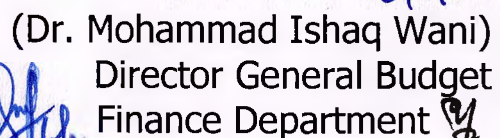
Government of Jammu and Kashmir
Civil Secretariat, Finance Department

NOTICE INVITING TENDER

Sealed tenders are invited for implementation of Group Mediclaim Insurance Policy for more than 3.50 lac Government Employees (Gazetted and Non Gazetted) including employees of PSUs, Autonomous Bodies, Local Bodies, Universities, Pensioners and their dependent family members not exceeding five from reputed and resourceful insurance companies with requisite experience in the field of health insurance for taking further steps in allotting the contract.

The tender document shall be available for download from the official website of Finance Department, J&K www.jakfinance.nic.in. Complete Sealed offers shall be submitted in the office of Director General, Budget, Finance Department, Room No. 1/11 First Floor, Civil Secretariat, Jammu on or before **1st March, 2017 5.00 P.M** through speed post/registered post/courier/ by hand only on any working days against proper receipt. The bids/offers received after the due date and time mentioned above will not be entertained under any circumstances. Those who send the tender documents by post, have to ensure that the documents should reach before the prescribed time & date and the Finance Department will not take any responsibility under any circumstances for courier/postal delays. Incomplete and unsigned bids or the bids not in prescribed format will be rejected without assigning any reason. No consortium bidding is allowed.



(Dr. Mohammad Ishaq Wani)
Director General Budget
Finance Department

No:- FD-VII-8(210)DONGE/2016
Dt:- 06/02/2017

REQUEST FOR PROPOSAL

FOR

GROUP MEDICLAIM INSURANCE POLICY FOR ALL GOVT EMPLOYEES/PSUs/AUTONOMOUS BODIES/ PENSIONERS

OF

JAMMU AND KASHMIR GOVERNMENT

DIRECTOR GENERAL BUDGET
FINANCE DEPARTMENT, GOVERNMENT OF JAMMU & KASHMIR
CIVIL SECRETARIAT, JAMMU.

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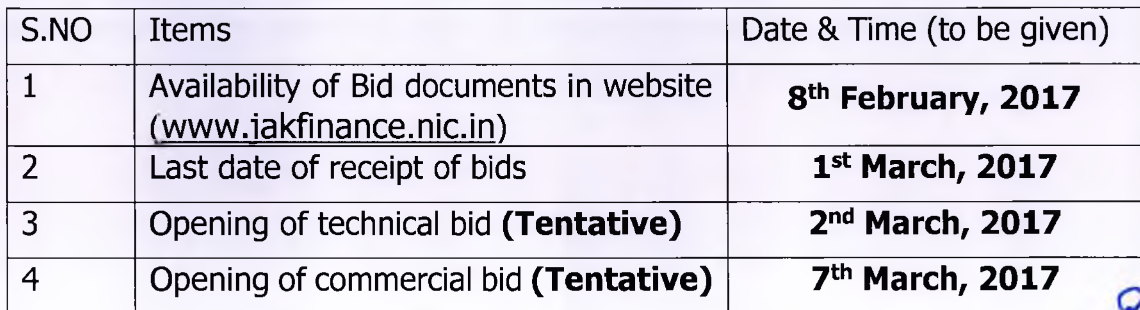


S.NO	Items	Date & Time (to be given)
1	Availability of Bid documents in website (www.jakfinance.nic.in)	**8th February, 2017**
2	Last date of receipt of bids	**1st March, 2017**
3	Opening of technical bid **(Tentative)**	**2nd March, 2017**
4	Opening of commercial bid **(Tentative)**	**7th March, 2017**

Instruction to bidder

Insurance companies eligible for participating in offers should submit their offers in two separate sealed envelopes one of which super-scribed with the words DOCUMENTS, should contain certificate of valid IRDA License, copies of experience/past performance in the relevant field and complete particulars of registered Third Party Administrator (TPA). The second sealed envelope should contain premium rates being offered and super-scribed with words FINANCIAL OFFER. The bidder is required to place both the envelopes in another sealed envelope addressed to the Director General Budget, Finance Department, Room No. 1/11 First Floor, Main Block, Civil Secretariat, Jammu.

The intending Insurance company will:

a) Enclose a valid copy of IRDA license.
b) Attach proof of past experience of having handled health insurance policy/policies with any state/central government or state/central PSUs/Autonomous Bodies which also include any other Government sponsored mass beneficiaries segment for at least 02 year.
c) Indicate the Third Party Administrator (TPA) licensed by the IRDA having good experience in handling such health insurance scheme or inbuilt TPA duly licensed by the IRDA, the concerned Insurance company shall certify that the TPA job is handled by the experts of the company themselves under rules approved by IRDA.
d) Furnishing of complete contact address of their licensed offices both at Srinagar and Jammu and in other districts of the State.
e) Tenders should be filled in with ink. No tender filled in by pencil or otherwise shall be considered. No additions and alternations or overwriting should be made in the tender. Correction, if any, should be done clearly and initialled.

f) The tenderer should sign the tender form at each page at the end in token of the acceptance of all the terms and conditions of the tender and the agreement.

g) The company should be registered with the Income Tax Department and in support shall endorse PAN Card and Income tax clearance from the Income Tax Department with the tender for the preceding year.

h) Remittance charge on payment made to the company will be borne by the Company itself.

i) Direct or indirect canvassing on the part of the tenderers or their representatives will disqualify their tenders.

j) All the legal proceedings, if necessary arises to institute any, by any of the parties (Government or Company), shall have to be lodged in courts situated in Jammu and Kashmir state and not elsewhere.

k) The bids shall not be entertained after the expiry of the scheduled date and time. The offers will be opened at 4.00 pm on the next day of the receipt of the offer by the Tender Opening Committee nominated for the purpose in presence of the tenderers who want to be present. The Government shall, however reserve the right to:-

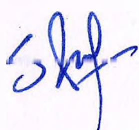
   i) Reject any or all offers with out assigning any reason thereof.

   ii) Reject incomplete and conditional offers.

l) All offers should be made in English. Conditional offers and offers qualified by vague and indefinite expressions such as subject to immediate acceptance, subject to prior sale, etc. will not be considered.

m) Request from tenderer in respect of additions, alternations, corrections of either terms and conditions or rates after opening of tender will not be considered.

n) On the date, time and location of the bid opening as specified in the tender, the evaluation committee shall open the proposal in the presence of bidders designated representatives who choose to be present. The bidder representatives who are present shall sign a register evidencing their



attendance. The bidders' name, and any such other detail as evaluation committee may consider appropriate will be announced by the evaluation committee at the opening. The tender evaluation committee (s) shall evaluate the prequalification bids, and technical bids. The decision of the Evaluation Committee (s) in the evaluation of all bids shall be final. No correspondence will be entertained outside the process of negotiation/discussion with the Committee (s). No discussion / interaction will be held with the bidders whose bid have been rejected/disqualified.

o) Bid Currencies: Price shall be quoted in Indian Rupees, Inclusive of all prevailing taxes.

p) Commercial Bid/Financial Bid: will be opened, in the presence of Bidder's or their representatives who wish to attend the Commercial Bid opening on date and time to be communicated to all the technically qualified bidders. The Commercial Bids of those bidders will be opened, which are successful in technical bid. No supporting document or printed literature shall be submitted with the Financial bid unless specifically asked for.

q) If the approved company fails either to render the services of the prescribed specification or meet the requirement of the scheme within the specified period, a penalty of 20% of the total value of the contract will be imposed on the company.

r) **Bidder should necessarily give a check list of documents attached in technical bid and number of total leaves.**

FORMAT FOR SUBMITTING TECHNICAL BID BY THE INSURANCE COMPANY

SL. No.	Particulars	Details
1.	Name of the Insurance company	
2.	Full particulars of the office/offices	
	a) Address	
	b) Telephone No.	
	c) Fax No.	
	d) E-Mail address	
3.	Registration details (attach self attested copies of certificates / Registrations/Licence etc.,	
	a) IRDA Reg. No.	
	b) PAN No.	
	c) Service Tax Reg. No.	
4.	Full particulars of the Third Party Administrators. If more than one is available all TPAs may be indicated.	
5.	Details of Group Mediclaim Policies offered by the Insurance company in the past 02 years.	
6.	Audited annual turnover of past 2 Financial years. **Note:** Attach Audit certified copy as proof. A certificate from Chartered Account for turnover under Health Insurance sector should be attached.	

DECLARATION

1. I have carefully read and understood all the terms and conditions of the tender and hereby accept the same.

2. The information/document furnished along with the above application is true and authentic to the best of knowledge and belief.

Date:

Signature of the authorized person
With Name, Designation and Contact No.

Place:

Company Seal

FORMAT FOR SUBMITTING FINANCIAL BID BY THE INSURANCE COMPANY:

Providing Group Mediclaim Insurance Policy to the Employees/Retirees of the Jammu and Kashmir State for the period 05 years w.e.f 2017-18 as per the details of Insurance Scheme:

Name of the Insurance Company (Tenderer)	Sum insured per family	Premium amount per family per year for five years.	Taxes as applicable	Total	
				In Figures	In Words
	Rs. 6,00,000/- (Rupees Six Lac Only) per family on floater basis.				

We agree with all the details of the Insurance Scheme and the Terms and Condition of Tender.

Date:

Signature of the authorized person
With Name, Designation and Contact No.

Place:

Company Seal

Introduction, Object & Purpose of the policy;

It has been observed that lot of difficulties are experienced by the Government Employees in settlement of their medical claims usually when they do not take necessary treatment in the notified hospitals (Private or Government) in or outside the State. To obviate these unnecessary hurdles faced by the employees during their treatment under J&K Civil Services Medical Attendance-cum-Allowance Rules, 1990 and in case of pensioners of State Government, the Government is desirous of providing good quality medical health care (Group Mediclaim Insurance Policy) to its serving and retired Government employees (Gazetted and Non Gazetted)/ Employees of State PSUs, Autonomous Bodies, Local Bodies, Universities with their 05 dependant family members and all government pensioners. In this behalf as a part of Employee friendly measure a customised Health Insurance policy outlined below is being introduced to provide the best health facilities to the employees of the State Government.

GROUP MEDICLAIM INSURANCE POLICY
For Employees/Pensioners of J&K State

1. **Name of the Scheme:** This scheme shall be called as **J&K Govt. Employees/Pensioners Group Mediclaim Insurance Policy**.

   Extent of Application: this shall be applicable to the following:

   a) All Gazetted/Non Gazetted Employees of State Government, PSUs, Autonomous Bodies, Local Bodies, Universities on mandatory basis.

   b) **Optional:** for all State Pensioners, retired employees of PSUs Autonomous Bodies, Local Bodies, and Universities, contractual, Adhoc, DRWs and Work charged/contingent paid employees.

2. **TARGET GROUP:**

   More than 3.50 lac Government Employees (Gazetted and Non-Gazetted) including employees of PSUs, Autonomous Bodies, Local Bodies, Universities and their dependent family members not exceeding five shall be offered this Scheme on compulsory basis and optional for other categories as defined above.

   Definitions: unless context otherwise provides,

3. **"Government"** means Government of Jammu and Kashmir.

4. **"Government Servant"** means an employee working in Permanent/Quasi Permanent /Temporary basis appointed in the regular scale of pay.

5. **"Beneficiary"** means more than 3.50 lac serving Government employees, Employees of PSUs, Autonomous Bodies, Universities, State Pensioners, retired employees of PSUs Autonomous Bodies, Local Bodies, Universities, contractual, Adhoc, DRWs and Work charged/contingent paid employees and their dependent family units as defined.

6. **"Family unit"** for Government Employees / PSUs / Autonomous Bodies / Local Bodies / Universities / Pensioners and all other categories of employees shall means family unit comprising himself/herself and his/her **5 dependent family** members only. Full details of the family members to be covered under the policy shall be intimated by the beneficiary on the prescribed format as may be decided by the Government to the successful Insurance Company and submit the same through his/her DDO concerned. New born shall be considered insured from day one till the expiry of the current policy irrespective of the number of members covered subject to eligibility under maternity **benefit.**

   Note:

   i. For the policy period, new born would be provided all benefits under the instant policy and will NOT be counted as a separate member. The child will be treated as part of the mother.

   ii. Verification for the new born could be done by any of the existing family members who are getting the benefits under the policy.

   iii. Member is required to enroll new born child at the time of renewal of the policy prior to expiry of the policy.

7. **New Employees** As regards the new incumbents the coverage in the insurance scheme is compulsory. The data of such employees will be provided by the concerned DDO to the insurer. Each of the New Employee of the Department would be provided with the enrolment form which needs to be filled in and submitted to the Insurance Company. The said employees would have to be covered in the Insurance Scheme from the date of joining. Thus for them the inclusion in the policy will be made by charging the pre-defined monthly prorata premium rate which would be less than the yearly premium rate. Family unit for the New Employees shall remain same as above.

8. **"Age of family Unit"** From the birth of a child to **100 years**.

9. **"Identification of Family"** Beneficiaries shall be identified by a "Photo Smart Card" issued by the insurer to all beneficiaries which would have all personal details, medical history, policy limits etc. of the policy. This card would be used in and outside the state to access Health Insurance Benefits.

10. **"Dependent"** means the Employee's family members i.e. husband, wife, parents including step mother/father in case residing with the employee, sons, daughters, step sons, step daughters, adopted Sons/ daughters. Minor brother/sisters up to the age of 25 years who are wholly dependent on the employee.

    A. Age limit of dependent for the purposes of Mediclaim Insurance Policy for J&K Govt Employees / Retirees includes:-

    1. Son - Till he starts earning or attains the age of 35 years, whichever is earlier;

2. Daughters - Till she starts earning or gets married, irrespective of age limit whichever is earlier. Further, Dependent divorced/abandoned or separated from their husband and widowed daughters – irrespective of age limit.
3. Sisters - Dependent unmarried /widowed / divorced/ abandoned / separated from their husband – irrespective of age limit.
4. Daughter in law- Widowed - irrespective of age limit.
5. Brothers – Up to the age of becoming a major.
6. Dependent Parents – upto 100 years.

B. Addition & Deletion of Family Members during currency of the policy:

i) Addition to the family is allowed in following contingencies during the policy:

a) Marriage of the beneficiary (requiring inclusion of spouse's name), or
b) Parents becoming dependents.
c) Divorced sisters.
d) Handicapped brothers/sisters

ii) **Deletion from Family is allowed in following contingencies:**

a) Death of covered beneficiary,
b) Divorce of the spouse,
c) Member becoming ineligible (on condition of dependency)

The age limit shall not, however, be applicable to sons/daughters, unmarried brothers/unmarried sisters, who are physically or mentally challenged and are wholly dependent on the insured person. Provided that in case of women employees, the family includes father-in-law and mother-in-law also in case they are residing with such employee.

11. **"Sum Insured"** The Scheme shall provide coverage for meeting all expenses relating to hospitalization of beneficiary members up to Rs. 6 lac (Rupees Six Lac Only) - per family per year on floater basis i.e. the total reimbursement of Rs. 6 lac can be availed by one individual or collectively by all members of the family in any of the Empaneled Hospital/Nursing Home/Day Care Unit. However, the excess amount beyond the insured amount shall be borne by the State Government under Medical Attendance Rules, 1990 in case of serving government employees.

12. **"Plan Period"** 05 years from the date of inception of policy.

13. **"Mode of Premium"** The mode of payment of premium to the successful insurance company shall be decided by the State Government. Any claim for increase in premium rates during the policy period on account of any reason whatsoever will not be entertained.

14. **Deduction of the Premium:** The amount of premium included taxes shall be deducted from the salaries of the State Government Employees and same shall be remitted against the proper Head of Accounts by the concerned DDO which shall be notified separately at the launch of the scheme.

However, in case of PSUs/autonomous bodies retirees/pensioners the net premium shall be paid to the concerned insurance company

directly by them in the shape of bank draft while as the taxes as applicable shall have to be remitted into the concerned Head of Accounts through government treasury.

Note : In case both husband and wife or any other family member are Govt. Employees, the premium shall be payable by any one of them only.

15. Payment of Premium:

As the policy would be renewed every year, the premium shall be paid to the Insurer as may be prescribed by the government from time to time.

a) The premium will be paid to the Insurers for the beneficiaries to be enrolled during the policy period in case of new joinees and existing employees/pensioners. This premium will also take care of the members inadvertently missed for any reasons.

b) The enrolment period shall be to the extent of 90 days for government and other defined category of employees/retirees from the date of the introduction of the Scheme. No enrolment shall be allowed after 90 days from the date of introduction of the Scheme.

c) In the case of new joinees and retires, the enrolment will continue throughout the year. In this case, premium will be paid on pro rata basis based on monthly calculation to the company directly by the new employees/retires.

d) Insurer will submit the statement along with the details of enrolment in a prescribed format to the Nodal agency on fortnightly/monthly basis.

e) Reconciliation of premium paid to the insurance company would be carried out at the end of the year.

16. "Refund/Adjustment of Premium" In case of excess/shortage of premium paid to the Insurance Company same shall have to be refunded by the Insurance Company after the expiry of the policy period or shall be adjusted with renewal premium by the State Government.

17. <u>Enrollment & its Process</u>

All the employees covered under the policy shall fill-up the prescribed enrolment Form and submit the same to the concerned Insurance Company through their DDOs complete in all respects as per the directions issued in this regard.

The other **categories of employees/retirees/pensioners** shall also fill-up the prescribed enrolment Form and submit the same directly to concerned insurance company complete in all respects along with his /her first contribution Demand Draft(s) for issuance of the Smart Card.

The successful Insurance Company shall have to keep available/accept on line enrollment registration for its quick processing.

a) Insurance Company will issue Smart Cards on the basis of information received of the beneficiaries for enrolment. Such Smart Cards along with the enrollment kit shall be sent directly to the insured persons (beneficiaries) by the concerned insurance company at their respective mailing addresses at insurer's cost within 7 days. At the time of delivering the smart card, the Insurer shall provide a booklet along with Photo Smart Card to the beneficiary indicating the list of the Networked Hospitals, the

availability of benefits and the names and details of the contact person/persons, and toll-free number of call center. To prevent damage to the smart card, a plastic jacket should be provided to keep the smart card.

b) Till the smart card is available the company shall provide the treatment in the empaneled hospitals on production of copy of enrollment form already submitted to the company duly attested by the DDO concerned, copy of Departmental ID and copy of premium deduction certificate from DDO concerned. After required processing, all relevant data shall be uploaded on the server and smart cards shall be issued by the insurer. The enrolment period in the first year shall be for 90 days for serving employees/retired/other defined category of employees. Insured will have the option to change the details regarding dependent beneficiary in the smart card under exceptional circumstances with approval of concerned DDO however the total number of dependents cannot be more than the number fixed at the time of renewal.

c) All future employees shall necessarily be covered under the policy, they shall have to fill up the prescribed form and submit the same to the concerned insurance company directly along with the first premium contribution. The insurer shall have to provide enrolment forms (printed as well as soft versions) at all such locations and arrange to collect the enrolment forms from the respective DDOs at tehsil/district level under acknowledgement.

Note: The Insurer will have to necessarily complete the following activities before the start of the enrollment process:-

1. Empanelment of the Hospitals/Nursing Homes/Day Care Clinics. The Company Shall provide a web-based application, which would be available to Head of Departments/official websites /beneficiaries. The empanelled Hospitals/Nursing Homes/Day Care Clinics and the beneficiaries shall have the access to the website to see their relevant information. Nodal Agency of the Finance Department will also monitor data related to Insurance plan like enrolment, empanelment of hospitals, authorization status, claims status, utilization statistics, network hospital status and other MIS through a website maintained by the Insurer.
2. Setting up of District KIOSK Offices, in all districts of the state.
3. Prepare the enrolment Form/user guide containing all important information and get it approved by the Government.
4. The Company has to adopt a special mechanism for online web based registration to the employees with upgradation of beneficiary list.

18. Smart Cards issued by the Insurer.

The Smart Cards means the electronic identification card issued by the Insurer to the Beneficiary Family Unit, for utilization of the Cover available to such Beneficiary Family Unit on a cashless basis. The card shall have to be acceptable across the country, by all empaneled/network hospitals /nursing homes/Day care clinics in the insurer's panel. Preparation of transaction systems, mechanism for data transfer, and establishment of

district centers and uploading of MIS on the websites is the responsibility of the insurer.

19. **"Insurer/Insurance Company"** shall mean the Insurance Company registered under Section 3 of the Insurance Act 1938, engaged in the business of providing General Insurance in India for a period not less than 02 years and duly licensed by the Insurance Regulatory And Development Authority (IRDA) of India for Group Mediclaim Insurance Policy (Health Insurance).

20. **Infrastructure of Insurer:** Insurer shall establish an exclusive Project Office at convenient places both at Jammu, Srinagar and also in other districts for coordination with the State Government/Nodal agency.

21. **Management Information Systems (MIS) Service through dedicated Website.**

The Insurer shall provide Management Information System (MIS) reports regarding the enrolment, admission, pre-authorization, claims settlement and such other information regarding the Services as required by the Government/Nodal Agency. The reports will be submitted by the INSURER to the Government/Nodal Agency on a regular basis as agreed between the Parties.

a) A dedicated website for data sharing purpose shall be designed by the insurer which shall be having real time data base pertaining to the scheme implementation & servicing. Persons having authority to access the data can access the website with user name & password supplied by the insurer. The said website shall have District/State wise Enrolment status, Claims, Treatments rendered, Hospitals

Data which shall be uploaded by the Insurance Company on periodical basis.

22. Call Centre Services

The Insurer shall provide dedicated telephone services for the guidance and benefit of the beneficiaries whereby the Insured Persons shall receive guidance about various issues by dialing a National Toll free number exclusively for this scheme. This service provided by the Insurer as detailed below is collectively referred to as the "Call Centre Service".

(i) Call Centre : The Insurer shall operate a Call Centre with dedicated national Toll free number with a minimum of 10 lines for the benefit of all Insured Persons. The Call Centre shall function for 24 hours a day, 7 days a week and round the year and for all years the scheme is in place. As a part of the Call Centre Service the Insurer shall provide the following :

a) Answers to queries related to Coverage and Benefits under the Policy.

b) Information on Insurer's office, procedures and information related to policy.

c) General guidance on the policy.

d) Information on cash-less treatment subject to the availability of medical details required by the medical team of the Insurer.

e) Information on Network Providers and contact numbers.

f) Claim status information.

g) Advising the hospital regarding the deficiencies in the documents for a full claim.

h) Any other relevant information/related service to the Beneficiaries.

i) Any of the required information available at the Call Centre to the Government/Nodal Agency.

j) Maintaining the data of receiving the calls and response on the system.

k) Any related service to the Government/Nodal Agency.

l) The cost of operating of the number shall be borne solely by the Insurer.

m) The Insurer will also operate a dedicated National Toll Free Fax. The cost of operating of the number shall be borne solely by the Insurer.

n) The Insurer will intimate the National Toll Free number/Fax number to all beneficiaries along with addresses and other telephone numbers of the Insurer's City units / Zonal units and Project Office in the user guide.

(ii) Language : The Insurer undertakes to provide services to the Insured Persons in English , Urdu and local languages.

23. **"TPA"** means Third Party Administrator, which in this policy shall be mandated and nominated by the Successful Insurance Company and Government duly licensed by IRDA. However, wherever the insurance

companies have their own inbuilt TPAs duly licensed by IRDA, they shall be also entertained. TPA is engaged in the business of formulating and administrating health care scheme and health care management and inter-alia providing assistance, advice and administration of various health care benefits. Third Party Administrator shall provide administrative, consultative and monitoring service to the policy negotiated and finalised by the Insurance Company to facilitate implementation of the policy subject to the terms and conditions stipulated in the policy.

24. **"Facility/Treatment"** The company has to provide cashless facilities to the beneficiary in all empanelled hospitals in an easier, hassle free manner and reimburse the claimed amount within 30 days to the beneficiary wherever the cashless facility is not available. However, any claim with regard to hidden money charged by the hospital authorities in addition to the cashless plan from the beneficiary shall not be entertained. The successful Insurance Company has to accommodate / reimburse the claims on account of investigations/diagnostic tests necessary for the beneficiary as may be prescribed by the Consulting Doctor of the empanelled hospital. All expenses incurred for treatment of Life consuming diseases if diagnosed after inception of the policy shall be reimbursed by the Insurance Company.

25. **Insurance coverage:**

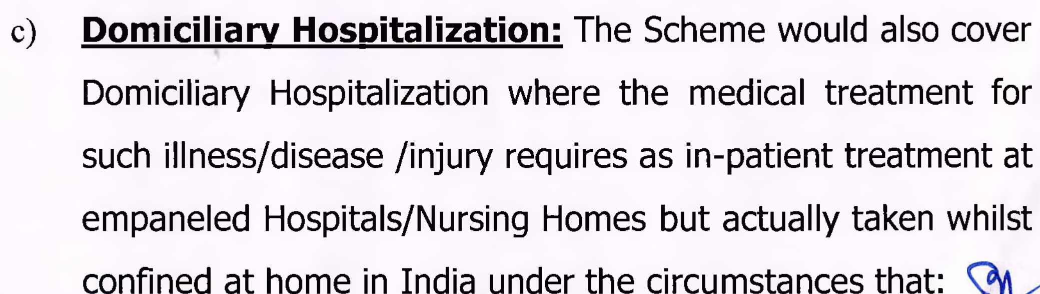
a) In-patient benefits – The Insurance Scheme shall pay all expenses incurred in course of medical treatment availed of by the beneficiaries in an Empaneled Hospitals/ Nursing Homes (24 hours admission clause) within the country, arising out of either illness/disease/injury and or sickness.

NOTE (1): In case of any organ transplant, the expenses incurred for the Donor are also payable under the scheme.

Note (2) In case beneficiary met with an Accident/Heart Attack/ Brain Stroke/Convulsion and is shifted to the nearby hospital which is either covered or not covered under empanelled/network hospital, the insurance company has to reimburse the full amount incurred on such treatment to the beneficiary directly within 30 days. After the discharge the beneficiary can take the follow up treatment in the said hospital as advised by the doctors or any network hospital.

b) **Coverage of Pre-existing diseases**: All diseases under the Scheme shall be covered from day one. A person suffering from any disease prior to the inception of the policy shall also be covered. The policy shall also cover expenses incurred for treatment of Life consuming diseases.

Pre & Post hospitalization benefit: Benefit up to 30 days for Pre-Hospitalization and 60 days for Post-Hospitalization, which would cover all expenses related to treatment/diagnostic tests of the sickness for which hospitalization was done. However, this condition shall not apply in case of those patients who required their follow up treatment even after 60 days as advised by the consulting doctor of empanelled/network hospital.



c) **Domiciliary Hospitalization:** The Scheme would also cover Domiciliary Hospitalization where the medical treatment for such illness/disease /injury requires as in-patient treatment at empaneled Hospitals/Nursing Homes but actually taken whilst confined at home in India under the circumstances that:

- His/her condition is such that patient cannot be moved to a hospital or,
- If no room is available in empaneled Hospitals/Nursing home within that area.

26. "Day care Treatment" refers to medical treatment, and/or surgical procedure which is undertaken under General or Local Anesthesia in a Hospital/Day care centre in less than 24 hours because of technological advancement, and which would have otherwise required a Hospitalisation of more than 24 hours. OPD services as mentioned below shall be part of Day Care facilities.

1. All Ophthalmology day care procedures.
2. All ENT day care procedures.
3. All Dental day care procedures.
4. Lithotripsy (kidney stone removal).
5. All Endoscopic day care procedures.
6. All Orthopedics day care procedures.
7. Tonsillectomy.
8. Dilation & Curettage.
9. Dental surgery following an accident
10. Surgery of Hydrocele
11. Surgery of Prostrate
12. Few Gastrointestinal Surgery
13. Genital Surgery
14. All day care Urology procedures.

15. Chemotherapy/Radiotherapy/all other day care procedures of Oncology.
16. Anti Rabies Vaccination for treatment related to dog bite/snake bite/any wild animal etc.
17. Treatment of fractures/dislocation, Contracture releases and minor reconstructive procedures of limbs which otherwise require hospitalization.
18. MRI/PET Scan/CT Scan/ Coronary Angiography/Coronary Angioplasty etc.
19. Adenoidectomy.
20. Appendectomy.
21. ERCP Endoscopic Retrograde Cholangiopancreatography.
22. Excision of Cyst/Granuloma/Lump.
23. CT Guided Biopsy.
24. Sinusitis.
25. Treatment for Fistula.
26. Haemo Dialysis/Peritoneal Dialysis.
27. Hydroceletomy.
28. Hernia.
29. Colonoscopy.
30. Cholecystectomy.
31. Liver Aspiration.
32. Mastodiectomy.
33. Haemorrhoidectomy.
34. Blood Transfusion.

35. Polypectomy/Ablation of Endometrium.
36. Sclerotherapy.
37. Septoplasty.
38. Varicose Vein Ligation.
39. Paranoid Schizophrenia.
40. Maniac Depression.
41. Circumcision for only two children born after the inception of the policy.
42. Treatment for Prostate Surgeries which includes : (i) TUMT (Transurethral Microwave Thermotherapy), (ii) TUNA (Transurethral Needle Ablation) (iii) Laser Prostatectomy, (iv) TURP (Transurethral Resection of Prostate), (v) Transurethral Electro – Vaporization of the Prostate (TUEVAP).
43. Laparoscopic therapeutic surgeries that can be done in day care.
44. Identified surgeries under General Anesthesia or any procedure mutually agreed upon between insurer and health care provider.
45. All other genuine day care procedures/investigations shall also be covered if not otherwise specified.

The expenses incurred for treatment taken in empaneled Hospitals/ Nursing Homes /Day Care Clinics by the beneficiaries suffering from such disabilities of the person with disabilities (equal opportunities, protection of rights and full participation) which includes blindness, low vision, leprosy–cured, hearing impairment, locomotors disability, mental retardation, mental illness etc. are

also payable irrespective of age and income limit subject to size limit of the family.

27. Maternity and Newborn Benefits:

A. Maternity benefit

1. This means treatment taken in Empanelled Hospital/ Nursing Home arising from childbirth including Normal Delivery/Caesarean Section including miscarriage or abortion induced by accident or other medical emergency.

2. This benefit would be limited to only first two living children in respect of Dependent Spouse/Female Employee covered from day one under the policy, without any waiting period.

B. Newborn benefit

1. Newborn child (single/twins) to an insured mother would be covered from day one up to the expiry of the current policy for the expenses incurred for treatment taken in empaneled Hospitals/Nursing Homes/Day Care Clinics as In-patient during the currency of the policy and will be treated as part of the mother subject to eligibility under maternity benefit. However, next year the child could be covered as a regular member of the family subject to size of the family.

2. In first pregnancy, if twins are born than the benefit will ceases for second pregnancy. However, in second pregnancy if twins are born than both will be covered till the expiry of the current policy.

3. Congenital diseases of new born child shall be covered.

28. **"Network hospitals"** shall mean all those hospitals, nursing homes, poly clinics and other health care providers in and outside the State approved by the State Government and accredited by TPA. The details of all required empanelled Government/Private Hospitals /Nursing homes and other health care centres in and outside the State for providing cashless facilities to the beneficiary under this policy shall be provided by the tenderer (Insurance Company/TPA), on the basis of which tender will be assessed by the government. All the government hospitals within and outside the State shall deemed to have been included in the list of network hospitals. In case any facility/treatment is not available in the network/empaneled hospital of the Insurance Company the expenses shall be borne by the insurance company wherever the treatment is available other than the network hospital. A separate list of hospitals covered under Jammu and Kashmir Medical-cum-Attendance Rules, 1990 and some other reputed hospitals in and outside the state shall also be provided by the State Government which is mandatory for inclusion with network hospitals by the successful bidder. The final list of Network Hospitals once approved shall not be subject to any change during the currency of the policy, without approval of the Government.

29. **Eligible Health Service Providers** Mediclaim Insurance Policy aspires to provide to all its beneficiaries high quality medical care services that are affordable. With this objective, it has prescribed National Accreditation Board for Hospitals & Healthcare Providers (NABH) Accreditation as minimum eligibility criteria for empanelment of both Public and Private hospitals.

The Hospitals/Nursing Homes/Day Care Clinics should be accredited with NABH /JCI (Joint Commission International)/ACHS (Australia) or by any other accreditation body approved by International Society for Quality in Health Care (ISQHC) as minimum eligibility criteria for empanelment of hospitals. Such Hospitals/Nursing Homes/Day Care Clinics should have the following facilities:

i) General purpose hospital having 100 or more beds with the following specialties :

General Medicine, General Surgery, Obstetrics and Gynecology, Pediatrics, Orthopedics (excluding Joint Replacement), ICU and Critical Care units ,ENT and Ophthalmology, (Dental specialty - desirable), Imaging facilities , in house laboratory facilities and Blood Bank.

ii) Specialty hospitals (specialties list given below) Hospitals having less than 100 beds can apply as a specialty hospital - provided they have at least 25 beds earmarked for each specialty applied for with at least 15 additional beds – Thus under this category a single specialty hospital would have at least 40 beds. However, under this category a maximum of three specialties is allowed.

Cardiology, Cardiovascular and Cardiothoracic Surgery.
Urology – including Dialysis and Lithotripsy.
Orthopedic – Surgery – including arthroscopic surgery and Joint Replacement Endoscopic surgery Neurosurgery.

iii) **Super-specialty Hospitals**- with 50 or more beds with treatment facilities in at least three of following Super Specialties in addition to Cardiology & Cardio-thoracic Surgery

and Specialized Orthopedic Treatment facilities that include Joint Replacement surgery:

- Nephrology & Urology incl. Renal Transplantation
- Endocrinology
- Neurosurgery
- Gastro- enterology & GI –Surgery incl. Liver Transplantation
- Oncology – (Surgery, Chemotherapy & Radiotherapy)

These hospitals shall provide treatment /services in all disciplines available in the hospital.

iv) Cancer hospitals having minimum of 50 beds and all treatment facilities for cancer including radio-therapy (approved by BARC/AERB).

v) The facility so defined above should have an operational pharmacy and diagnostic services.

vi) Those Hospitals/Nursing Homes/Day Care Clinics undertaking surgical operations should have a fully equipped Operating Theatre of their own.

vii) Fully qualified and senior doctors and nursing staff under its employment round the clock.

viii) The insurer shall fix cost of packages for each identified procedures as approved under the scheme so that no confusion exist regarding it once scheme is in implementation.

a) These package rates shall mean and include lump sum cost of inpatient treatment/day care/diagnostic procedures for which policy beneficiary is admitted from the time of admission to

discharge including (but not limited to) Registration charges, Admission charges, Accommodation charges including Patients diet, Operation Charges, Injection charges, dressing charges, Doctors/ Consultant visit charges, ICU/ICCU charges, Monitoring charges, Transfusion charges, Anesthesia charges, Pre-anesthetic checkups, Operation Theater charges, Procedural Charges/Surgeon charges, Cost of surgical disposables and sundries used during hospitalization, Cost of Medicines and Drugs, Blood, Oxygen etc, Related routine and essential diagnostic investigations, Physiotherapy charges etc, Nursing care and charges for its services. The list is illustrative only.

b) In order to remove the scope of any ambiguity on the point of package rates, it is reiterated that the package rate for a particular procedure is inclusive of all sub-procedures and all related procedures to complete the treatment procedure. The patient shall not be asked to bear the cost of any such procedure/item.

c) No additional charge on account of extended period of stay shall be allowed, if, the extension is due to infection on the consequences of surgical procedure or due to any improper procedure.

d) Cost of implants is payable in addition to package rates as per policy ceiling rates for defined implants or as per actual, in case there is no policy prescribed ceiling rates. The decision of doctor advising implant shall be binding in this regard.

e) Cost of External Equipment required for treatment as listed in policy scheme is payable in addition.

f) Expenses incurred for treatment of new born baby are separately payable in addition to delivery charges to mother.

g) Additional Benefits to be Provided by Empaneled Hospitals / Nursing Homes /Day Care Clinics. In addition to the benefits mentioned above, both Empanelled Public and Private Hospitals/Nursing Homes/Day Care Clinics should be in a position to provide following additional benefits to the beneficiaries free OPD consultation including pre and post hospitalization consultation.

30. Cashless Access Service : The Insurer has to ensure that all policy members are provided with adequate facilities so that they do not have to pay any deposits at the commencement of the treatment or at the end of treatment to the extent as the Services are covered under the Scheme. The service provided by the Insurer alongwith subject to responsibilities of the Insurer as detailed in this clause is collectively referred to as the "Cashless Access Service." Cashless treatment shall be given without charging any money from the beneficiary.

The services have to be provided by the Empanelled Hospitals/Nursing Homes/Day Care Clinics to the beneficiary based on Photo Smart Card authentication only without any delay. The beneficiaries shall be provided treatment free of cost for all such ailments covered under the Scheme within the limits/sub-limits of defined package rates and sum insured, that is not specifically excluded under the scheme.

(i) No Pre-Authorization for Cashless Access in case of Emergency/Planned Hospitalization for Listed /Non Listed packaged procedures.

(ii) Packaged procedures would mean the rates for various procedures approved by the policy based on city and the same shall be treated for that State/ Zone. It would be the responsibility of the Insurer to have all empanelled hospitals/nursing homes/ day care clinics agreed to the same.

(iii) Once the identity of the beneficiary and/ or his/her family member is established by verifying the Photo Smart Card, shall be swiped Photo Smart Card for on line verification and following procedure shall be followed for providing the health care facility listed/not listed in packages.

(iv) In case of non-listed procedure, the Empanelled Hospitals/Nursing Homes/Day Care Clinics and Insurer shall negotiate the cost of package based on the type of treatment required; the agreed amount shall become a package rate of that procedure.

(v) The insurer shall have to ensure that all data are uploaded on the insured's server and a read-only access shall be provided, through a link, to the beneficiary.

(vi) On completion of treatment discharge documents are signed.

Note: In cases where the beneficiary is admitted in a hospital during the current policy period but is discharged after the end of the policy period, the claim has to be paid by the insurance company under operating policy in which beneficiary was admitted.

31. RUN-OFF PERIOD

A Run-Off period of two months will be allowed in case of cancellation/non-renewal of the policy. This means that preauthorization's done till the cancellation/non renewal of the policy period and treatment/surgeries for such preauthorization's done up to two months after the expiry of policy period, all such claims will be honored.

32. REPUDIATION OF CLAIMS

In case of any claim is found untenable, the Insurer shall communicate reasons to the Health provider and Designated Authority of the State Government for this purpose with a copy to the Beneficiary. All such claims shall be reviewed by the State Government on monthly /quarterly basis.

33. EXCLUSIONS

The Insurer shall not be liable to make any payment under this Scheme in respect of any expenses whatsoever incurred in connection with or in respect of the following:

A. Hospitalization Benefits:

1) Conditions that do not require hospitalization:

a) Outpatient Diagnostic, Medical and Surgical procedures or treatments unless necessary for treatment of a disease covered under Day Care procedures or Inpatient hospitalization.

b) Expenses incurred at Hospital or Nursing Home on telephone, cosmetics / toiletries, etc.

c) Congenital external diseases etc: Congenital External Diseases or Defects or Anomalies,

Convalescence, General Debility, "Run Down" condition or Rest Cure.

d) Sex change or treatment which results from or is in any way related to sex change.

e) Vaccination/Cosmetic or of aesthetic treatment: Vaccination, Inoculation or change of life or cosmetic or of aesthetic treatment of any description and Plastic Surgery other than as may be necessitated due to an accident or as a part of any illness

f) Suicide etc: Intentional self-injury/Suicide/Self manmade injuries.

2) Naturopathy, Homeopathy, Unani, Siddha, Ayurveda:

a) Homeopathy, Unani, Siddha, Ayurveda treatment unless taken as inpatient in a network hospital.

b) Naturopathy, unproven procedure or treatment, experimental or alternative medicine including acupressure, acupuncture, magnetic and such other therapies etc. Any treatment received in convalescent home, convalescent hospital, health hydro, nature care clinic or similar establishments.

B. Maternity Benefit Exclusion Clauses:

a. Those insured persons who are already having two or more living children will not be eligible for this benefit. Claim in respect of only first two living children will be

considered in respect of any one insured person covered under the policy or any renewal thereof. In such situation any such child born during the policy period, the same shall be covered as an additional member at the time of renewal only.

b. Expenses incurred in connection with voluntary medical termination of pregnancy during the first twelve weeks from the date of conception are not covered except induced by accident or other medical emergency to save the life of mother.

c. Pre-natal and post-natal expenses are not covered unless admitted in Hospital/nursing home and treatment is taken there.

34. **Redressal Cell for Beneficiaries:** The successful insurance company has to establish a redressal cell for immediate redressal of the grievances of the complainants within the company to expeditiously dispose off the complaints. Similar cell shall be designated at government level as well.

35. DISPUTE RESOLUTION AND GRIEVANCE REDRESSAL

If any dispute arises between the parties during the subsistence of the policy period or thereafter, in connection with the validity, interpretation, implementation or alleged breach of any provision of the scheme, it will be settled in the following way:

a) Dispute between Beneficiary and the Insurance Company: Grievance Redressal Centre shall be set up in each District/State level for all possible redressal of grievance of beneficiaries / Health provider by the Insurer.

b) Dispute between Insurance Company and the State Government: A dispute between the State Government /Nodal Agency and Insurance Company shall be referred to the respective Chairmen/ CEO's/CMD's of the Insurer for resolution. In the event that the Chairmen/ CEO's / CMD's are unable to resolve the dispute within {60 } days of it being referred to them, then either Party may refer the dispute for resolution to a sole arbitrator who shall be jointly appointed by both parties, or, in the event that the parties are unable to agree on the person to act as the sole arbitrator within {30 } days after any party has claimed for an arbitration in written form, by three arbitrators, one to be appointed by each party with power to the two arbitrators so appointed, to appoint a third arbitrator.

c) The law governing the arbitration shall be the Arbitration and Conciliation Act, 1996 as amended or re-enacted from time to time.

d) The proceedings of arbitration shall be conducted in the English language.

e) The arbitration shall be held in Jammu / Srinagar (J&K only.

f) Notwithstanding arbitration mechanism given above, all efforts shall be made in the first instance to resolve the issues if any cropped up. Finance Secretary shall be the deciding authority.

36. AGREEMENTS:

1) A brief Service Level Agreements (SLAs)/MOUs having all the terms and conditions binding on both the parties shall

be signed with Insurance Company and proper mechanism for ensuring compliance established including penalty clauses.

2) Insurer will also enter into SLAs/MOUs with other intermediaries for ensuring compliance established including penalty clauses.

37. TERM & TERMINATION OF AGREEMENT BETWEEN INSURER & STATE GOVERNMENT

The Agreement shall take effect on the date of signature hereof by both Parties, and shall remain in force till the end of the policy period and the runoff period subject to a right to the State Government to terminate the Agreement, on the basis of review of the performance of the INSURER before the same period. The Government will review the performance of the INSURER based on factors including but not limited to:

a) Compliance with the guidelines specified in respect of enrolment & transaction.

b) The facilities set up and arrangements made by the INSURER toward servicing the beneficiaries such as quality assurance, handling of grievances, availability of benefits and hassle free transactions etc agreed to between stakeholders.

c) Empanelment of Hospitals/ Nursing Homes/Day Care Clinics.

d) The quality of service provided.

e) The beneficiaries' satisfaction reports received.

f) Grievance Redressal.

g) Any withholding of information as sought by the State Government at the bidding and implementation stage of the Scheme; and

h) Such other factors as the State Government deems fit.

The Agreement may be terminated:

a) By the State Government before the period mentioned above.

b) By both parties by mutual consent provided it gives the other party at least 60 days prior written notice. In case of termination as given above:

   i. The Insurer will pay back to the Government within one week the unutilized amount of premium left plus service tax after settlement of claims for which the preauthorization is given till date of termination.

   ii. If the insurer fails to do as per clause above, the insurer will pay the Government, the total package amount for all the cases for which preauthorization has been given, but claim not settled.

   iii. In addition to above the Insurer shall pay interest at the rate of 15% per annum on the amount refundable as determined by clauses (a) and (b) above for the period extending from the date of premium paid till the date of receipt of refund.

   iv. The Government reserves the right to re-allot the policy to any other insurer as it deems fit for the rest of the period in the event of termination and the Insurer shall not have any claims to it.

38. PERFORMANCE PARAMETERS AND PENALTY CLAUSE:

Insurer is required to perform multiple activities in performance of their obligations arising out of the insurance contract to them. Any activity not performed by the insurer within the given time line shall hamper implementation of policy from the planned date. Such activities will be required to be completed within the specified period from the date of award of the insurance contract to them failing which a penalty of 20% on total premium shall be payable by them to the Govt. of J&K for the period of delay.

39. NODAL AGENCY :

1) The Finance Department, J&K Civil Secretariat would be the Nodal Agency for the implementation of this Group Mediclaim Insurance Policy.

2) A Coordination Committee having the representatives from Finance Department, General Administration Department, Health & Medical Education Department for monitoring the implementation of the Scheme on a regular basis.

3) Nodal Cell at the Finance Department level will monitor data related plan like enrolment, empanelment of hospitals, authorization status, claims status, utilization statistics, network hospital status and other MIS through a website maintained by the Insurer.

40. MEDICAL AUDIT: The Insurance Company shall also carry out inspection of hospitals, investigations, on the spot verification of inpatient admissions, periodic medical audits, to ensure proper care and counselling for the patient at network hospital by coordinating with hospital authorities, feedback from patients, attend to complaints from beneficiaries, hospitals etc on regular basis. Proper records of all such activities shall be maintained electronically by the Insurer.

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