Norton Software India Pvt. Ltd

2024 – 2025

Employee Health & Benefits

Businesses of Marsh McLennan

Health Policy – Top-Up Plan Terms

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Top-Up Health Policy

Policy Details	
Insurer	Bajaj Allianz General Insurance Company Limited
Policy Period	03-Oct-2024 To 02-Oct-2025
Third Party Administrator (TPA)	Health Administration Team In-House TPA Bajaj Allianz General Insurance Co. Ltd.
Geographical Limits	India (Covers Treatment In India Only)

What Does The Health Policy Cover?

The benefit of a Health Policy is coverage against any Medical Contingency requiring the member to be hospitalized. In case of hospitalization only (i.e. hospitalization for more than 24 hours), the insurance company will pay the insured person the reasonable amount of expenses incurred towards treatment up to the Sum Insured limits and subject to the insurance policy guidelines.

Non Medical expenses like Administration Charges. Registration Charges, Telephone Charges/Fax charges; food charges if not part of room rent for patient and food charges for relatives/ attendant etc. are not covered.

Top-Up Health Policy Terms

Benefits	Applicability
Sum Insured Type	INR 300,000 / INR 500,000 / INR 700,000 / INR 1,000,000 As Per Employee Choice
Family Unit Definition	Members who are part of the base policy will only be part of the top-up policy
Top-Up Trigger Point	Top-up will trigger only when the claim up to the sum insured i.e. INR 600,000 is exhausted in one single or multiple claim. Upon employee's exit, the Top-up will trigger from INR 500,001 which means that the claim up to INR 600,000 has to be borne by the employee through some other insurance policy or by him / herself
Maternity Benefit	Not Covered
Pre & Post Natal Expenses	Not Covered
Infertility Related Treatment	Not Covered
Newborn Baby Coverage	Covered From Day 1 Of Childbirth Within Family Floater Sum Insured (Subject To Timely Intimation For Coverage) Details to be shared within 15 days from date of birth
Pre-existing Disease Coverage	Covered From Day 1, Without Any Sublimit
Time Based Waiting Periods	Waived Off
Pre & Post Hospitalisation Period	Covered For 30 Days & 60 Days, Without Any Sub Limits

Top-Up Health Policy Terms

Benefits	Applicability
Ambulance Services Coverage	Covered For INR 4,000 Per Case
Air Ambulance, Repatriation And Burial Expenses	Covered For INR 10,000 Per Case
Normal Room Rent Limit Per Day	Single AC Room Entry level, For All Hospitals Throughout The Country. Associated Costs (Excluding Medicine Charges) To Be Paid In Proportion To Room Rent Capping.
ICU Room Rent Limit Per Day	At Actual
Co- Pay	20% On Each & Every Parental Claim. However, If The Admissible Amount Of The Claim Is More Than The Sum Insured Then Co-Pay To Be Applicable On Admissible Amount And Not On Sum Insured.
Covid 19 Home Isolation	Covered For INR 10,000 Per Case
Treatment For HIV, STD & AIDS Or Any Similar Ailment	Covered
Treatment For Morbid Obesity	Obesity/ Weight Control(Code- Excl06) Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions: Surgery to be conducted is upon the advice of the Doctor The surgery/Procedure conducted should be supported by clinical protocols The member has to be 18 years of age or older and Body Mass Index (BMI); greater than or equal to 40 or greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss: Obesity-related cardiomyopathy / Coronary heart disease / Severe Sleep Apnea / Uncontrolled Type2 Diabetes
Internal Congenital Disease	Covered On OPD And IPD Basis
External Congenital Disease	Covered

Top-Up Health Policy

Benefits	Applicability
Cyber-Knife Treatment, Gamma Knife Treatment, Stem Cell Transplantation, All Types Of Robotic Surgery, Bone Marrow Transplant	Not Covered under top-Up Policy being capped ailment
Autism / Parkinson Related Treatment	Covered On OPD And IPD Basis
Treatment For Correction Of Eyesight	Covered Beyond + / - 5, Including Lasik Surgery Without Any Sub-Limit
Coverage Of Psychiatric / Psychosomatic Disorders & Treatment	Covered, Subject To Sublimit Of INR 50,000 Including Treatment Taken On OPD Basis
Terrorism Related Hospitalisation	Covered
Genetic Disorder	Not Covered
Same Sex Partner Coverage (LGBTQ Cover)	Covered Including Taken On OPD Basis
Maternity & Infertility Coverage For Same Sex Partner	Covered
Enrolment Of Same Sex Partner Minor Dependents	Covered upto 2 dependent child, who are either biological or adopted (relevant doc will be required i.e. birth certificate / adoption document etc

Top-Up Health Policy

Benefits	Applicability
Dependent Coverage In Case of Employee Death	In the event of demise of the primary member the dependent will continue to be covered till the date of expiry of the current policy
No Deductions In Case Of Death Of Member	Non-Medical Expenses which are generally not paid under the policy to be paid in case of death of a member upto applicable sum insured
Cost Of Avastin Or Any Other Intravitreal Injections Or Medication On Advice Of Treating Doctor / ARMD Including Taken On OPD Basis	Covered Upto Applicable Sum Insured
MTMAT* (Modern Treatment Methods and Advancement in Technology)	The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment or OPD in a hospital upto Applicable Sum Insured 1. Uterine Artery Embolization and HIFU (High intensity focused ultrasound) 2. Balloon Sinuplasty. 3. Deep Brain stimulation. 4. Stereotactic radio surgeries. 5. Bronchial Thermoplasty. 6. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment). 7. IONM - (Intra Operative Neuro Monitoring).
Immunotherapy Coverage	Under claim in absence of any other treatment and recommended by doctor, Immunotherapy / Targeted Therapy Targeted and Adjuvant Chemotherapy treatment is covered for all kinds of ailments. Monoclonal Antibody injection / Drugs Etc. Covered Upto Applicable Sum Insured

Top-Up Rate Chart

Top-Up Sum Insured	Premium Excluding GST	Premium Including GST
INR 300,000	INR 9,945	INR 11,735
INR 500,000	INR 12,393	INR 14,624
INR 700,000	INR 15,759	INR 18,596
INR 800,000	INR 18,207	INR 21,484
INR 1,000,000	INR 22,338	INR 26,359
INR 1,200,000	INR 26,469	INR 31,233
INR 1,500,000	INR 31,442	INR 37,102

Top-Up Health Policy – Enrollment, Claims, Exclusions & FAQ's

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Enrollment Process

Dependent Enrolment for all NortonLifeLock Employees

All New Joinees are requested to enroll their dependents within 15 days from the date of their joining.

Note: *There will be no midyear enrolment allowed during the year except:

(a) Marital Status Change

(b) Birth of a child, provided there is scope available to cover the dependent.

*Intimation should be provided to HR / MARSH within 15 days from the date of marriage and 15 days from the date of birth in case of new born

To add the baby to the policy we do not need the name of the baby, we need the Empl. ID, Empl. Name, DOB of Baby, Gender of Baby

To Enroll

Step	Action
1	HR Team to share the new joiner's data with Marsh on weekly basis
2	Marsh shares the data with Insurance Company for endorsement in the first week on following month
3	E-card will be available on Bajaj Allianz Portal within 5 days of the issuance of endorsement. In case of any hospitalisation until then the employee can use the **NortonLifeLock** employee ID and have the claim processed. In case of any query, you can connect with TPA / Marsh POC

Cashless Process

Cashless means the Administrator may authorize upon a Policyholder's request for direct settlement of eligible services and it's 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.

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 needs to submitted separately as part of the claim's reimbursement.

Hospitals in the network (please refer to the website for the updated list)

For Updated List visit to TPA link as below:

https://general.bajajallianz.com/BagicNxt/hm/hmSearchState.do

Cashless Process Emergency Hospitalisation

Step 1: Get Admitted
In cases of emergency, the member should get admitted in the nearest network hospital by showing their ID card.

Step 2: Pre-Authorization by hospital
Relatives of admitted member should inform the call center within 24 hours about the hospitalization & Seek pre authorization. The preauthorization letter would be directly given to the hospital. In case of denial member would be informed directly

Step 3: Treatment & Discharge
After your hospitalization has been pre- authorized the employee is not required to pay the hospitalization bill in case of a network hospital. The bill will be sent directly to, and settled by Administrator

Member gets admitted in the hospital in case of emergency by showing his ID Card

Pre-authorization given by the Administrator

NO

Non cashless Hospitalization Process

YES

Member/Hospital applies for pre- authorization to the Administrator within 24 hrs. of admission

Member gets treated and discharged after paying all non medical expenses like refreshments, etc.

Administrator verifies applicability of the claim to be registered and issue pre-authorization

Hospital sends complete set of claims documents for processing to the Administrator

Click to Access the

https://general.bajajallianz.com/BagicNxt/hm/hmSearchState.do

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Cashless Process Planned Hospitalisation

Step 1: Pre-Authorization
All non-emergency hospitalization instances must be pre-authorized with the Administrator, as per the procedure detailed below. This is done to ensure that the best healthcare possible, is obtained, and the patient/employee is not inconvenienced when taking admission into a Network Hospital.

Member intimates Administrator of the planned hospitalization in a specifiedpre-authorization format at-least 48 hours in advance

Claim Registered by the Administrator on same day

YES

Administrator authorizes cashless as per SLA for planned hospitalization to the hospital

Pre - Authorization Completed

NO

Follow non cashless process

Step 2: Admission, Treatment & discharge
After your hospitalization has been pre-authorized, you need to secure admission to a hospital. A letter of credit will be issued by Administrator to the hospital. Kindly present your ID card at the Hospital admission desk. The employee is not required to pay the hospitalization bill in case of a network hospital. The bill will be sent directly to, and settled by Administrator

Member produces ID card at the network hospital and gets admitted

Member gets treated and discharged after paying all non entitled benefits like refreshments, etc.

Hospital sends complete set of claims documents for processing to Administrator

Claims Processing & Settlement by Administrator Insurer

Please Note: At the time of discharge when the Administrator receives the final bill, they try to renegotiate with the Hospital for a better price. Hence it may take some time for Administrator to revert back with final approval. This exercise checks the hospital to overcharge you and helps keep your sum insured utilization optimized for any future exigencies. Please be patient

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Reimbursement Process

Reimbursement Process

Admission Procedure

- 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 to ensure eligibility for reimbursement of hospitalization expenses from the insurer.

Discharge Procedure

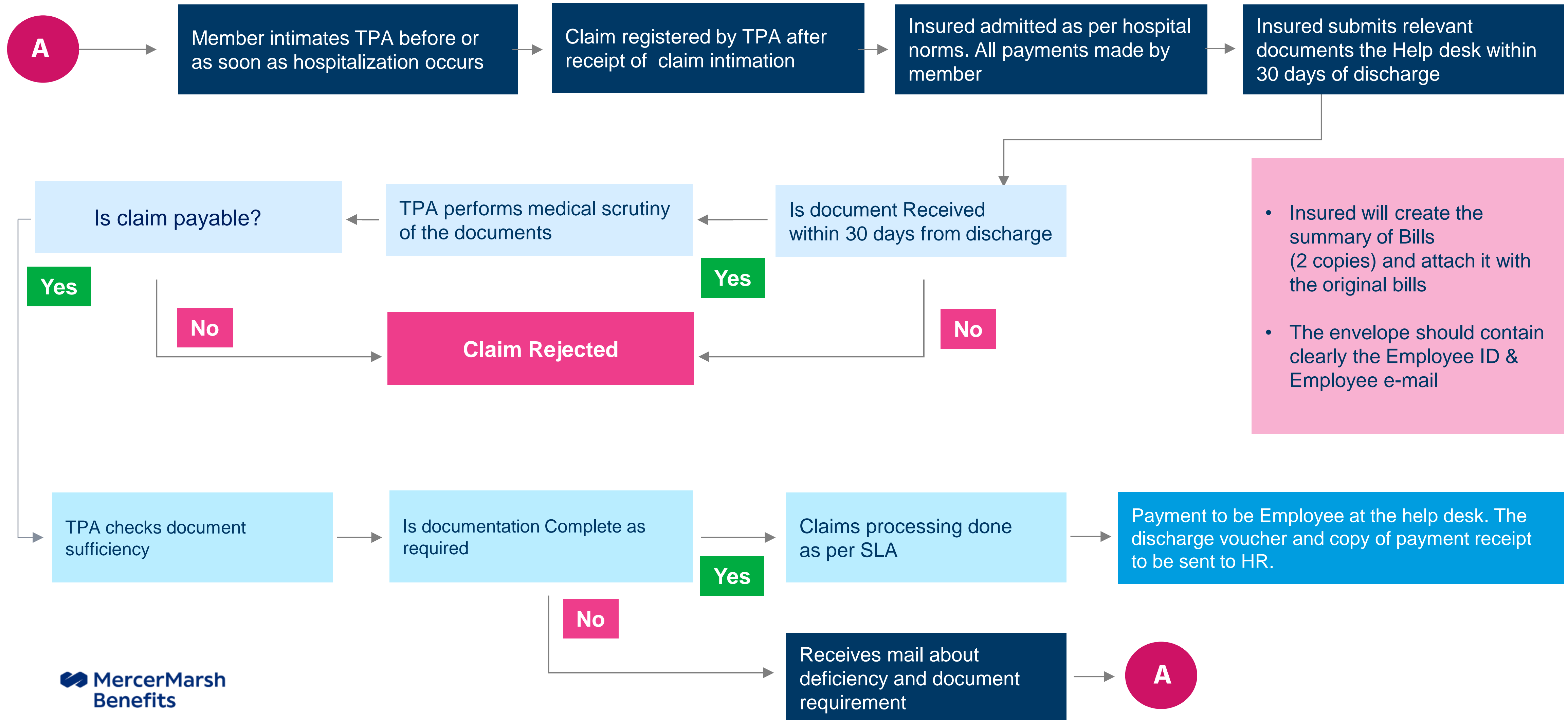
- In case of non network hospital, you will be required to clear the bills and submit the claim to TPA for reimbursement from the insurer. Please ensure that you collect all necessary documents such as - discharge summary, investigation reports etc. for submitting your claim

Reimbursement Process

Submission of Hospitalization Claim

- You must submit the final claim with all relevant documents within 30 days from the date of discharge from the hospital.
- Submission of claim documents to be done on “***Caringly Yours App”*** of Bajaj Allianz however *Its compulsory to write* ***“Claimed With Bajaj Allianz General Insurance Co. Ltd.” On All Original documents like Bills, Discharge Summary / Card). Claimed With Bajaj Allianz General Insurance Co. Ltd.*** should be handwritten and not printed. Along with this an undertaking that as and when the Insurer / TPA sends a request for submission of original documents in physical form the employee will have to submit the same.

Reimbursement Process



Documents Check List

The list of basic documents to be submitted within 30 days from date of discharge from hospital under the Mediclaim policy is as below :

- Duly filled & signed claim form with contact number of patient.(Part A). (Mention Cashless card No. or Emp. ID No. and official email-id on the claim form)
- Duly filled claim form from hospital with number of beds of hospital registration no., infra structure, treating doctor's name and registration number, sign & stamp of hospital authority.(Part B)
- Cancelled cheque with employee name pre-printed on it
- Original Discharge Summary
- Hospital bills in original (with bill no; signed and stamped by the hospital) with all charges itemized and the original receipts
- Attending doctors' bills and receipts (if separate from hospital bill) and certificate regarding diagnosis
- All Originals of Doctors prescription, Investigations Reports, Bills and / or Receipts
- All original payment receipts must be taken from the hospital including invoices for implants and stickers in case of lenses
- Follow-up advice or letter for line of treatment after discharge from hospital, from Doctor.
- Break up details of Pharmacy items, Materials, Investigations even though it is there in the main bill
- 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 and 24 x 7 fully equipped operation theatre
- 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
- Claim documents need to be submitted within 30 days from the date of discharge. In case of pre & post hospitalization claim documents need to be submitted within 7 days from the date of completion of 60 days or treatment whichever is earlier

Note: There may be additional documents other than the above mentioned list, required by the TPA, based on specific treatments.

Additional Document Required For Specific Claims

Maternity Claims

- Report of last Sonography done prior to the delivery.
- A letter from the treating doctor stating detail of Obstetric history in GPLA format (Gravidity and Parity of the patient, No. of Living children and Abortion) if not mentioned in Discharge Card.
- Type of delivery – Normal or LSCS (Lower segment caesarean section), if LSCS, Indication for the same

Cataract Claims

- A-scan report & IOL Sticker [Intra Ocular Lens Sticker] along with original purchase invoice of lens used in surgery

Specific Claims

- Angioplasty –Sticker and purchase Invoice of stent, CAG report required
- Bypass Surgery (Coronary artery bypass graft) –CAG report required
- Knee Replacement / joint Replacement –Sticker and purchase Invoice of Implant

Accident Claims

- Attested copy of First Information Report (FIR) from police or Medico-Legal Case certificate (MLC) from hospital is mandatory in case of RTA i.e. Road Traffic Accident or any major accident. In case of minor accident a self declaration from employee giving the details of the accident to be provided. However the insurance company will have the final call on whether the self declaration is sufficient or FIR / MLC is required to process the claim
- Treating doctor's certificate stating whether patient was under influence of alcohol / other narcotics substance at the time of accident

Chemotherapy / Radiotherapy / Dialysis Claims

- Doctor's letter stating number of sittings and frequency of each sitting

Note

- Please keep one set of photocopy of all documents submitted for reimbursement without fail
- TPA reserves the right to request for any additional documents for medical investigation to determine eligibility of the claim
- Document once submitted will not be returned back

Exclusions – Top-Up Health Policy

- Injury or disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, Warlike operation (Whether war be declared or not) and injury or disease directly or indirectly caused by or contributed to by nuclear weapons/materials
- Circumcision unless necessary for treatment or a disease not excluded hereunder or as may be necessitated due to an accident, vaccination or inoculation or change of life or cosmetic or 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, correction of Refractive errors, multifocal / Torex / Bifocal lenses covered for cataract but only upto cataract sub limit otherwise not covered, hearing aids including cochlear implants and durable medical equipment's etc.
- Dental Treatment or surgery - corrective, cosmetic or aesthetic procedure, filling of cavity, root canal, wear and tear unless arising due to an accident and requiring hospitalization
- Convalescence, general debility ‘run-down' condition or rest cure, congenital external disease or defects or anomalies, venereal disease, intentional self-injury, accident due to misuse or abuse of drugs/alcohol or use of intoxicating substance
- All expenses arising out of any condition directly or indirectly caused to or associated with Human T-cell Lymphotrophic Virus Type III (HTLB-III) or Lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome
- Naturopathy, unproven procedure/treatment, experimental or alternative medicine/treatment including acupuncture, acupressure, magneto therapy etc.
- Any kind of service charges / surcharges, admission fees / registration charges etc. levied by the hospital
- Expenses on vitamins and tonics unless forming part of treatment for injury or diseases as certified by the attending physician
- Stay in hospital for domestic reason where no active regular treatment is given by specialist
- Treatment which the insured was on before hospitalization and required to be on after discharge for the ailment / disease / injury different from the one for which hospitalization was necessary
- Treatment for obesity or condition arising there from and any other weight control program / services / supplies
- Injury arising from any hazardous activity including scuba diving, motor racing parachuting, hand gliding, rock or mountain climbing etc., unless agreed by insurer
- Treatment received in convalescent home / hospital, health hydro / nature care clinic and similar establishments
- External / durable medical / non-medical equipment's of any kind used for diagnosis / treatment including CPAP, CAPD, infusion pump etc., ambulatory devices like walker / crutches / belts / collars / caps / splints /slings / braces / stockings / diabetic footwear / glucometer / thermometer & similar related items & any medical equipment which could be used at home subsequently

Exclusions – Top-Up Health Policy

- Non-medical expenses including personal comfort/ convenient items/ services such as telephone / television / aaya / barber / beauty services / diet charges / baby food / cosmetics / napkins / toiletries / guest services, Instrument used in treatment of Sleep Apnoea Syndrome (C.P.A.P.) and Continuous Peritoneal Ambulatory Dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition, 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
- Expenses incurred primarily for evaluation / diagnostic purpose not followed by active treatment during hospitalization
- Doctor's home visit charges / attendant, nursing charges during pre and post hospitalization period, RMO Charges
- Out-patient diagnostic/medical/surgical procedures/treatments, non-prescribed drugs/medical supplies/hormone replacement therapy,
- Treatment for Age related Macular Degeneration (ARMD), treatment such as Rotational Field Quantum magnetic Resonance (RFQMR), Enhanced External Counter Pulsation (EECP), Injection Avastin & Macujen, Absorbable stent, etc.
- Expenses on irrelevant investigations/treatment; private nursing charges, referral fee to family physician, outstation doctor / surgeon / consultant's fees etc.
- Procedure / treatment usually done in out-patient department are not payable under the policy even if converted as an in-patient in the hospital for more than 24 hours
- Voluntary medical termination of pregnancy during first 20 weeks from date of conception
- Treatment taken outside India
- Monitoring are outside the scope of the policy
- As per Insurance Company's Guideline Surgeon, Anaesthetist, Medical Practitioner, Consultant, Specialists Fees is part of the Final Hospital Bill and also if there is an additional separate bill / receipt wherein the charges are paid directly to the Surgeon, Anaesthetist, Medical Practitioner, Consultant, Specialists then the insurer company will pay only one i.e. lower of the two.

Note:

- Members must ensure that Hospital / Nursing Home where treatment is availed is a registered with local authorities & is under supervision of a qualified Medical Practitioner
- All medical/surgical treatments under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency only
- **This is an illustrative list of exclusions; detailed policy exclusion will be always as per contract between Norton Group & Bajaj Allianz**

Frequently Asked Questions – FAQ's

1. What is Medical Insurance?

Medical Insurance is a pure hospitalization policy which provides coverage to you as an employee and also covers your family i.e. spouse, dependent children as declared and covered under the policy towards treatment in case of a medical emergency, as per policy terms and conditions.

2. What is Pre-Existing Disease Coverage?

Under the **NortonLifeLock** customized policy Pre-Existing disease coverage is offered to all members without any waiting period. This helps the member get a complete coverage for all medical emergencies, including ailments that may have been there before the start of this policy.

3. What is Waiver of 1 Year Waiting Period for nine specified disease?

Under the **NortonLifeLock** customized policy there is No one year waiting period for the nine specified aliments - Cataract, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagia or Fibromyoma Hernia, Hydrocele, Fistula in anus, Piles, Sinusitis and related disorders.

4. What is Waiver of 30 days waiting period for non-accidental claims?

Under the **NortonLifeLock** customized policy there is No 30 days waiting period for enrolled members for filing any claim due to illness.

5. Is Maternity Benefit Covered under the Policy?

No

6. Is Newborn Baby Covered in the policy?

Newborn baby will be covered from Day1 i.e. from the date of birth. Employee has to send the request for adding the child under the policy within 15 days from the date of birth.

Please note to add the baby under the policy the name of the baby is not mandatory, only Empl. ID, Empl. Name, DOB & Gender Of Child is required.

Frequently Asked Questions – FAQ's

7. Is the baby covered from Day 1?

On Delivery of a child, the child is prone to many health disorders like jaundice or expenses incurred for incubator for pre-mature births or any other complication to the child. Please note that for such complications, the baby will be covered from DAY 1 in the overall family floater Sum Insured (Vaccination charges, Paediatric Charges & Observation charges are not payable if there is no active line of treatment).

8. What is Pre & Post Hospitalization Benefit?

Relevant medical expenses incurred during a period up to 30 days prior to and 60 days after hospitalization will be considered as part of claim and therefore settled as per policy guidelines.

9. What expenditures will generally be covered under the Pre-Hospitalization Clause?

Medical expenses incurred for Laboratory Test, Pathological Test and such similar overheads are usually incurred prior to hospitalization and will be covered under the Pre - Hospitalization Clause.

10. What expenditures will generally be covered under the Post Hospitalization Clause?

Medical expenses incurred for recommended health checkup subsequent to discharge from hospitalization and other such similar overheads usually incurred post hospitalization will be covered under the Post Hospitalization Clause.

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

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

12. Is 24 hours Hospitalization mandatory for filing a claim in the Mediclaim Policy?

Yes, Only 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 (Cataract only) Lithotripsy (kidney stone removal), Tonsillectomy 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.

Frequently Asked Questions – FAQ's

13. What is the Admission Request Note (ARN)?

This is a Request for Cashless Hospitalization. ARN is available at the network hospital and has to be duly filled up, signed and stamped by the Treating Doctor. Thereafter the hospital will fax / email it to the TPA. Members are requested to confirm with TPA the receipt of the fax / e-mail sent & also inform **Mr. Sunil Hoval on +91 7767009619 / Sunil.Hoval@bajajallianz.co.in** that he/she is availing cashless benefit for further assistance if needed.

14. How do I know whether my Claim has been admitted for Cashless or not?

Authorization Letter or Denial Letter will be faxed directly to the Hospital. For an update, member can contact the TPA representative **Mr. Sunil Hoval on +91 7767009619 / Sunil.Hoval@bajajallianz.co.in** after sending the fax / e-mail and inform the, about the same.

15. What is an Authorization Letter?

Authorization Letter is the Communication Ascertaining the Admissibility or Acceptance of the Cashless Service. The same is issued by TPA subject to admissibility of the claim and availability of balance sum insured for the member.

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

HOSPITAL / NURSING HOME means any institution in India established for indoor care and treatment of sickness and injuries and which

a)has been registered as a Hospital or Nursing Home with the local authorities and is under the supervision of a registered and qualified Medical Practitioner AND

b)Should comply with following criteria's:-

i. It should have at least 15 inpatient beds.
ii. Fully equipped operation theatre of its own wherever surgical operations are carried out.
iii. Fully qualified Nursing Staff under its employment round the clock.
iv. Fully qualified Doctor (s) should be in-charge round the clock.
v. Maintains a daily records of each patients

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

Frequently Asked Questions – FAQ's

17. What is meant by a Networked / Empanelled Hospital?

The hospitals which have a tie up with the TPA servicing the Mediclaim policy is called a network / empanelled hospital. An exhaustive list of Network Hospitals is available on **https://general.bajajallianz.com/BagicNxt/hm/hmSearchState.do**

18. What is family floater?

Under the family floater, the insurance cover will be available to all members of the family unit. The sum insured is available for utilization by any member of the family. It is however subject to the overall family sum insured for all members put together.

19. Will my stay be covered under Mediclaim, if I have been admitted under doctors instructions but there has been no proper line of treatment?

No. Hospitalization not accompanied with active line of treatment is not covered.

20. Are homeopathic, Unani expenses covered?

Homeopathic, Unani expenses are covered under this policy as per AYUSH guidelines.

21. Does pre-existing disease cover mean that all diseases and medical procedures are covered?

Pre-existing disease benefit helps the member get a complete coverage for all medical emergencies, including ailments that may have been there before the start of this policy. However, it does not cover congenital external ailments other than life threatening / illness / defect, except in case of new born children.

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

No. If the expenses form part of the hospitalization process and if the amount is approved and payable as per the terms and conditions of the policy, then they are reimbursable up to the sum insured amount.

23. Is Dental Treatment covered?

Under Base GMC Policy : Dental treatment or surgery is covered only in case of accidental injuries with 24 hours of hospitalisation and active line of treatment and not otherwise.

Under OPD – Dental treatment is covered

Frequently Asked Questions – FAQ's

24. Are all pregnancy related expenses covered?

Voluntary medical termination of pregnancy is not covered under Mediclaim. Only cases of abortions where mother's life is under threat and doctor has advised an abortion during first 20 weeks from the date of conception is covered in the Mediclaim policy.

25. Can I file more than one claim in a year?

You can claim as many times as possible you are hospitalized during the period of Insurance but the insurance company's liability in respect of all claims put together shall not exceed the Sum Insured

26. Are congenital diseases covered under the Policy?

Congenital Diseases means the abnormalities of structure or function which are present at birth. They may or may not be inherited. Yes, Internal & External Congenital is covered

27. How do you define dependency and in whose case is it applicable?

Dependency means a person is financially dependent on the primary insured i.e. they are not engaged in any kind of profession of earning their livelihood or are gainfully employed. They should be dependent on the Employee.

28. What happens if my family status changes during the policy?

If the family status changes (by reason of marriage or birth), the employee needs to enroll the details of the new dependent within 30 days from date of marriage or date of birth, as applicable

29. Will location of dependent family members matter?

As per the policy terms and conditions the coverage for treatment taken within India, the employee and dependent family members can avail benefit, at any approved/registered hospital in India

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

After completion of treatment, the patient has been discharged from the hospital, you must submit the final claim within 30 calendar days from the date of discharge from the hospital.

Frequently Asked Questions – FAQ's

31. What happens if me and my spouse or siblings are working in the same organization?

An individual can be covered in the policy only once. In such a case, you are advised not to declare each other under the definition of family, and may cover your children or parents, only once under any of the two families

32. Will I get my claim papers back?

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

33. Within how many days will I get my Mediclaim (medical insurance) Card?

Mediclaim cards will be available within 30 days after necessary endorsement is processed by the insurance company.

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

Ideally, you should always carry a print of the e-card with yourself, when getting admitted to the hospital from the available list of network hospital with the TPA. But, in the event that you do not have the cashless card, you should get in touch with Marsh representative who will provide the required assistance. It is advisable to carry a valid photo id proof (Employee ID Card, Driving license, Election card or any card which is approved by Govt. of India), irrespective of whether you are carrying the cashless card or not.

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

The claim would be settled without the cards, provided the claimant is declared in the policy within specified timelines. You would be entitled to cashless treatment but in such case, you are requested to get in touch with **MARSH SPOC**, before or at the time of hospitalization.

36. My e-card does not have your photograph; then how can the hospital identify you?

Hospital will cross check all the details using Medicard number with TPA Network. However, Hospital will also ask for photo identity proof (Employee ID Card, Driving license, Election card or any card which is approved by Government of India) as a part of general verification

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

Please send a request to Marsh (Pune) EH&B Client Operations on **CsPune.eb@marsh.com** with cc to Suraj S Shinde on **Suraj.S.Shinde@marsh.com** and your HR with the correction. Marsh will get necessary corrections done in the insurance database and get a new e card issued by the TPA.

Frequently Asked Questions – FAQ's

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

Please send a request Marsh on **nortonlifelock@marsh.com** and your HR with the correction. Marsh get necessary changes done in the insurance database and get a new e card issued by the TPA.

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

All expenses that are covered under the Insurance Policy will be paid for by the Insurer. However, you will be required to pay for non-admissible expenses, if any, such as Registration charges, charges incurred on account of person accompanying you, etc.

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

40. What is meant by a PPN Hospital?

PPN hospital means a network of hospitals which have agreed to a cashless packaged pricing for certain procedures for the insured person. If the member goes for reimbursement at PPN hospital and if the hospital charges higher amount than the agreed PPN rate's then such claim will be settled as per PPN package rate

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

You can get treated in any registered hospital, which meets the hospital criteria, within the country but the cashless facility will be available only at the network hospitals. Expenses incurred in non-network hospitals will be reimbursed to you, after following the applicable reimbursement process.

42. What if we get admitted in a hospital outside the Network List?

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

43. Is it possible to have cashless approval for Pre and Post Hospitalization?

Cashless will not be possible for Pre & Post Hospitalization claims. Reimbursement of same expenses is possible on submission of complete bills & documents relating to the claim within specified timeline.

44. Is Genetic Disorders related treatment covered under the policy?

Treatment for Genetic related disorder is not covered under the policy

Support Matrix

Health Insurance Support Matrix				
Insurance Company	Bajaj Allianz General Insurance Company Limited			
TPA	Health Administration Team In-House TPA Bajaj Allianz General Insurance Co. Ltd.			
Bajaj Allianz Contact Matrix				
Contact Person	Contact Number	E-mail ID	Level	Remarks
Shruti Bhawar / Medicall Team	020 67031777	Medicall.Support@bajajallianz.co.in	Level 1	Claims & Cards
Sunil Hoval	+91 77670 09619	Sunil.Hoval@bajajallianz.co.in	Level 2	Claims & Cards
Rasika Mohol	+91 77670 09620	Rasika.Mohol@bajajallianz.co.in	Escalation 1	Claims & Cards
Raghavendra Singh	+91 70307 17766	Raghavendra.Singh@bajajallianz.co.in	Escalation 2	Claims & Cards
Marsh Contact Matrix				
Contact Person	Contact Number	E-mail ID	Level	Remarks
Sajid Shaikh	+91 89768 73672	nortonlifelock@marsh.com	Level 1	All Matters
Sugriv Suryavanshi	+91 73500 14716	Sugriv.Suryavanshi@marsh.com	Escalation	All Matters

MercerMarsh Benefits

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