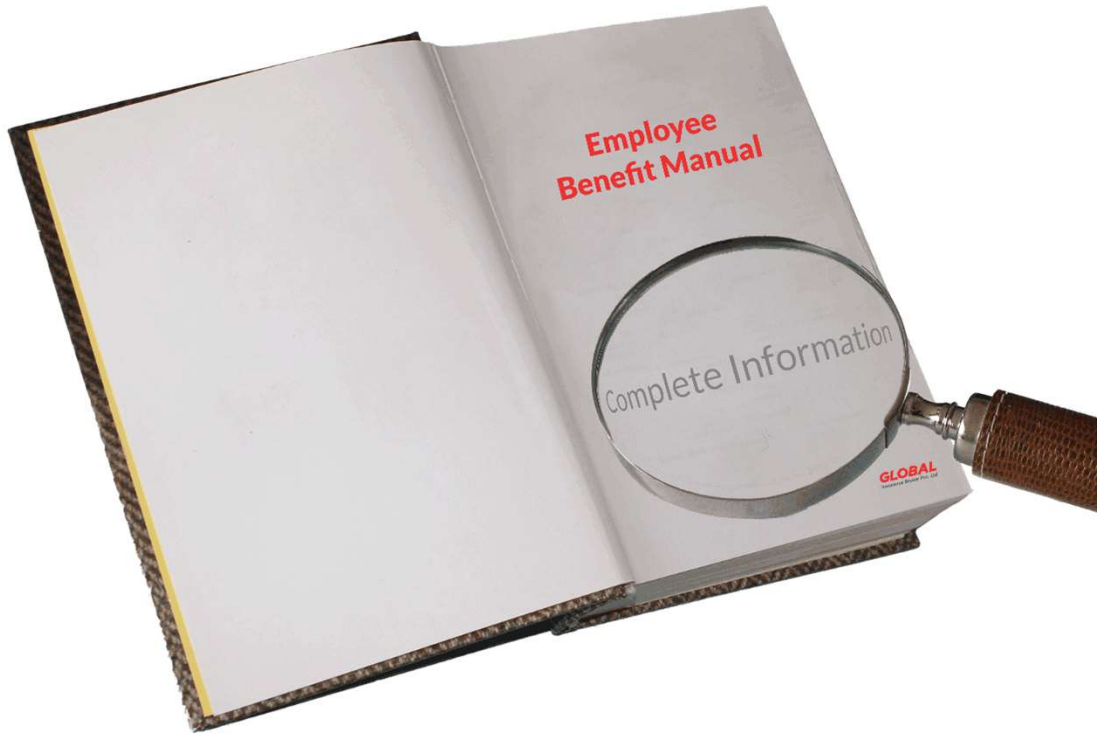
GLOBAL
Insurance Broke₹ Pvt Ltd

TEKsystems Own change | Global Services

Employee Insurance Benefits Manual
FY : 2023-24

About This Employee Benefits Manual

This Employee Benefits Manual is a reference guide to the benefits provided by **Teksystems Global Services Pvt Ltd** . For complete information on the benefit terms and conditions please refer to the policy documents/wordings provided by the respective insurer.



Prepared By :

Health & Benefits Team
Global Insurance Broke₹ Pvt. Ltd.

Group Medical Insurance Policy

The **Group Medical policy cove₹** expenses by the insured persons on account of hospitalization due to **sickness or accident**. The policy cove₹ expenses incurred on room rent, medicines, surgery etc. Expenses for hospitalization are payable only if a **24-hour hospitalization has been taken** (Except for named day care procedures as per ICICI Lombard Insurer List, which do not require a 24-hour hospitalization). Typical expense heads covered under the policy are the following: room/boarding expenses as provided by the hospital, nursing expenses , surgeon, anesthetist , medical practitioner, consultant , specialist fees, anesthesia, blood, oxygen, operation theater charges, medicines and drugs, diagnostic material and X-Ray, dialysis, chemotherapy, radiotherapy, and similar expenses

ICICI Lombard
Nibhaye Vaade

Medi Assist™
Medi Assist Insurance TPA Pvt. Ltd.

Group Medical Plan

Benefit	Benefits/Coverages & Condition's
Insurer	**ICICI Lombard General Insurance Company Limited**
TPA	**Medi Assist Healthcare Services Private Limited**
Inception Date	**12-Aug-23 to 11-Aug-24**
Sum insured Definition	Family Floater
Sum Insured Limit - Per Family	**₹ 3,00,000**
Family Definition/ Member Eligible	• Employee • Spouse • First 2 Children's (3rd Child is covered in case of Twin or Triplet Child) • 2 Parents or Parent in Laws (Any one set. Cross combination not allowed)
LGBTQ & Live in relation, Live in partner	• Covered • LGBTQ is an initialism that stands for lesbian, gay, bisexual, and transgender • As per the policy covers either legal spouse or LGBT • Condition: Emp Can either add Legal Spouse / Same Sex / Domestic Partner (Live in Relation) • Exclusion: Except for Gender Change Treatment
Age	Parent or in-laws • Entry Age up **to 90 Years**. (Age Limit Applicable only for new joiners). • For existing Parent's (or) in-laws there is no age restriction. Dependent Child : • Biological or legally adopted who is financially dependent and does not have his or her independent source of income and not over **25 years.** • Physically / Mentally challenged kids to be considered as dependents even if they **cross the age mentioned**.
Dependents Declaration	• Dependents are to be declared at the time of inception of the policy if policy structure is with dependents (Physically / Mentally challenged kids to be considered as dependents even if they cross the age mentioned).
Widow widower	In case of death of employee during policy period. Dependents coverage extended up to end of the policy

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

Group Medical : Mid Term & New Addition

Existing Employees + Dependents	
Commencement Date for Existing Employees + Dependents	12-Aug-23
Termination Date for Existing Employees + Dependents	11-Aug-24 (Mid Night)
New Joinees + Dependents : Intimation By HR to GIB for Enrolment Window (Monthly)	
Commencement Date	Date of joining (Provided the intimation is given within 30 days from DOJ)
Termination Date	11-Aug-24 (Mid Night)
New Dependents (Newly Wed Spouse / Newborn Baby) : Enrolment by Employee in GBS Portal	
Commencement Date	Date of Intimation of such event (declaration within 30 days from the date of Marriage for new Spouse addition & date of birth for newborn Baby addition)
Termination Date	11-Aug-24(Mid Night)

Mid-Term Enrollment Condition:

- Allowed, only for New Joiner & Family / Newly wedded Spouse / New -born Baby within 30 days from the date of such event

Intimation Timeline as below:

- **New Joiner**: Monthly intimation by HR- Auto Process
- **Newly Married Spouse**: intimation within 30 Days from Date of Married in **Global Benefit Solution Portal by Employee**
- **Newly Born Baby**: intimation within 30 Days from Date of birth in **Global Benefit Solution Portal by Employee**

In the event Non intimation within given timeline :

- There is **no exceptional** mechanism to add under current policy.
- In case the member is not insured at the time of hospitalization then Insurance/ Insurer shall not be liable to process the claim

No member shall be covered twice under the same insurance policy :

- If Employee and spouse is working in the same organization, then both cannot be declared each other as dependents in the policy.

Global Benefit Solution URL

- https://tek.globalinsurance.co.in

For Enrolment Login: Global Benefit Solution (GBS) Portal

Group Medical Plan

Benefit	Benefits/Coverages & Condition's
Standard Hospitalization	Covered
Day Care Procedures	Covered, Only Day Care Procedures Listed in ICICI Lombard
30 days waiting Period	Waived Off
1-4 year Waiting Exclusion	Waived Off
Pre-existing Diseases Exclusion	Waived Off
Pre & Post Hospitalisation limits	• Pre-Hospitalization Expenses Covered up to **60 days** (Before date of admission) • Post Hospitalization Expenses Covered up to **90 days** (After date of discharge) • Note : Subject to main claim is admissibility
Room Rent limits including Boarding, Nursing Charges, etc.	• For Normal Room rent ₹ 6000/- per day • For ICU ₹ 15,000/- per day. • No Room rent capping for Covid claims.
Room Rent Condition/ Proportionate Clause	Proportionate clause is applicable. If the Insured occupies a room with a room rent limit other than his eligibility as per the insurance policy, all the other charges shall be limited to the charges applicable for the eligible room rent or actuals, and whichever is lower.
Geographical Limits	India (Treatment Taken Within the Geographical limit of India under Register Hospital are eligible to claim under policy)
Co-pay	• Co-pay- **10% for all Parental Claims only (Applicable on admissible amount).** • No copay for parents for Covid claims

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

Group Medical Plan

Benefit	Benefits/Coverages & Condition's
Nil Deduction – Claims / Bereavement Cover	• **No deduction in claim amount in case of death of patient.** 100% of the claimed amount maximum/up-to Family Sum Insured limit is paid if the claimant passes away during Standard hospitalization. • **Applicable**: only for Employees • **Condition**: Agreed subject to a maximum of ₹.5,00,000/- for entire policy period & Policy Limit.
People with Disability Coverage	Any inpatient hospitalization is covered.
Ambulance Expenses limits	• Emergency ambulance charges **up-to/Maximum of ₹ 2500/- Per Hospitalization**. • Ambulance charges will be applicable for transferring patient to Hospital or between Hospitals in the Hospitals ambulance or in an ambulance provided by any ambulance service provider only.
Dental Treatment	Due to Injury / Accident / Illness in case of Standard Hospitalization
Oral chemotherapy	Covered for all within family floater Sum Insured **including Top Up**
Congenital internal disease	Covered, Subject to Standard Hospitalization
Congenital External disease	Covered in case of **Life Threating Conditions**, Subject to Standard Hospitalization
Any Animal / serpent attack	• Any Animal / serpent attack resulting in treatment on inpatient • Subject to Standard Hospitalization

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

Group Medical Plan

TREATMENT & AILMENT CAPPING/LIMIT

Benefit	Benefits/Coverages & Condition's
Autism/Psychiatric treatments	• Covered • Autism combined limit of **Maximum 50 cases with a per Family cap of ₹25,000**. • Overall policy limit of ₹ 10,00,000. • **Standard Exclusion:** OPD requirements & external aids.
Lasik Treatment	Only if power of eye is equal to or above **+/- 7.5**, is payable
Ayurvedic Treatment	✓ Covered up to 25% (₹ 75,000) of the sum insured. ✓ **Subject** : only when treatment taken in Government Hospital or in any institute recognized by the government and / or accredited by the Quality Council of India/ National Accreditation Board.

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

Group Medical Plan

ADVANCED MEDICAL PROCEDURES / MODERN TREATMENT COVERED:

Benefit	Benefits/Coverages & Condition's
Modern Treatments	✓ Modern treatment will be at 50% of the sum insured (both Base and Top Up put together) ✓ Cyber knife treatment : 50% Co-Pay ✓ Cochlear Implant treatment shall be restricted to 50% of the FSI Limit. ✓ Modern day care treatment up to 50% of FSI Limit.

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

Group Medical Plan

MATERNITY RELATED BENEFITS

Benefit	Benefits/Coverages & Condition's
Maternity Applicable	Maternity Benefit is available only for Self and Spouse
Maternity Benefits limits	**Normal - ₹ 50,000** **Caesarean- ₹ 75,000**
Pre & Post natal	• Covered ₹ 5000/- • Applicable only for IPD as part of above-mentioned maternity limits.
New-Born Baby	• Newborn Baby covered form Day one (**Subject to employee Enrolment within 30 Days form date of Birth in GBS Portal**) • The benefit payable hereunder shall be up to full floater sum insured.
Well mother expenses	Covered within Maternity Limit
Healthy Baby Expenses / Well Baby Care Expenses	• Covered for Expenses Incurred for a Normal baby after the birth till discharge. • Automatic coverage for necessary expenses related to the newborn wellbeing after birth and before discharge. • Expenses like doctors check- up and any other check-up tests performed to ensure that the baby is well at birth, to be covered within Maternity Limit
Surgical Infertility treatment including IVF & Surrogacy	Not 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..

Voluntary Group Medical Insurance
Top Up Policy

ICICI Lombard
Nibhaye Vaade

Medi Assist™
Medi Assist Insurance TPA Pvt. Ltd.

GLOBAL
Insurance Broke₹ Pvt Ltd

TOP UP PLAN

Why evaluate a Top Up Medical Plan ?

- Healthcare costs are rapidly rising with medical inflation being in the range of 15% to 20%. In such a situation, an employee may feel that his or her insured amount in the group health insurance is inadequate. Top Up plan provides an additional coverage to employees over and above the company sponsored Sum insured limit.
- The premium rates are lower vis-à-vis an employee purchasing an additional retail insurance policy.

Advantages of the Top Up Medical Plan

- Coverage is identical to the main medical policy terms.
- Employee can choose the cover as per his/her needs.
- The main & top up medical plan can be claimed together for the same hospitalization. except for maternity benefit
- Employee gets a tax benefit on the premium paid towards the top up plan.
- This is a customized health top up plan designed exclusively for Tek employees only and at customized and negotiated standard premium across all age groups pricing

TOP UP – COMPARISON : GROUP VS RETAIL

Existing Current Policy Benefits	Market Retail Policy	Tek Top Up Benefits
Preexisting Disease coverage	First 4 Years excluded	Day one coverage
30 days waiting period	Applicable	Day one coverage
2-year exclusions for Named ailments like Cataract, Hernia etc.	Applicable	Day one coverage
80 D Benefit	Applicable	Applicable
TPA	Choice of Insurance company	Same as of Corporate Policy to help in faster claims processing
Coverage for parents	Limited Sum Insured is available in RETAIL(subject to medical tests)	Sum Insured extendable up to Rs. 12 lakhs
Medical Tests	Any Person >45 needs to go for a Medical Test on own cost	Not required for any age group

Voluntary Top Up Policy: Standard Benefit

Plan Name	Benefits/Coverages & Condition's
Insurer	ICICI Lombard General Insurance Company Limited
TPA	Medi Assist TPA
Policy Period	12-Aug-23 to 11-Aug-24
Pre- Existing Disease coverage	Day one coverage
Room Rent limits including Boarding, Nursing Charges, etc,	• Restricted to 6000/- for normal and ICU 15000/- • If the Insured occupies a room with a room rent limit other than his eligibility as per the insurance policy, all the other charges shall be limited to the charges applicable for the eligible room rent or actuals whichever is lower.
Co-pay	Co-pay- 10% for all Parental Claims only
30 days waiting period	Waived Off

Member Covered: Same set Member enrolled is **Base Mediclaim** policy is default covered under Top-up.

Benefits & Condition's: All the terms and conditions are as per the base policy.

Base policy sublimit/ Capping Ailment: **Not covered under Top-up**

Exclusion: As per Standard Exclusion

Claims: Being a Voluntary super Top-up policy. The claim can only be entertained under the said policy If the Sum Insured under the base policy is completely exhausted.

Enrolment: Policy can only be opted during the **initial Enrolment window in Global Benefit Solution Portal** . Once after the enrolment closure there is no exceptional Mechanism to Enroll/ opt TOPUP during the present/existing policy.

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

Top Up Policy: Premium Chart

Top-up Policy Annual Per Family

Sum Insured	Annual Premium Excl. GST @ 18%	Annual Premium Incl. GST @ 18%
2,00,000	3,999	4,719
3,00,000	5,204	6,141
4,00,000	7,645	9,021
5,00,000	9,938	11,727
6,00,000	12,920	15,246
9,00,000	16,796	19,819
12,00,000	23,827	28,116
15,00,000	30,853	36,407
18,00,000	45,440	53,619

Premium Payable

- **Inception Employee:** Annual Premium Incl. GST @ 18%
- **New Joiner** : Prorate premium from date of Joining to end of policy

Enrolment:

- Policy can only be opted during the **initial Enrolment window in Global Benefit Solution Portal** . Once after the enrolment closure there is no exceptional Mechanism to Enroll/ opt TOPUP during the present/existing policy.

Mid Term Enrolment:

- Allowed only for New Joiner within given Enrolment window

Resignation:

- In case an employee quits during the policy period, he/she will be deleted from the main policy and top-up policy effective from the date of leaving the company & the insurance company will refund the pro-rata premium for the remaining policy period subject to nil claims from the members covered under the policy.

Addition Newborn & Newly Married Spouse

- Newborn Baby & Newly married Spouse (From DOJ / Policy Inception/ Post enrolment closure- Which ever is later) Subject to intimation in GBs portal within 30 Days

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

Claim Intimation Timelines Applicable for all Mediclaim Policy

Benefit	Benefits/Coverages & Condition's
Claim Intimation	Reimbursement Claims to be intimated to Mediassit within 72 Hours of Admission/Discharge which ever is earlier, except for Accidental claims
Claim Submission (Mandatory)	Within 30 Days from the Date Of Discharge Document must reach the TPA Mediassit.
Pre -Post Claim Submission (Mandatory)	• Pre to be submitted with in 30 days from discharge • Post to be submitted within in 7 days on completion of 90 days post hospitalization limit.

PROCESS FLOW FOR THE CLAIM INTIMATION

Login : portal.mediassist.in

Home page: Click on “Intimate reimbursement”

Update details like Date of Admission, Date of Discharge, Estimation cost etc..

Post updating the mandatory details, Claim intimation number will get generated..

Mention the claim intimation number in Claim form during the physical submission.

Importance:

Raise and track your reimbursement claim online and in real-time.

Avoid a possible Denial of claim due to Delay in submission/intimation

Mediassit Portal will be activated post ecard issuance/ For any claim intimation prior to Ecard Issuance please email TPA bharathi.s@mediassist.in with following details (Emp ID/DOA/Patient Name & relation/Ailment/DOD)

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

Group Medical Plan

Benefit	Benefits/Coverages & Condition's
Co Morbidity	In case of any hospitalization (Example-Maternity, heart, cancer, etc.) if member is infected with COVID and if there is a treatment involved. Member will be covered up to total sum insured.
Reasonable and Customary Clause	Applicable
PPN and GIPSA rates	• Applicable, In case of Reimbursement claims from Network Hospital

GIPSA

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

Group Medical Plan : Definitions

Standard Hospitalization

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 below-mentioned hospitalization expenses will be reimbursed under your group medical plan. 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.

- ✓ Room rent and boarding expenses
- ✓ Doctors' fees (A medical practitioner)
- ✓ Intensive Care Unit
- ✓ 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

Note: As per the standard Insurance policy, will cover only the Conventional procedure of Treatment cost. In any case Pt. /employee opted for an Advance procedure/ treatment then the policy will only honor the conventional cost of treatment

Group Medical Plan : Definitions

Definition of Hospital

Hospital/Nursing Home means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

a. Has qualified nursing staff under its employment round the clock;
b. Has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in- patient beds in all other places;
c. Has qualified medical practitioner(s) in charge round the clock.
d. Has a fully equipped operation theatre of its own where surgical procedures are carried out;
e. Maintains daily records of patients and makes these accessible to the

- The expenses shall be reimbursed provided that they are incurred in India and 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 on Hospitalization for minimum period of 24 hours are admissible. However this time limit will not apply for specific treatments i.e. Dialysis, Chemotherapy, Radiotherapy, Eye surgery, Dental Surgery, Lithotripsy (kidney stone removal), Tonsillectomy, D & C taken in the Hospital/Nursing home and the insured is discharged on the same day of the treatment will be considered to be taken under Hospitalization Benefit.

Please Note: Settlement of cashless claims in PPN/GIPSA network hospitals includes hospital discount.

The above-mentioned discount is not applicable in case of Reimbursement claims from PPN/GIPSA network hospitals and the same will be deducted at the time of final settlement.

Group Medical Plan : Definitions

Pre & Post Hospitalization	
Pre- Hospitalization Expenses	If the Insured member is diagnosed with an Illness which results in his / her immediate Hospitalization and for which the Insurer accepts a claim, the Insurer will also reimburse the Insured Member's Pre-hospitalization Expenses for up to 60 days prior to his / her Hospitalization.
Condition	Such Medical Expenses were in fact 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-hospitalization Expenses for up to 90 days period.
Condition	Such costs are incurred in respect of the same condition for which the Insured Person's earlier Hospitalization was required

What is Family Floater?

Insurer will pay the medical expenses up to the amount mentioned per family.
Either one member or including all family member can claim up to this amount only.

Group Medical Plan : Definitions

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.	Waived off
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, 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 too	Waived off
Room Rent & ICU	Insured employees are requested to use **prudence and proper negotiation** with Hospital/ Nursing home in availing the eligible room category. Proportionate clause is applicable if member opted for higher room / ICU	Covered
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	Charges incurred at Hospital or Nursing Home primarily for diagnostic, X-Ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment in a hospital of the positive existence of any ailment, sickness or injury for which confinement is required at a Hospital/Nursing Home is not covered under the plan	Not Covered
Dental & Vision	Any dental treatment or surgery of a corrective, cosmetic or aesthetic nature unless it requires Hospitalization; is carried out under general anesthesia and is necessitated by Illness or Accidental Bodily Injury.	Not Covered

Group Medical Plan : Standard / General Exclusion

- 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 eye sight, cost of spectacles, contact lenses, hearing aids etc.
- Any surgery which is corrective, cosmetic or of aesthetic procedure 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
- Doctor’s home visit charges, Attendant / Nursing charges during pre and post hospitalization 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.

Note:

Above exclusions are only indicative, please refer Insurance Company Policy Copy Insurer Portal / IRDA website for complete Standard List

In case of any of the above ailment represented in Benefit as coverage. Then the policy will honor claim as per policy T&C

Group Medical Plan : Standard / General Exclusion

- 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.
- 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 hospitalization 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

Note:

Above exclusions are only indicative, please refer Insurance Company Policy Copy Insurer Portal / IRDA website for complete Standard List

In case of any of the above ailment represented in Benefit as coverage. Then the policy will honor claim as per policy T&C

Group Medical Plan : Standard / General Exclusion

- 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 / Nonmedical 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.
- 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 / Nonmedical 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.

Note:

Above exclusions are only indicative, please refer Insurance Company Policy Copy Insurer Portal / IRDA website for complete Standard List

In case of any of the above ailment represented in Benefit as coverage. Then the policy will honor claim as per policy T&C

Standard Non-Payable Expense

As per IRDA under Mediclaim Policy Consumables/ Non-Medical Expenses are standard Exclusions. PFB few indicative list (This may have few addition based on case to case)

- Admission/Registration
- Telephone charges
- Attendant's charges
- Home Visit/Nursing charges - at residence after discharge
- Assistant fee/Follow up charges in advance
- Sundry/Medico Legal Charges/Diabetic chart charges
- Thermometer Charges
- Container for Specimen/Disposable Bag charges
- Admission Kit
- External Surgical Aids: Lumbo-sacral/Collar belt /Kneecap/Knee brace/ walker/hot water bag/baby kit/urine pot / traction kit/ folding commode etc.
- Inhaler/ Nebulizer /Glucometer or any other equipment
- Diet charges
- Special/protein diet/health drinks unless prescribed by the doctor
- Documentation/Folder/Stationery/In Patient chart charges
- Ain case of Advance Procedure only the conventional cost is payable
- PPE Kit etc

Note: Above exclusions are only indicative, please refer Insurer website / IRDA website for complete Standard List

Hospitalization Procedure

Definition of Cashless

Cashless hospitalization means Insurer & TPA may authorize (upon an Insured person's request) for direct settlement of eligible services and the corresponding charges between a Network Hospital, Insurer & TPA. In such case, Insurer 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.

- **There are 2 types of cashless hospitalization: Planned hospitalization & Emergency hospitalization**
- **Hospital Network List** : Website - https://mediassisttpa.in/network-hospital-search/

https://mediassisttpa.in/network-hospital-search/ → Select Insurer ICICI Lombard → Search Prefer : Network Hospital

Definition of Reimbursement

In case you choose a non-network hospital, you will have to liaise directly for admission. However, you are advised to follow the preauthorization procedure to ensure eligibility for reimbursement of hospitalization expenses from the insurer.

To know about cashless or reimbursement, please see subsequent pages.

Please Note: Settlement of cashless claims in PPN/GIPSA network hospitals includes hospital discount.

The above-mentioned discount is not applicable in case of Reimbursement claims from PPN/GIPSA network hospitals and the same will be deducted at the time of final settlement.

Cashless Planned Hospitalization

Cashless Hospitalization : Planned

Step 1
Pre-Authorization

All non-emergency hospitalization instances must be pre-authorized with the Help Desk, as per the procedure detailed below. This is done to ensure that the best healthcare possible, is obtained, and the Insured Member is not inconvenienced when taking admission into a Network Hospital.
The Insured Person shall provide the documentation and information your TPA may require to establish the circumstances of the claim

Member intimates of the planned hospitalization in a specified pre-authorization format 45 Hrs (min) prior to hospitalization

→ **Claim Registered by the TPA on same day**

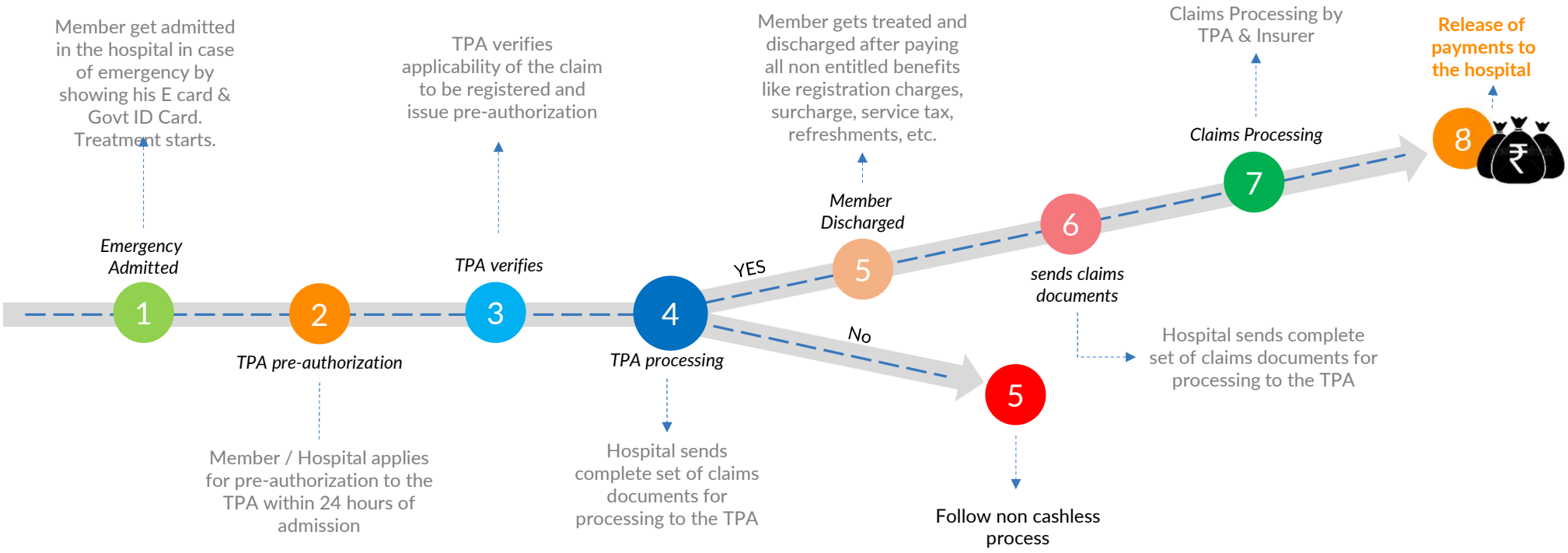
Yes/ Approved → TPA issues letter of credit within 3 hours for planned hospitalization to the hospital The letter will depend on the plan benefits and available sum insured. → Process Completed

No/ Denied → Follow non cashless process

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 need to be submitted separately as part of non-cashless/ Reimbursement claims.
- Incase additional information is required, TPA will inform the Hospital

Emergency Cashless Hospitalization



Reimbursement Hospitalization

Admission procedure

In case you choose a non-network hospital, you will have to liaise directly for admission.
However, you are advised to follow the preauthorization procedure to ensure eligibility for reimbursement of hospitalization expenses from the insurer.

Discharge procedure

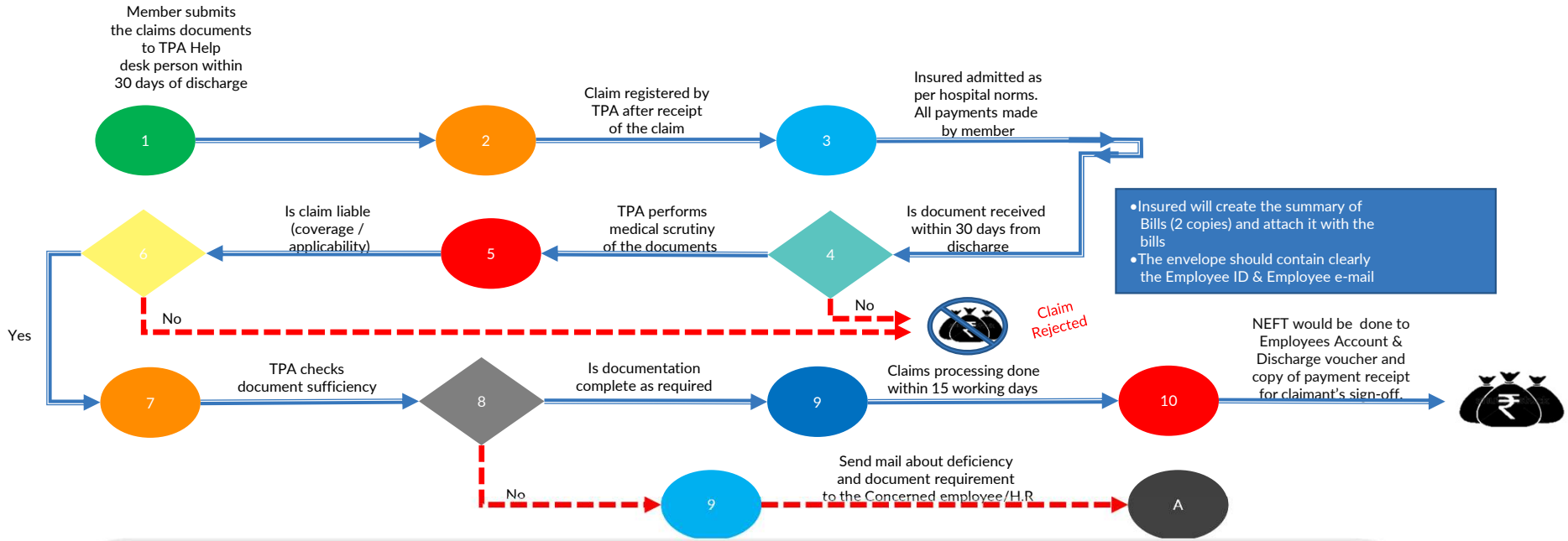
In case of non network hospital, you will be required to clear the bill and submit the claim to TPA for reimbursement from the insurer. Please ensure that you collect all necessary documents such as discharge summary, investigation reports etc. for submitting your claim.

Submission of hospitalization claim

1. After the hospitalization is complete and the patient has been discharged from the hospital, you must submit the final claim within 30 days from the date of discharge from the hospital.

2. Under hospitalization claims, you are also permitted to claim for treatment expenses 60 days prior to hospitalization and 90 days after the date of discharge. Please submit the pre/post hospitalization claim within 7 days from the treatment completion date or 7th days from the 90th day whichever is earlier.

Reimbursement Hospitalization Process



Claim Documents Envelope Address Format

To,
Mediassist Insurance TPA Pvt Ltd.
Ms. Bharathi, Client Servicing No: 58/1A, Singha Sandra Village,
Hosur Main Road, Begur Hobli Bangalore South Taluk - 560068

From
Corporate Name :Tek System
Employee Name_____
Employee ID _____
Ecard No_____
Address _____
Ph No:

Reimbursement Claim Documents

No.	Reimbursement Claim Documents
1	Duly filled and signed Insurance Claim Form Part A & Part B
2	Original Discharge Summary stating the date of admission, date of discharge, presenting complaints with duration, clinical condition, detailed line of treatment, final diagnosis and past medical and surgical history with duration..
3	Original Hospital Bill giving detailed break up of all expense heads mentioned in the bill. Clear break ups have to be mentioned for OT Charges, Doctor's Consultation and Visit Charges, OT Consumables, medicines, Transfusions, Room Rent, etc.
4	Original Paid Receipt with revenue stamp, hospital seal and signature towards the final hospital bill of Hospital for hospitalization period.
5	All Laboratory and Diagnostic Test Reports In Original E.g. X-Ray, E.C.G, USG, MRI Scan, Hemogram etc.
6	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 along with the treating doctor registration no on hospital letter head duly signed and stamped
7	In case of Surgeries where Implant and Stent has been used ,copy of invoice /stickers/Barcode of Implant used will have to be enclosed.
8	Obstetric History (in case of maternity) [Gravida-Para-Living-Abortion and LMP & EDD]. Time of Admission & Time of Discharge (it is MUST for 24hrs hospitalizations).
9	In case of accidents, please note **FIR or MLC** (medico legal certificate) is mandatory.
10	Completely filled NEFT Details stating Branch MICR Code, IFSC Code & Account type, Complete Account Number duly signed by Policy Holder/proposer with Preprinted canceled cheque (Note :First page of Bank passbook or statement would be mandatory if account number is ink stamped and name of the account holder is not printed. All Fields in the form are mandatory to process)for claim disbursement purpose and Aadhaar & Pan card / Form60 is mandatory in all type of claim as per IRDA Guideline and needs to be complied

IMPORTANT:- Intimation and Submission Timeframes:

Intimation of claim:- 48 hours prior to getting hospitalized for planned hospitalization and 24 hours within hospitalization for emergency hospitalization

Submission of claim :- TPA must receive the claim documents for all reimbursements within 30 days of discharge from hospital.

Kindly retain photocopies of all the documents. KYC – Government issued Photo ID and Address proof

The above is an indicative list and additional documents can be requested to process a claim.

Kindly retain photocopies 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.

Group Medical Plan : Contact Details

DEDICATED POINT OF CONTACT		
Contact Person	Mobile number	Mail id
Mr Rajesh S	9886167265	Rajesh.s@globalinsurance.co.in

In view of "Tek System" : Group being Corporate Insurance, Employee must contact above Dedicated SPOC Only

ESCALATION MATRIX		
Contact Person	**Mobile number**	**Mail id**
Ms. Vanitha	7022158511	Vanitha.Ramachandran@globalinsurance.co.in

Group Term Life Policy

Group Term Life Insurance

The policy indemnifies the beneficiaries in the event of death, during the covered period. Death can be accidental, natural, etc.

Group Term Life : Policy Details

Benefit Plan	Coverage & Condition
Policy Master Policy Holder	Tek System
Insurer	Bajaj Life
Inception Date	03-Jun-23
Expiry Date	02-Jun-24
Members Covered	**Employee**
Sum Insured Limits	**3 Times Annual CTC with a maximum of INR 2 crores**
Geographical Limits	Worldwide
Minimum age for coverage	18
Maximum age Without IUW	65
Maximum risk cover ceasing age for a member (years)	65
Actively at work clause	Waived Off
Terrorism	Covered
FCL	2,00,00,000

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

Group Term Life : Benefit Details

Coverages

Death benefit – provides 100% of the sum assured incase of unfortunate event of death- accidental or natural . Payment of any benefits under this policy shall be made to the Nominee /policy holder as receiving agent for the Insured Members /employees legal representative (s)or to the beneficiary of the employee /member as the case may be .

Free cover Limit: INR. 2,00,00,000

Employees whose amount of Insurance is greater than the above stated amount of FCL, their amount of Insurance shall be restricted to FCL ,till the company completes the required underwriting process based on statements and information including medical tests, provided by the Insured Member/employees .The Insured employee shall be covered for full amount of Insurance for which they are eligible once the underwriting process is completed ,the full premium is paid and risk is accepted by the company in writing .
Incase the insured member does not complete the requirements necessary for underwriting process within the prescribed limits, the amount of Insurance shall be restricted to the FCL. The insured member may also be declined the additional coverage , in which case the insurance cover shall be restricted to FCL.

Exclusion

Travel to a country that is declared by the government of India as no travel zone . Before a person leaving for international assignment the same needs to be informed to the insurance company .

Assuring of our best services at all times....