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Waters™

Group Mediclaim Insurance: Benefit Manual 2025-26

Prepared By

Aon Risk India Insurance Brokers Private Limited (formerly GIB an Aon company)
CIN:U67200MH2002PTC137954, , Composite Insurance Broker, IRDAI License No.119, Valid till 02/03/2027
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01

The **current benefits** in your Insurance plan

02

Key **exclusions**

03

The limits of each **benefit covered**

04

How to **claim?**

Know Your Insurance Policies

Group Medical Insurance : Base

Covers in-patient hospitalization and day care expenses incurred by an employee and his insured dependents for a diagnosed ailment with an active line of treatment. 24 hours of hospitalization is compulsory to register a valid claim under the group Mediclaim policy.

Group Medical Insurance : Top-up

Top-up health insurance works as a supplement to your primary health cover. These plans offer you the desired medical coverage in case the sum insured amount of your current health insurance policy gets exhausted .

Group Personal Accident

insurance policy covers expenses by the insured persons (employee covered) on account of death or permanent/partial/temporary, total or partial disability due to an accident.

1

GROUP MEDICAL INSURANCE PLAN

BASE

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Group Medical Insurance Plan – What's Covered

Room rent & boarding expenses

Anaesthesia, blood, oxygen, Intensive Care Unit, operation theatre charges

Nursing expenses, surgeon, anaesthetist, medical practitioner, consultant & specialist fees

Medicines and drugs

Diagnostic procedures (such as laboratory, x-ray, diagnostic tests)

Costs of Implants if implanted internally during a surgical procedure

Organ transplantation including the treatment costs of the donor but excluding the costs of the organ

Day care procedures e.g. dialysis, chemotherapy etc.

Reasonable and Customary charges

Please note that your insurance benefit plan (like all insurance plans) covers medical expense charges that are reasonable and customary in nature
Reasonable and Customary charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, and considering the nature of the Illness / Injury involved

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Group Medical Insurance Plan – What's Changed

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External Congenital Treatment

- External Congenital Treatment to be covered in the Policy in case of life-threatening condition

Base policy sublimit/ Capping Ailment under Top-up

- Capped ailments cannot be covered under Top-up unless Base S.I. is exhausted subject to insurer approval

Bereavement cover

- Complete amount settlement in case of death of the Insured (Both Emp & Dependent)

Group Medical Insurance Plan – Key Information

Policy Period

Your policy is active from **9th February 2025** till **8th Feb 2026, 00:00 hrs**.

Insurance company

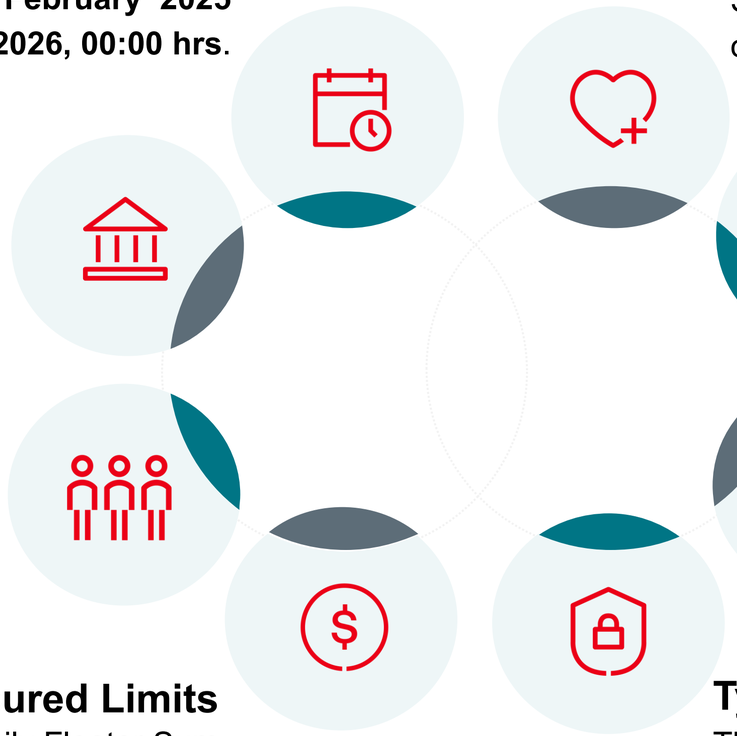
The insurance company for the group medical policy is **The New India Assurance Company Ltd**

Third Party Assistance

FHPL TPA will be servicing all claims

Sum Insured Limits

INR **5,00,000** Family Floater Sum Insured Limit per family



Voluntary Top-up Medical Insurance Cover

Sublimit of **INR 500,000 or 10,00,000** are available over and above base Sum Insured limit.

Age Limit

Employee : 18 – 65 years

Spouse: 0 – 65 years

Children – 0 – 25 years

Parents – up to 100 years

Family Definition

Employee, Spouse, First 2 Living Children, Either set of Parents/Parent – In laws

Type of cover

The policy is on a **floater** basis for your enrolled family members

Benefits Summary

Pre-Existing diseases	Covered
Pre-Post hospitalization	Covered
Waiting period	Waived off
Maternity	Covered
Pre-Post Natal expense	Covered
New-born baby coverage	Covered

Ambulance services	Covered
Day Care procedures	Covered
Ayurvedic Treatment	Covered
Dental & Vision OPD	Not Covered
Room Rent	Covered
Co-payment	Nil

Benefit descriptions in this benefit manual are to be treated as indicative only.
For a complete list of benefits and exclusions, please also refer to the policy document.

Benefits Summary

POLICY TERMS	
Insurer	The New India Assurance Company Ltd
Geographical Limits	India (Treatment Taken Within the Geographical limit of India under Register Hospital are eligible to claim under policy)
POLICY PERIOD	
From	09/02/2025
To	08/02/2026
TPA	Family Health Plan Insurance TPA Limited
Policy Type	Family Floater
Group Composition	Self + Spouse + 2 Dependent Children + 2 Dependent Parents / In Laws
Family Size	1+5
Sum insured basis	Family Floater
Basic Sum Insured	Family Floater Sum Insured of INR 500,000 (Base Policy)

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Benefits Summary

SCHEDULE OF BENEFITS	
Pre-hospitalization	Covered up to 30 days(Before date of admission)
Post hospitalization	Covered up to 60 days(after date of discharge)
Pre-existing diseases	Covered for all
First 30 days exclusion	Waived for all
1st , 2nd AND 4th Year Exclusion Clause	Waived for all
Standard Hospitalization	Covered
Day Care Procedures	Covered As per the IRDA & NIA List
Less Than 24hrs Hospitalization	Capped at 1% of the Group size (Investigation & Diagnostic charges, no active line of treatment cases/OPD subject to specific HR recommendation
Diagnostics Expenses on standalone basis	Not Covered
Ambulance Services	Rs.5000/- per person per event
Ayush Treatment	Expenses incurred for Ayurveda, Yoga, Unani, Siddha & Homeopathy Treatment are admissible up to 25% of the sum insured provided the treatment for Illness and accidental injuries, is taken in AYUSH Hospital. Subject: Provide the treatment is taken in Government or Government recognized Center/Hospital approved by National Accreditation Board for Hospitals & Healthcare
Congenital Internal	Covered for all
External Congenital Treatment	External Congenital Treatment to be covered in the Policy in case of life-threatening condition
PPE Kit	Covered
Hospitalization / Injury Arising out of Terrorism	Covered
Physiological disorders	As per standard NIA Coverages
Organ donor cover to be provided	Hospitalization expenses (excluding cost of organ) incurred on the donor during the course of organ transplant to the insured person

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Benefit descriptions in this benefit manual are to be treated as indicative only.
For a complete list of benefits and exclusions, please also refer to the policy document.

Benefits Summary

MATERNITY RELATED BENEFITS

Pregnancy is the most cherish moment of one's life. Water's India wants to ensure that you are adequately covered for this moment.

Maternity benefit covers the cost related to the birth of the child

Benefit	Coverages & Condition's
Maternity Benefits	Covered
Maternity Limits (Normal & Caesarian Section)	Employee Not Opted Topup: Maternity Limit 75K both Normal & C Section Employee Opted Topup : Rs. 100000 for both Normal & Caesarean in base policy
Surgical Infertility treatment including IVF	Surgical Infertility including IVF in case of IPD/OPD//Day care through Medicine/Surgical Procedure/Assisted Conception including Intrauterine Insemination (IUI) and IVF / ZIFT/GIFT/ICSI Covered within Maternity Limit
Surrogacy	Covers only Maternity Expense of Surrogate mother within Maternity Limit
Pre & Post Natal Expenses	Pre- and post-natal expenses upto Rs 5000/- over and above maternity limit
9-Months Waiting Period for Maternity	Waived off
Newborn Baby cover/ Well Baby	Covered (Well baby expenses are covered up to 5000 within the maternity limit and Newborn baby is covered from day 1)
Well Mother Cover	Not Covered
Exclusion	▪ Expenses incurred in connection with voluntary medical termination of pregnancy during the first 12 weeks from the date of conception are not covered. ▪ Applicable only for the birth of first 2 children

Benefits Explained: Room Rent

Room Rent

Room Rent means the amount charged by a Hospital for the occupancy of a bed per day (twenty-four hours) basis and shall include associated medical expenses. Sub-limit on room rent would mean that the insurer defines the maximum amount it will pay towards the room rent. Mostly, this limit is defined as a percentage of sum insured.

Benefit

Normal/ Ward Stay Room rent cap : 1.5% of base policy Sum insured (INR 500000) for Normal Hospitalization
ICU Room rent cap : No Limit.

Note

Room Rent : Room rent includes bed charges, duty doctor, nursing charges and service charges or amenities (if any)
ICU Rent : ICU charges includes ICU bed, general medical support, medical devices expenses, critical care nursing and intensivist charges

Proportionate Deduction : Proportionate clause is not applicable. How ever only the room rent difference has to be paid by the member

Opting for a room of a higher category than the eligible category will result in higher cost for all hospitalization services, which must be borne by the claimant – There is no Proportionate charges. However, the difference in room rent must be paid by the member – Room Rent includes, doctor & Nursing Charges.

Benefits Explained: Ailment Capping

Ailment Capping

Ailment capping in form of cost containment method to ensure only reasonable and customary charges are payable under the insurance policy.

DISEASE -WISE CAPPING	
Limit on any one Disease / Ailment/ Cataract including Multi Focal Lenses	No Capping
Lasik surgery	Covered if the refractive error of eye is beyond +/- 6.5
Autism	Covered up to the age of 10 Years up to 30,000 per person
Cochlear Implant	Cochlear Implant Covered Surgery Covered (Device cost not covered)
Genetic Disorders	are covered with a sub-limit of 25% of Sum Insured per policy period with 48 months waiting periods. This limit shall be within the Sum Insured and does not increase the overall Sum Insured.
SPECIAL CONDITIONS	Capped ailments cannot be covered under Top-up unless Base S.I. is exhausted subject to insurer approval

GMC:
Base

Benefits Explained: Co-pay

Co-Pay

A co pay is the amount of the claim that is borne by the employee. For.eg during a claim process, the admissible claimed amount is INR 100,000. The policy has a 10% co pay, INR 10,000 will be borne by the employee and rest INR 90,000 will be paid by the insurance company.

Benefit

Water’s India provide benefit of Nil co-payment.

Benefits Summary - Advanced Medical Treatments

Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	Up to 20% of Sum Insured subject to Maximum Rs. 2 Lakh
Balloon Sinuplasty	Up to 20% of Sum Insured subject to Maximum Rs. 2 Lakh
Deep Brain stimulation	Up to 50% of Sum Insured subject to Maximum Rs. 5 Lakh
Oral chemotherapy	Up to 10% of Sum Insured subject to Maximum Rs. 1 Lakh
Immunotherapy- Monoclonal Antibody to be given as injection	Up to 25% of Sum Insured subject to Maximum Rs 2 Lakh
Intravitreal injections	Up to 10% of Sum Insured subject to Maximum Rs.75,000
Robotic surgeries	Up to 50% of Sum Insured subject to Maximum Rs. 5 Lakh
Stereotactic radio surgeries	Up to 50% of Sum Insured subject to Maximum Rs. 3 Lakh
Bronchial Thermoplasty	Up to 50% of Sum Insured subject to Maximum Rs. 2.5 Lakh
Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)	Up to 50% of Sum Insured subject to Maximum Rs. 2.5 Lakh
IONM - (Intra Operative Neuro Monitoring)	Up to 10% of Sum Insured subject to Maximum Rs. 50,000
Stem cell therapy Hematopoietic stem cells for bone marrow transplant in haematological condition	Up to 50% of Sum Insured subject to Maximum Rs. 2.5 Lakh

Benefit descriptions in this benefit manual are to be treated as indicative only.
For a complete list of benefits and exclusions, please also refer to the policy document.

Benefits Summary

OTHER TERMS AND CONDITIONS	
Widow/ widower / Continuity Coverage	If an employee passes away during the course of the policy, the benefits can be extended to the dependents up to expiry of policy period provided they are not sought for deletion under the policy.
Deductible and Co pay	Not Applicable
GIPSA/PPN Network	Not Applicable
Death Claim No deduction/Bereavement cover	if the claimant (Both Self & Dependent) passes away during hospitalization : Complete amount settlement in case of death of the Insured (Both Emp & Dependent)
Special Conditions	Surrogacy, LGBTQ, Live in Relationships, and HIV & AIDS treatments
All Other Terms and Conditions	AS PER STANDARD GROUP MEDICLAIM CLAUSE Note: Maternity Benefits & Corporate Buffer not applicable to Top-up Policy

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GROUP MEDICAL INSURANCE PLAN

Top up

Why Top Up 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

This provides an additional coverage to employees over and above the company sponsored 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 can be identical to the main medical plan.
- Employee can fine tune the level of cover as per his/her needs.
- The main medical plan and the top up plan can be claimed together for the same hospitalization upon exhaustion of the basic sum insured limit.
- Employee gets a tax benefit on the premium paid towards the top up plan

Benefits of Water's India Top-up Policy

- This is a customized health top up plan designed exclusively for Water's India employees only and at customized and negotiated standard premium across all age groups pricing.
- Terms and conditions in line with the corporate policy covering Pre-Existing etc.
- Provides financial support in case of any critical illness where the company provided sum insured is also exhausted.

Existing Current Policy Benefits	Market Retail Policy	Water's India - 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	Limited Sum Insured is available in RETAIL(subject to medical tests)	Sum Insured extendable up to Rs.5 lakhs or Rs.10 lakhs
Medical Tests	Any Person >45 needs to go for a Medical Test on own cost	Not required for any age group

Benefits Summary

Benefits	Coverages & Condition's
Insurer	**New India Assurance**
TPA	FHPL TPA
Policy Period	09-Feb-25 to 08-Feb-26
Pre- Existing Disease coverage	Day one coverage
Co-pay	Nil copay
30 days waiting period	Waived Off

TOP-UP POLICY ANNUAL PREMIUM PER FAMILY

Sum Insured	Annual Premium Excl. GST @ 18%	Annual Premium Incl. GST @ 18%
5.00,000	6,134	7,238
10,00,00	14,753	17,409

Benefits Summary

GMC: Top-up

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/ Maternity Limit

Covered Subject to Base Sum Insured Exhausted for any other Hospitalization/Claim/Ailments

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** . Once after the enrolment closure there is no exceptional Mechanism to Enroll/ opt TOPUP during the present/existing policy.

Exclusion

As per Standard Exclusion of IRDA / Insurer

Benefits Summary

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** . 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 within 30 Days

General Exclusion : Non-Medical Expenses

GMC Both Base & Top-up

Expenses	Admissibility
Baby Bottles	Not Payable
Baby Food	Not Payable
Baby Set	Not Payable
Baby Utilites Charges	Not Payable
Barber Charges	Not Payable
Beauty Services	Not Payable
Bed Pan	Not Payable
Bed Under Pad Charges	Not Payable
Belts/ Braces	Essential and may be paid specifically for cases who have undergone surgery of thoraic or lumbar spine.
Brush	Not Payable
Buds	Not Payable
Camera Cover	Not Payable
Caps	Not Payable
Carry Bags	Not Payable
Cliniplast	Not Payable
Cold Pack/Hot Pack	Not Payable
Comb	Not Payable
Cosy Towel	Not Payable

Expenses	Admissibility
Cradle Charges	Not Payable
Crepe Bandage	Not Payable
Curapore	Not Payable
Diaper Of Any Type	Not Payable
Disposables Razors Charges (For Site Preparations)	Payable
Dvd, Cd Charges	Not Payable
Eau-De-Cologne / Room Freshners	Not Payable
Email / Internet Charges	Not Payable
Eye Sheild	Not Payable
Face Mask	Not Payable
Blade	Not Payable
Apron	Not Payable
Torniquet	Not Payable
Dressing Charges	Not Payable

Expenses	Admissibility
Admission Kit	Not Payable
Misc Expenses	Not Payable
Birth Certificate	Not Payable
Blood Reservation Charges And Ante Natal Booking Charges	Not Payable
Certificate Charges	Not Payable
Courier Charges	Not Payable
Convenyance Charges	Not Payable
Diabetic Chart Charges	Not Payable
Documentation Charges / Administrative Expenses	Not Payable
Discharge Procedure Charges	Not Payable
Daily Chart Charges	Not Payable
Entrance Pass / Visitors Pass Charges	Not Payable
Medical Records	Not Payable

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Above mentioned items are for illustrative purpose.
For a complete list of NME and exclusions, please also refer to the policy document.

General Exclusion

CAPD (Continuous Ambulatory Peritoneal Dialysis) Expenses	Not Covered
Cyber Knife Treatment Procedure Expenses	Not Covered
Adjuvant & Hormonal Therapy	Not Covered
Gamma knife treatment	Not Covered
Femto laser Treatment For Eye	Not Covered
Stress or Psychological Disorders	Not Covered
Adjuvant & Hormonal Therapy	Not Covered
Domiciliary hospitalization	Not Covered
Neurodegenerative Disorders	Not Covered
Dental & Vision OPD	Not Covered
Psychosomatic/ Psychiatric Disorder	Not Covered
Mental Illness	Not Covered

Benefit descriptions in this benefit manual are to be treated as indicative only.
For a complete list of benefits and exclusions, please also refer to the policy document.

General Exclusion

GMC Both Base & Top-up

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.
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 (unless for a life-threatening situation)
Convalescence, general debility, "run down" condition or rest cure, sterility, any fertility, sub-fertility or assisted conception procedure, venereal diseases, intentional self-injury/suicide, 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 an active treatment for the ailment during the hospitalized 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.

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Above mentioned items are for illustrative purpose.
For a complete list of NME and exclusions, please also refer to the policy document.

Claim Intimation : Timelines Applicable for all Mediclaim Policy

Benefit	Benefits/Coverages & Condition's
Main Hospitalization Claim Submission (Mandatory)	Within 45 Days from the Date Of Discharge Document must reach the FHPL TPA.
Pre -Post Claim Submission (Mandatory)	▪ Pre to be submitted with in 7 days from date of discharge (Main Claim) ▪ Post to be submitted within in 7 days on completion of 60 days post hospitalization limit.

Mid Term Enrolment

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 *	Only newly married employees' spouses & newborn children covered subject to declaration within 30 days from Date of Marriage / Date of Birth

Claims Process

Making a Claim

Hospitalisation 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.
- **There are 2 types of cashless hospitalization: Planned hospitalization & Emergency hospitalization**
- Intimation of claim:- 48 hours prior to getting hospitalized for planned hospitalization and 24 hours within hospitalization for emergency hospitalization

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 preauthorization procedure and intimate the TPA about the claim to ensure eligibility for reimbursement of hospitalization expenses from the insurer.

Submission of claim :- TPA must receive the claim documents for all reimbursements within 45 days of discharge from hospital

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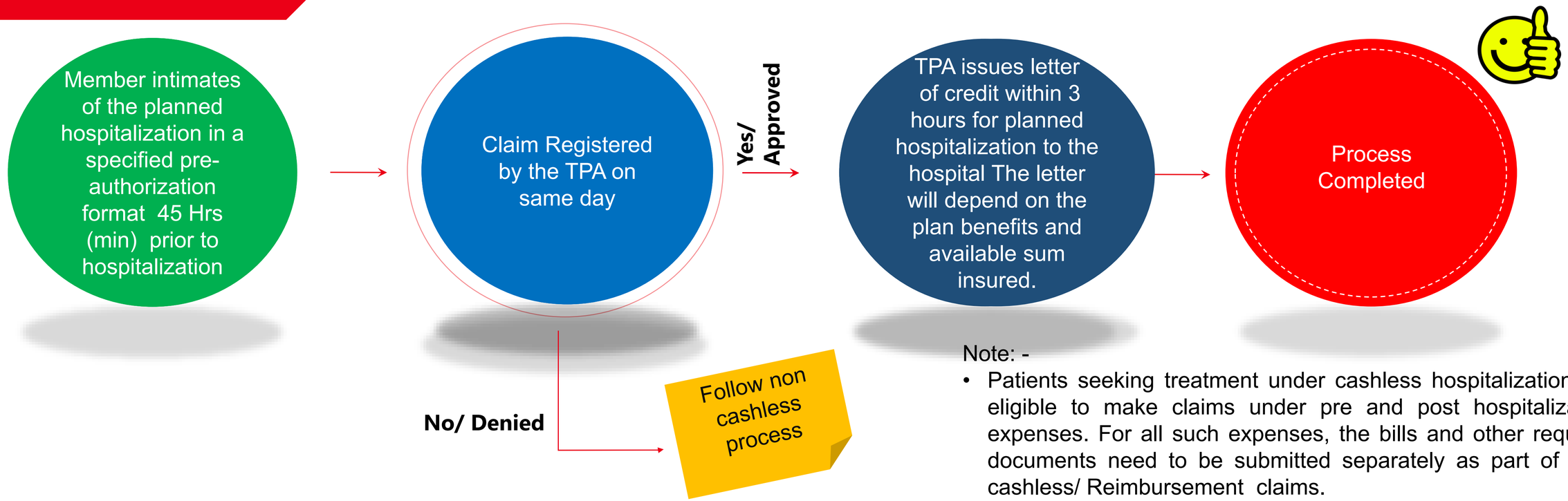
Cashless Planned Hospitalization

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

Step 1
Pre-Authorization



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

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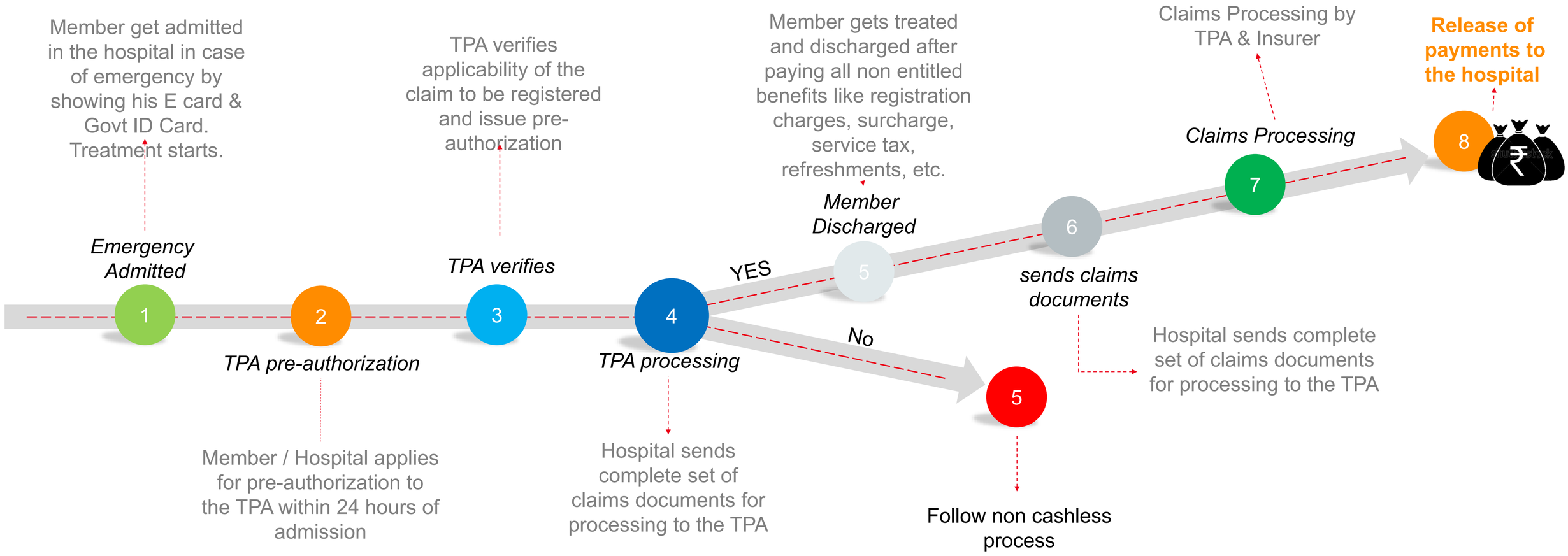
Emergency Cashless Hospitalization Process



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

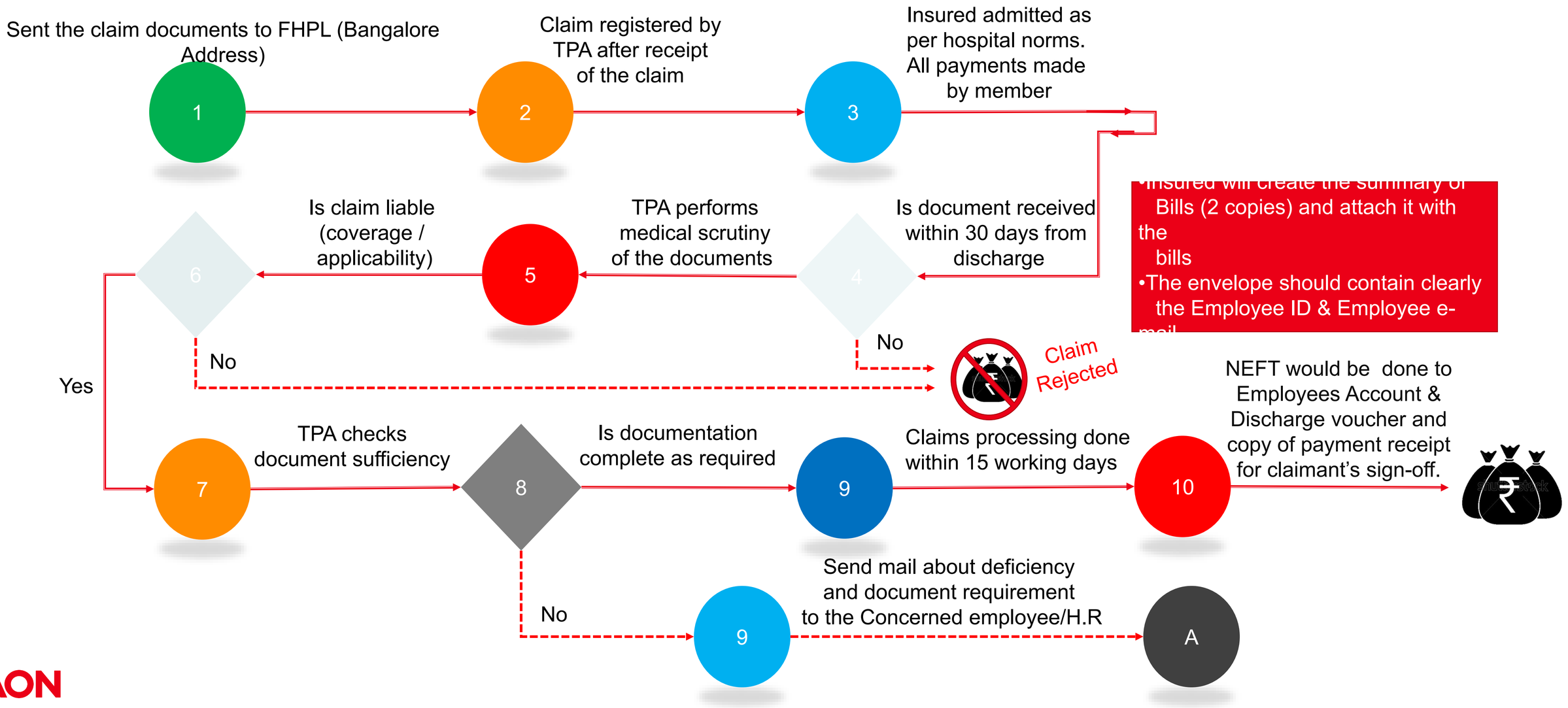
In case of non network hospital, you will be required to clear the bill and submit the claim to TPA for reimbursement from the insurer. Please ensure that you collect all necessary documents such as discharge summary, investigation reports etc. for submitting your claim.

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 45 days from the date of discharge from the hospital.

2. Under hospitalization claims, you are also permitted to claim for treatment expenses 30 days prior to hospitalization and 60 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 60th day whichever is earlier.

Reimbursement Hospitalization Process



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
11	Maternity: Gravida Report

Reimbursement Claim Documents

Claim Documents Envelope Address Format

Important Links

Download and keep your E-cards handy for you and your family

For Instant E-card / Download of Forms / online claim registration FHPL Portal

For Cashless hospitalization

- Click on Website – https://www.fhpl.net/#/hospital_networks Select Insurer as : New India assurance insurance
- Planned hospitalization to improve overall cost of care.
- Blacklisted/Cautious / Excluded Hospital List: https://www.fhpl.net/#/hospital_networks

For Reimbursement-

- Ensure that you obtain all necessary documents and bills in original.
- Submit your documents to your TPA servicing branch location or in Portal.

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Employee Insurance Contact Matrix

Point of Contact

Dedicated point of contact claims		
Name	**Mobile**	**Email**
Dinakaran K	9986455600	dinakaran.k@fhpl.net

In view of "waters India" Group being Corporate Insurance, Employee must contact above Dedicated SPOC Only

Escalation Matrix			
Level	**Contact Person**	**Mobile number**	**Mail id**
1	Hajira Rasheed	9243479825	hajira.rasheed@fhpl.net
2	Dr Abdul Zama	9206398010	abdul.zama@aon.com
3	Dr Saima Rahman	6001671491	Saima.Rahman@aon.com
4	Vanitha Ramachandran	7022158511	Vanitha.Ramachandran5@aon.com

3

GROUP PERSONAL ACCIDENT INSURANCE PLAN

GPA

Group Personal Accident Insurance Plan

Plan Details

Policy Period

1st April 2025

to 31st March 2026

midnight

Insurance Company

New India Assurance Insurance

Basis of Sum Insured

60 Times of the monthly basic salary

Members Covered

Employee

- The group personal accident policy indemnifies the insured (only Employee's) or the dependents (Declared beneficiaries) of the insured person in case of an "Accidental Uncertainty/risk occurs only to Employee" during the covered period.
- Uncertainty like: Death , Permanent Total Disability , Permanent Partial Disability , Temporary total disablement etc.
- Proximate cause of uncertainty must be "Accident"

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GPA

Group Personal Accident Insurance Plan

Plan Benefits

Accidental Death	Permanent Total Disability	Permanent Partial Disability
Covered	Covered	Covered up to a specified percentage of the full sum insured limit.

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Group Personal Accident Insurance Plan

Plan Benefits

Temporary Total Disablement

Weekly Benefit - 1%of Capital Sum Insured subject to a maximum of INR 5000 per week, up to a maximum of 100 weeks

Medical Expenses

Medical expenses with a limit of 10%of CSI or 40%of admissible claims amount or actual whichever is lower

Geographical Limits

24*7 Worldwide

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Group Personal Accident Insurance Plan

Plan Benefits

Transportation cost or carriage of dead body to Home including funeral charges

Covered up to Rs.5,000/-

Education Fund

One Child- 10% of C.S.I
Subject to a maximum of Rs.5000/-
Two Child-10% of C.S.I
Subject to a maximum of Rs.10000/-

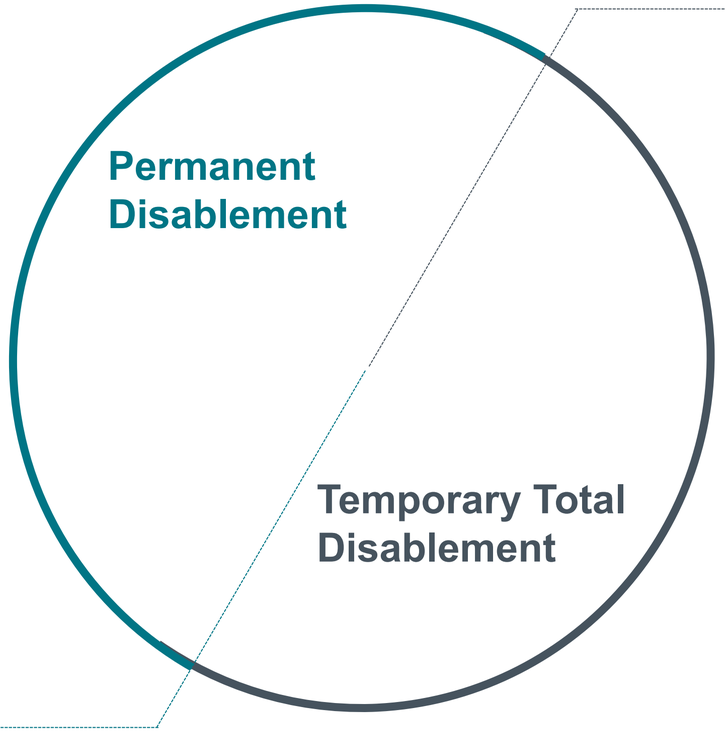
Terrorism

Covered

Group Personal Accident Insurance Plan

Key Terms

Permanent Disablement means disablement which permanently and entirely prevents an Insured Person from engaging in or giving attention to the Insured Person's usual occupation resulting in losing of his/her earning capacity.

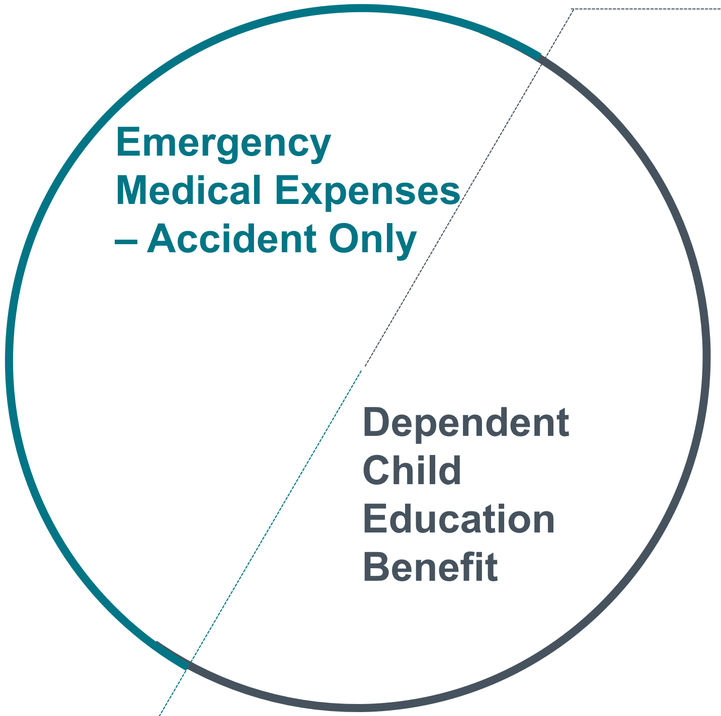


Temporary Total Disablement means disablement which temporarily and entirely prevents an Insured Person from engaging in or giving attention to the Insured Person's usual occupation.

Group Personal Accident Insurance Plan

Key Terms

If, during the Period of Insurance, an Insured Person sustains Bodily Injury, then the Company will reimburse the Insured Person the necessary Usual and Reasonable Medical Expenses, incurred within twelve (12) months from the Date of Loss up to the Sum Insured stated in the Schedule, subject to the Terms and Conditions of this Policy. The Deductible or Franchise, if applicable, shall be deducted from the Compensation payable.



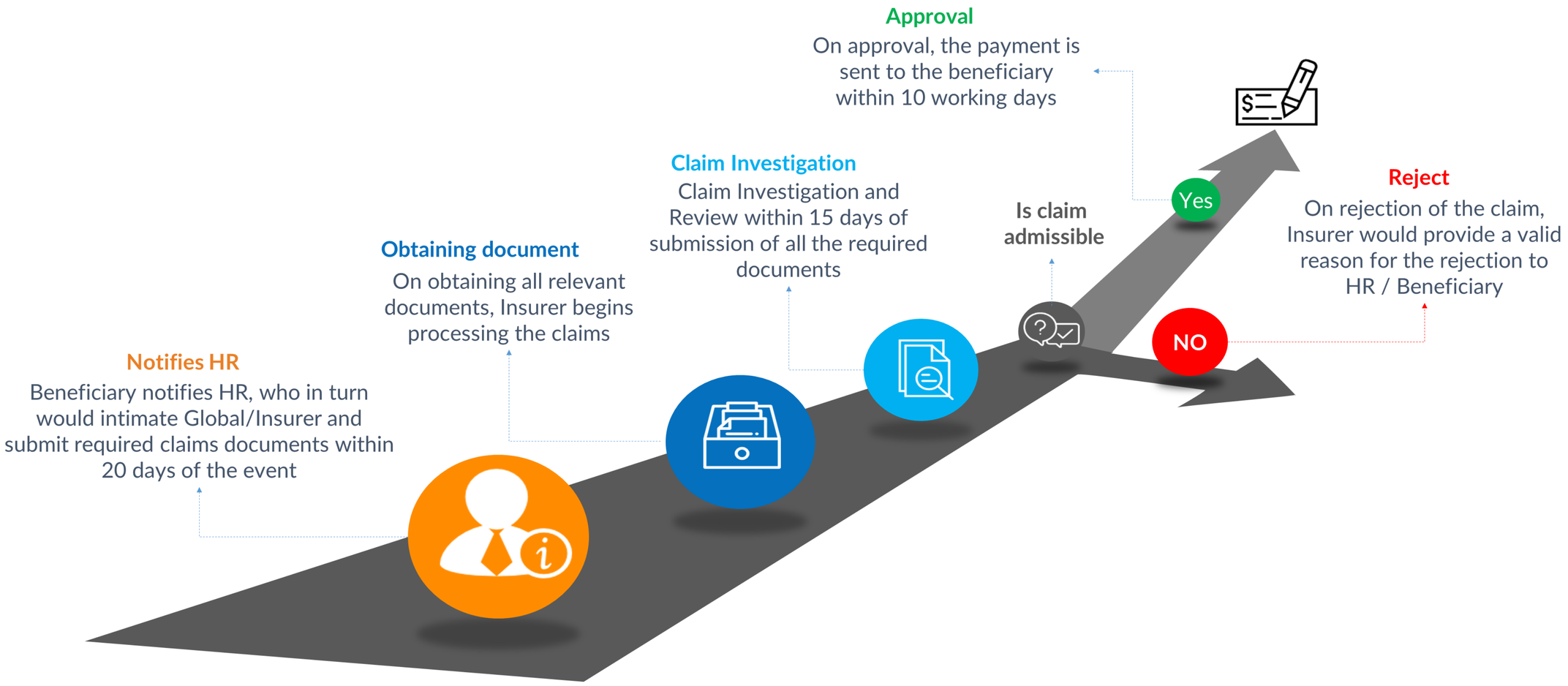
If during the Period of Insurance an Insured Person sustains Bodily Injury which directly and independently of all other causes results in death within twelve (12) months of the Date of Loss, then the Company agrees to pay the education fees for the Insured Person's surviving Dependent Child up to the amount stated in the Schedule per year up to the number of years stated in the Schedule

Group Personal Accident Insurance Plan

General 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 towards saving human life)
- Loss due to childbirth or pregnancy.
- Bodily Injury or Sickness occasioned by Civil War or Foreign War

Group Personal Accident: Claim Procedure



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Group Personal Accident: 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

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	Police Inquest report, wherever applicable

- In case of additional documents requirement, Insurer will let the HR know at the time of claim.
- Policyholder shall inform the insurance company of any claim within 30 days of the claim event.

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4

Definitions

Benefits Summary

Standard Hospitalization	In the event of a hospitalization claim (more than 24 hrs.), the insurance company will pay the insured person the amount of such expenses as would fall under different heads mentioned below, and as are reasonably and necessarily incurred thereof by or on behalf of such insured person, but not exceeding the sum insured in aggregate mentioned in the policy: • Room Charges, • Nursing expenses, • Surgeon, Anesthetist, Medical Practitioner, Consultant, Specialists Fees, • Anesthesia, Blood, Oxygen, Operation Theatre Charges Surgical Appliances, Medicines & Drugs, & similar expenses.
Pre-existing diseases	Pre-existing diseases is a condition for which the insured has been diagnosed with or treated for before the policy commencement date. The most common examples of such conditions are diabetes, hypertension, thyroid etc. **Your policy covers pre-existing diseases from day 1.**
Pre-hospitalization	Pre-hospitalization expenses include various charges related to consultation fees, medical tests and medicine cost before an individual gets hospitalized. Doctors/physicians conduct a slew of tests to accurately diagnose the medical condition of a patient before prescribing treatment. However, in most cases, charges incurred by an individual 30 days prior to his or her hospitalization fall within the ambit of pre-hospitalization expenses. For instance, several tests such as blood test, urine test and X-ray among others are categorized as pre-hospitalization expenses. **Your policy covers 30 days of pre-hospitalization benefit.**

Benefits Summary

Post-hospitalization	Post hospitalization expenses include all expenses or charges incurred by an individual after he or she is discharged from the hospital. For instance, the consulting physician may prescribe medicine along with certain tests to ascertain the progress or recovery of a patient. Expenses related to various therapies, namely, acupuncture and naturopathy are not included by insurance providers in the category of post hospitalization expenses. However, diagnostic charges, consulting fees and medicine costs are covered. **Your policy covers 60 days of post-hospitalization benefits.**
Waiting period	A waiting period is the amount of time an insured must wait before some or all their coverage comes into effect. The insured may not receive benefits for claims filed during the waiting period. In a corporate group policy, waiting period of 30 days , 1 year and 9 months are waived off. However, in a retail policy most of the waiting period continue to exist. **Your policy has no waiting period.**
Maternity Benefits	Maternity benefit covers the cost related to the birth of the child. It includes the delivery charges for both normal and c-section. Maternity benefit can be availed for the birth of first two children. Maternity benefit will not be applicable in case two biological children already exist in the family. • 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.

Benefits Summary

Pre/Post Natal	Pre and Post natal expenses are those which are incurred pre delivery and post delivery e.g., Ultrasound, regular checkups, doctor's consultation fee, medicines and so on. **Your policy covers Pre/Post Natal expenses over and above the maternity limit**
Newborn baby cover	A Newborn baby is covered in the family floater sum insured limits from day 1. However, the birth of the child needs to be intimated to the HR team or updated on the benefits portal within 30 days of date of event. **Your policy covers newborn baby cover from day 1.**
Ambulance Services	Ambulance charges include emergency transport of the patient from the residence/place of accident/illness to the hospital where treatment is undergone. **Your policy covers ambulance charges for INR 5,000 per incidence.**

Benefits Summary

Day Care Services	Due to medical advancement, a list of treatments do not require 24 hours of hospitalization. For example : Cataract operation, kidney stones removal etc. **Your policy covers list of day care procedures as per the insurer list**
Ayurvedic treatment	Ayurvedic is a form of non-allopathic treatment. Under insurance policy ayurvedic treatment undertaken in a Government Hospital or in any Institute recognised by the Government and/or accredited by Quality Council of India/National Accreditation Board on Health is only admissible. The ayurvedic treatment is covered only on in-patient basis. **Your policy covers ayurvedic treatment up to 25% of sum insured undertaken only in a government registered hospital.**
Dental cover	Dental treatment is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants. The dental cover is a standard exclusion under the policy except treatment undertaken in case of an accident. **Your policy covers dental treatment only in case of accident. No other form of dental treatment is covered in the policy.**

Benefits Summary

Vision cover	Vision cover refers to the maintenance of the health and wellness of the eyes or eye care and includes routine preventive eye care and prescription of glasses. This remains as a standard exclusion under the medical insurance. **Your policy does not cover vision benefit.**
Co-pay	A co pay is the amount of the claim that is borne by the employee. For.eg during a claim process , the admissible claimed amount is INR 100,000 and the policy has a 10% co pay . The employee will have to bear INR 10,000 and the insurance company will pay the remaining INR 90,000. **Your policy has a Nil co-pay .**
Ailment capping	Ailment capping in form of cost containment method to ensure only reasonable and customary charges are payable under the insurance policy. The most common form of ailment capping are cataract, knee replacement surgery, oral chemotherapy etc. Please refer to your policy terms and conditions to understand the ailment caps under your corporate policy.

Benefits Summary

Room Rent	Room Rent means the amount charged by a Hospital for the occupancy of a bed per day (twenty-four hours) basis and shall include associated medical expenses. Sub-limit on room rent would mean that the insurer defines the maximum amount it will pay towards the room rent. Mostly, this limit is defined as a percentage of sum insured. As an example, a 1% (of Sum Insured) per day cap for a normal room in a policy with a sum insured of Rs 3 lakh means that the insurer will only pay Rs3,000 per day towards room rent. In other words, you would be eligible to stay in a room with a tariff of up to Rs3,000 per day. If you choose a room with higher tariff, the insurer will not pay, and you will pay the difference. But that's not all. You don't only pay the difference in the room rent alone, but the associated difference in cost of doctors' fees, nursing fees and surgery costs. This is so because the cost of medical procedures is linked to the room that you choose. So, for the same line of treatment a person with a twin-sharing room will pay less compared to a person with a single room. Your policy eligibility is: **1.5% of the sum insured for normal room category and No restriction of the sum insured for ICU room category per day.**

Benefits Summary

Congenital Ailments	Congenital Disease means anomaly at the time of birth. This I of two types : Internal and External. Internal Congenital anomaly is a type of birth defect which is invisible in accessible parts of the body. For example: Atrial septal defect. External Congenital Anomaly is a type of birth defect which is in the visible and is in accessible parts of the body. For example: Cleft lip/palate **Your policy covers internal congenital defects and external congenital defects only in case of life-threatening conditions.**
Domiciliary hospitalization	Domiciliary hospitalization is a conditions where in the insured is treated as hospitalised even when he is at home Your policy covers internal congenital defects and external congenital defects up to 6 years only in case of life-threatening conditions. **Your policy does not cover domiciliary treatments.**

Thank You

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