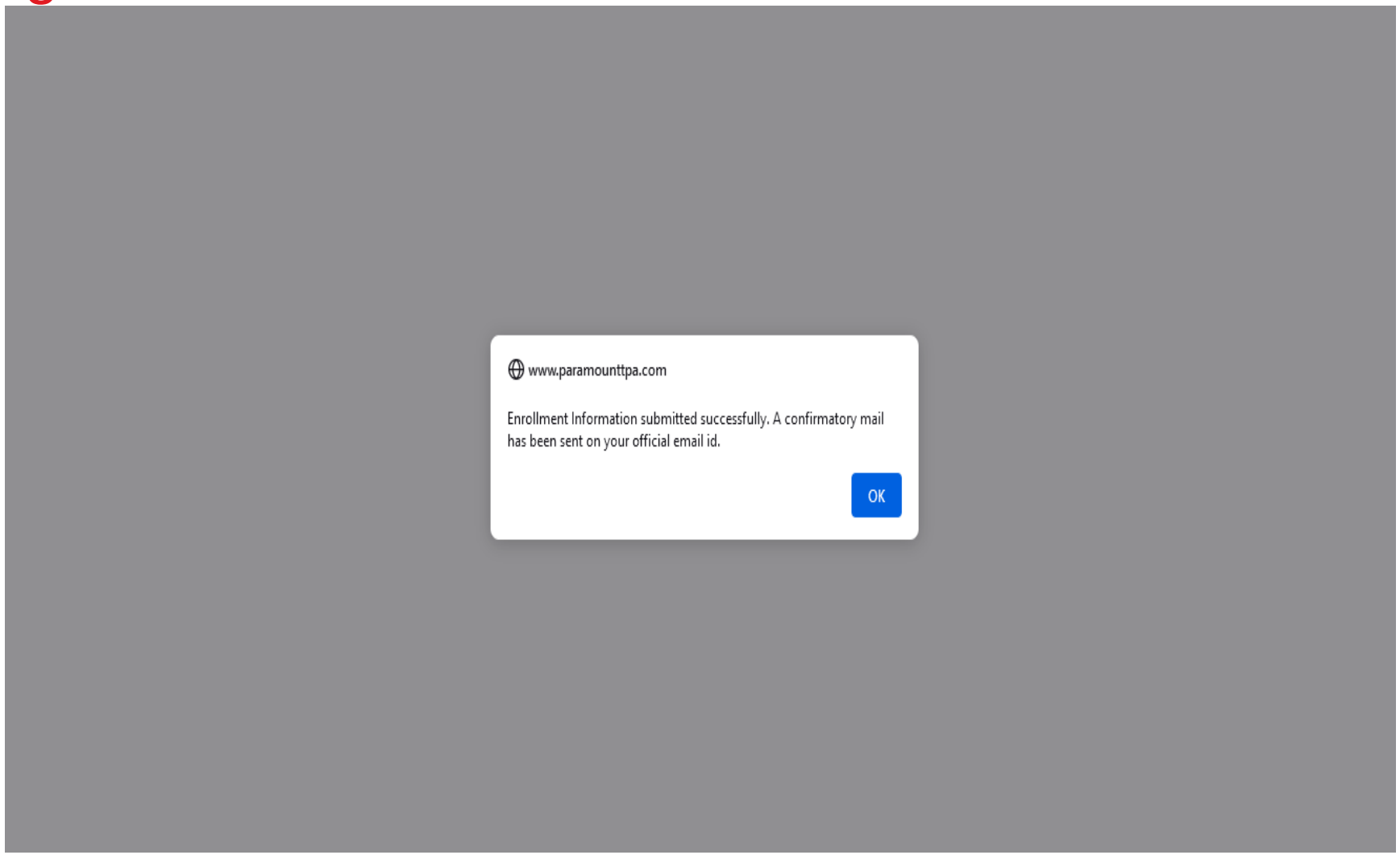


Final Authentication before submission

Verify the Mobile before submission
If the details are Correct then Click on “Yes” otherwise “No” to back page



On Final Submission you will get an acknowledgment mail on your registered Email ID



Making A Claim

The Hospitalization Procedure

You can avail either 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 the 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 deposits at the commencement of the 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 know about cashless or reimbursement, please visit the desired section mentioned below:

Making A Claim

Process for Cashless

Cashless hospitalization means the Administrator may authorizes upon a Policyholder’s request for direct settlement of eligible services and its according 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 as these services are covered under the Policy.

List of hospitals in the TPA's network eligible for cashless hospitalization	
Hospital Network List	**Email ID:** legato.phs@paramounttpa.com
Click on Website - https://legato.paramounttpa.com/ (Select Hospital Network)	For Intimation: 1800226655 / 18002093377
Select State and City to view the Network Hospital List.	For Assistance : Dr Nidhi Ahankari : 8976940936 Ms. Veena Koppikar :8976940935
Contact Call Centre at 24 X 7 Customer Service Centre -	1800226655

Group Medical – Cashless Hospitalization

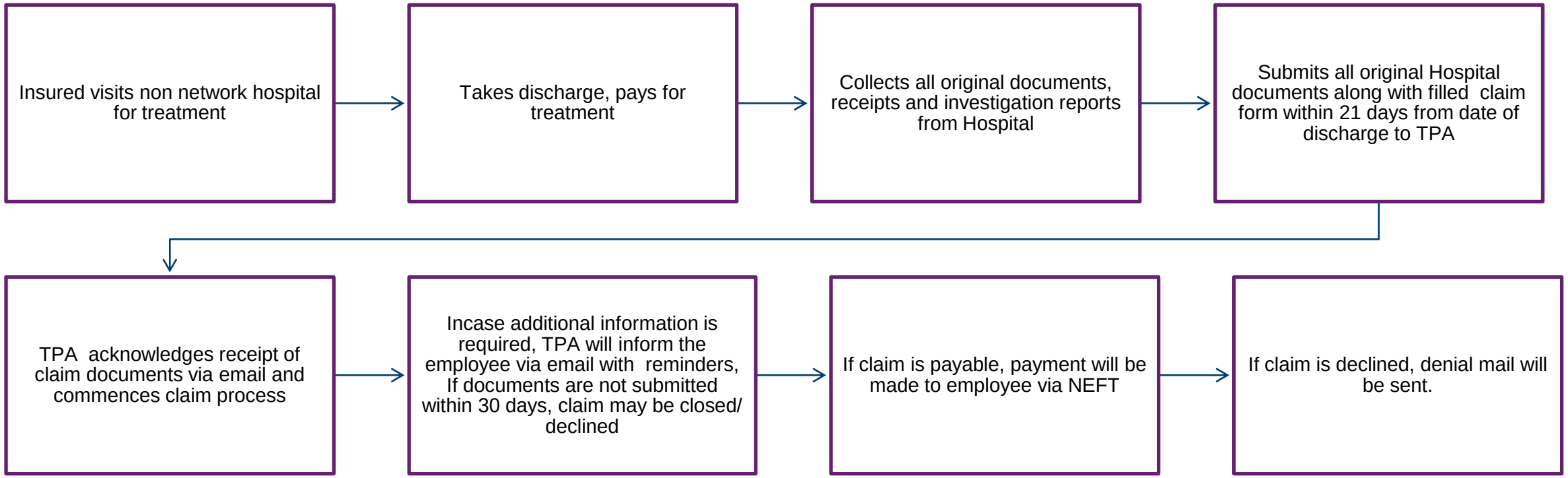
Planned Hospitalization

- Approach hospital 48 hrs. prior to admission, produces TPA card and completes pre-authorization formalities
- Faxes Pre-Authorization letter to TPA for Approval
- If all the documents are in order, TPA will issue authorization letter to hospital within 3 hours
- If the case is Declined, Denial Letter will be issued to hospital (*denial of cashless does not mean denial of treatment or claim*)
- Incase additional information is required, TPA will inform the Hospital / Employee

Emergency Hospitalization

- Admission in Hospital
- Pre-Authorization formalities to be completed within 24 hrs and sent to TPA for Approval
- If all the documents are in order, TPA will issue authorization letter to hospital within 3 hours
- If the case is Declined, Denial Letter will be issued (*denial of cashless does not mean denial of treatment or claim*)
- Incase additional information is required, TPA will inform the Hospital / Employee

Group Medical – Reimbursement



Making A Claim

Claims Document Check List & Attachments

No.	Document Required (All in ORIGINAL)
1	Signed Claim form (KYC form is mandatory for claims above INR 100,000)
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/Summary (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 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	In case of accidents, please note **FIR** or **MLC** (medico legal certificate) is mandatory.

Note: Kindly retain photo copies of all the documents. KYC – Government issued Photo ID and Address proof. The above is an indicative list and additional documents can be requested for to process a claim.

Making A Claim

Group Medical – Important FAQs

- **What are network hospitals? What should I do when I reach the hospital (NETWORK)?**

These are hospitals where TPA has a tie up for the cashless hospitalization. There are two kinds of network hospitals; PPN Network hospitals where cashless services can be obtained for emergency and planned treatments and Standard (Non PPN) network hospitals where cashless services can be obtained for planned hospitalisation.

Once you have reached there, please show your ID card for identification. TPA will also send a letter of credit (on pre-authorization) to the hospital to make sure that they extend credit facility. Please complete the pre-authorization procedure listed earlier. If the pre-authorization is not done, you must collect all reports and discharge card when you get discharged. Please make sure that you sign the hospital bill before leaving the hospital. You can then submit the claim along with all the necessary supporting documents to TPA as a reimbursement . If however, you go to a non network hospital , it is still advisable to fill the preauthorization form (use the copy attached with the Benefits Manual). Please fill the claim form, attach the relevant documents and send it to TPA office for reimbursement.

- **How can I claim my pre & post hospitalization expenses?**

The policy covers pre-hospitalization expenses made prior to 60 days of hospitalization and incurred towards the same illness/ disease due to which hospitalization happens. It also covers all medical expenses for up to 60 days post discharge as advised by the Medical Practitioner. All bills with summary have to be sent to TPA as a reimbursement.

Making A Claim

Things To Remember

- **Always aim to pre-authorize your benefits with the TPA**

This will help you in the following ways:

- You will be informed in advance regarding your coverage for the treatment and whether it is covered under your medical plan or not . This will help you know in advance if your claim may get rejected at a later stage and you do not end up paying out of pocket.
- It will help you ensure that the treatment cost is appropriate and not inflated. as the TPA will be able to cross check costs with the hospital in question. This will also help TPA in planning your hospitalization expenditure such that you do not run out of the cover that you are entitled to.
- It will help TPA in registering the impending claim with the insurer

- **Ensure your dependent list is always updated and claims submitted as per protocols**

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. 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 .

Please check that your documents are submitted completely at the first instance itself and originals are submitted wherever requested for . Do note that incomplete submissions will not be considered as exceptions by the insurers and will only delay the process further for you and a delay may lead to the claim getting closed. Please also retain a copy of all claim documents submitted to the insurer

Making A Claim

Things To Remember

- **Know that it is possible that benefits under your plan could be reduced v/s your eligible sum insured**

The following are some common reasons for rejection although these are NOT the only reasons why a claim could be reduced

1. Limits for the specific ailment exceed the reasonable cap on ailments listed in the manual,
2. Claim amount exceeds the permissible limit under the policy for you (denied to the extent of the excess),
3. Some expense items are non payable for e.g. toiletries , food charges for visitors etc.

- **Know that it is possible that your claim could also be completely rejected under the plan?**

The following are some common reasons for rejection although these are NOT the only reasons why a claim could be rejected

1. Treatment taken after leaving the organization. (If you have been transferred from one group business to another, please confirm with your HR that you have been included for coverage under your new entity)
2. Treatment that should have been taken on an outpatient basis (unnecessary inpatient admission and / or no active line of treatment.) or where hospitalization has been done primarily from a preventive perspective. Please remember that on occasion your personal doctor may recommend hospital admission for observation purposes however such admissions are not covered under your medical plan
3. Treatment taken is not covered as per policy conditions or excluded, under the policy. Please go through the list of standard exclusions listed earlier. (for e.g. : Ailment is a because of alcohol abuse is a standard exclusion, similarly cosmetic treatments or treatments for external conditions like squint correction etc are not covered) . Hospitalization taken in a hospital which is not covered as per policy conditions (Ex. less than 10 bed hospitals), Admission is before/after the policy period or details of the member are not updated on the insurer's list of covered members . Additionally in case original documents are not submitted as per the claim submission protocol,

Point of Contacts – Paramount Health Services (TPA)

Level	Name	Mobile Number	Email ID
1st point of contact	Toll free number	1800226655	--
1st point of contact	**Dedicated Legato Toll free number**	**18002093377**	--
SPOC	Dr Nidhi Ahankari	8976940936	Legato.phs@paramounttpa.com
Escalation 1	Ms. Veena Koppikar	8976940935	veena.koppikar@paramounttpa.com
Escalation 2	Ms. Ameeta Pawar	9322798264	ameeta.pawar@paramounttpa.com
Escalation 3	Mr. Srihari K.P.	9343728900	srihari.kulkarnI@paramounttpa.com

Point of Contacts - AON

Level	Name	Mobile Number	Email ID
Escalation 4	Mr. Naveen Kumar N	9535652071	naveen.kumar.n2@aon.com
Escalation 5	Mr. Om Prakash Kashyap	9243458500	om.kashyap@aon.com

TPA Address (For Reimbursement Documents):

Paramount Health Services & Insurance TPA Pvt. Ltd
No. 4/2, 1st Floor, Shirdi Krupa Complex, Nagappa Street, Above Bank of India,
Sheshadripuram, BANGALORE - 560 020

Group Personal Accident Benefits (GPA)

Know Your Benefits

The Group Personal Accident policy covers expenses by the insured persons (employee covered) on account of death or permanent / temporary, total or partial disability due to an accident. Accidental Permanent Disablement means disablement caused due to an accident which entirely prevents an insured person from attending to any business or occupation of any and every kind and which lasts 12 months and at the expiry of that period is beyond hope of improvement. Accidental Temporary Total Disablement means disablement caused due to an accident which temporarily and totally prevents the Insured Person from attending to the duties of his usual business or occupation and shall be payable during such disablement from the date on which the Insured person first became disabled. Accidental Permanent Partial Disablement is a doctor certified total and continuous loss or impairment of a body part or sensory organ caused due to an accident , to the extent specified in the chart provided by the insurer

Confidential Document

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

Your Plan Details

Plan Name	Group Personal Accident
Policy Holder	Legato Health Technologies LLP
Policy period	25th January 2022 – 24th January 2023
Insurer	Aditya Birla Health insurance Co.
Sum Insured	5 times of CTC
Members Covered	Employee
Age limit	18 – 65 years
Geographical Limits	Worldwide
Schedule of benefits	Accidental Death up to 100% of SI
	Dismemberment (100% SA)
	Permanent Total Disability (100% SA)
	Permanent Partial Disability
	TTD Benefit -1 % of Sum Insured or INR 25,000/- for Level up-to Managers and 1 % of Sum Insured INR 50,000 for level Sr Manager and above or actual weekly salary whichever is lower.
	Medical extension :covered up to INR 15,000 for accidental Injury on IPD or OPD Ambulance- INR 3,000
	Terrorism is covered

Partial Accident Disability Chart

Event	Percentage of Sum Insured Payable
The sight of one eye or the actual loss by physical separation of one entire hand or one entire foot.50%	50%
Use of a hand or a foot without physical separation	50%
Loss of speech	50%
Loss of toes – all	20%
Loss of toes great - both phalanges	5%
Loss of toes great - one phalanx	2%
Loss of toes other than great, if more than one toe lost: each	2%
Loss of hearing - both ears	75%
Loss of hearing - one ear	30%
Loss of four fingers and thumb of one hand	50%
Loss of four fingers of one hand	40%

Partial Accident Disability Chart

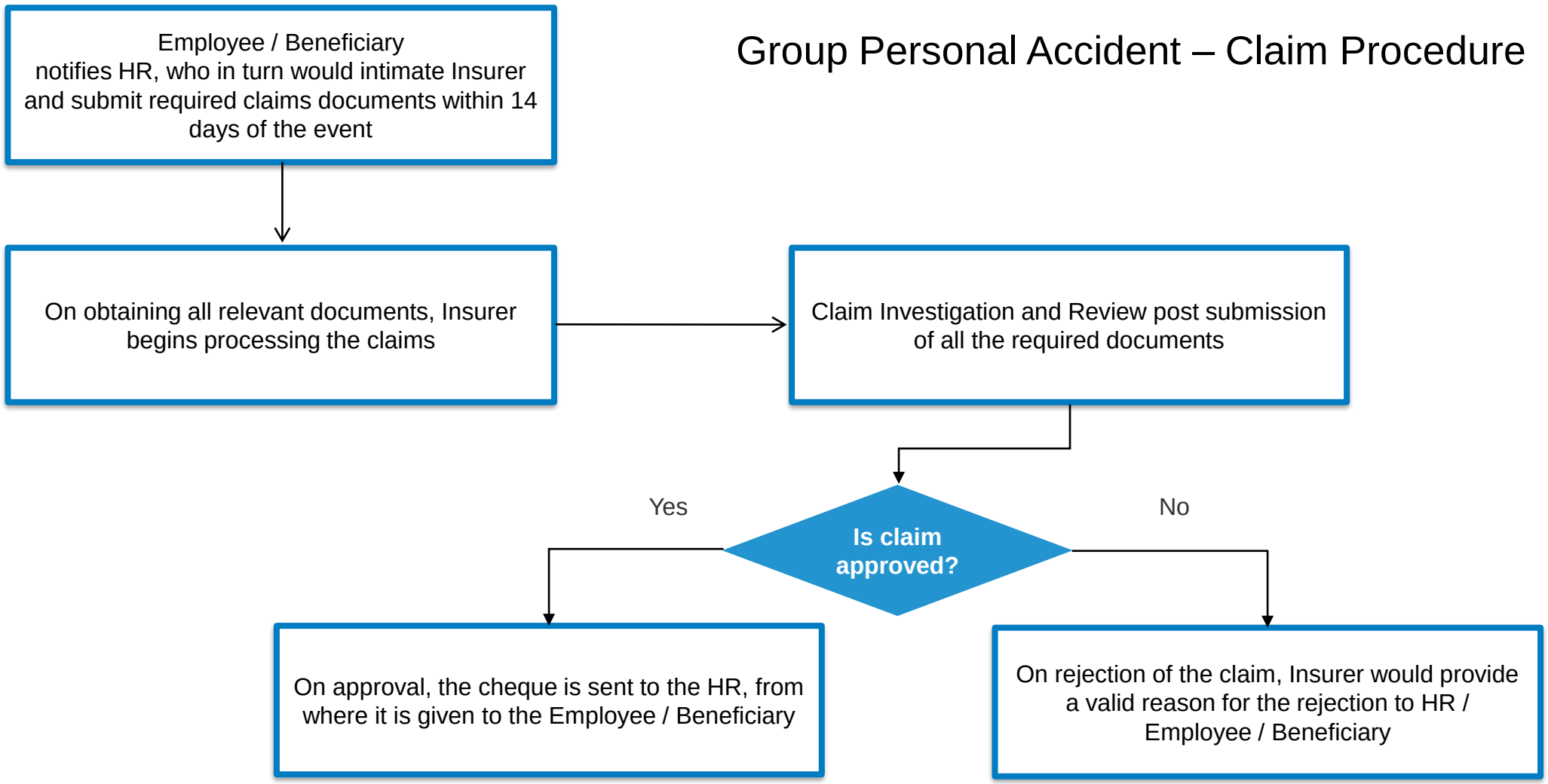
Event	Percentage of Sum Insured Payable
Loss of thumb - both phalanges	25%
Loss of thumb – one phalanx	10%
Loss of index finger – three phalanges	15%
Loss of index finger – two phalanges	10%
Loss of index finger - one phalanx	5%
Loss of middle finger or ring finger or little finger – three phalanges	10%
Loss of middle finger or ring finger or little finger – two phalanges	7%
Loss of middle finger or ring finger or little finger - one phalanx	3%
Loss of thumb - both phalanges	25%
Loss of thumb – one phalanx	10%
Loss of index finger – three phalanges	15%

Your Plan Details

Key Exclusions

- Suicide, attempted suicide (whether sane or insane) or intentionally self-inflicted Injury or illness, or sexually transmitted conditions, mental or nervous disorder, anxiety, stress or depression, Acquired Immune Deficiency Syndrome (AIDS), Human Immune-deficiency Virus (HIV) infection; or
- Being under the influence of drugs, alcohol, or other intoxicants or hallucinogens unless properly prescribed by a Physician and taken as prescribed; or
- Participation in an actual or attempted felony, riot, crime, misdemeanor, (excluding traffic violations) or civil commotion; or
- Operating or learning to operate any aircraft, or performing duties as a member of the crew on any aircraft; or Scheduled Aircraft.; or
- Self exposure to needless peril (except in an attempt to save human life);
- Loss due to child birth or pregnancy.

Making A Claim



Making A Claim

Typical Documents Needed

Document Check List

Weekly Benefit / Temporary Disability Claims

	Document Details
1	Completed Claim form
2	Doctor's Report
3	Disability Certificate from the Doctor, if any
4	Investigation/ Lab reports (x-ray etc.)
5	Original Admission / discharge card, if hospitalized
6	Employers Leave Certificate & Details of salary

Disablement Claims

	Document Details
1	Completed Claim form
2	Doctor's Report
3	Disability Certificate from the Doctor, if any
4	Investigation / Lab reports (x-ray etc.)
5	Original Admission / discharge card, if hospitalized
6	Police Inquest report, wherever applicable

This is an indicative list of documents and there may be additional documents required by the insurer. It is mandatory to provide the details for nomination of beneficiary.

Group Term Life Benefits (GTL)

Know Your Benefits

Group Term Life Insurance Scheme is meant to provide life insurance protection to the employees. The Policy provides for payment of a lump sum to the nominated beneficiary in the unfortunate event of the employee's death due to any cause. Plans may be subject to a Free Cover Limit and requirement for medical tests or these may be waived off as per specific terms relating to your group

Confidential Document

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

Your Plan Details

Plan Name	Group Term Life
Policy Holder	Legato Health Technologies LLP
Policy period	07th February 2022 – 06th February 2023
Insurer	Aditya Birla Sun Life Insurance Co.
Sum Insured	5 times of CTC
Members Covered	Employee
Age limit	18 – 65 years
Schedule of benefits	Accidental Death up to 100% of SI Free Cover Limit of INR 50,000,000

Making A Claim

Claim Procedure & Claim Documents

Type of Claim	Requirement
Death (all causes of death #) Critical Illness And Disability	1. Claim Forms Part I: Application Form for Death Claim (Claimant's Statement) # Part II: Physician's Statement, relevant Hospital records and report from the concerned medical specialist giving nature of disability and illness (for Critical Illness claims).
	2. Death Certificate issued by a local government body like Municipal Corporation/Village Panchayat #
	3. Medical Cause of Death Certificate issued by attending physician/hospital #
	4. Attested True Copies of Indoor case Papers of the hospital(s)
	5. Post-mortem Report (Autopsy Report) & Chemical Viscera Report – if performed #
	6. The Beneficiary : - Photo ID with DOB with relationship to the insured - Proof of legal title to the claim proceeds (e.g., legal succession papers, assignment deed etc.)
	7. Employer's Certificate
	8. Leave Records for the past 3 years
If Death due to Accident (submit in addition to the above)	All Police Reports / First Information & Final Investigation Report
	Proof of Accident – Panchnama / Inquest Report
	Newspaper cutting / Photographs of the accident – if available

The above is an indicative list of documents, and the insurer reserves the right to ask for additional proofs & documents in support of the claim. Policyholder shall inform the insurance company of any claim within 30 days of the claim event.

Legal Disclaimer

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Thank you