

Government of Jammu & Kashmir

POLICY PRODUCT

FOR

**CHIEF MINISTER'S GROUP MEDICLAIM INSURANCE
POLICY FOR ALL GOVERNMENT EMPLOYEES AND
EMPLOYEES OF PSUs/AUTONOMOUS BODIES /LOCAL
BODIES / UNIVERSITIES AND PENSIONERS**

**INSURANCE DIVISION
FINANCE DEPARTMENT, GOVERNMENT OF
JAMMU & KASHMIR
CIVIL SECRETARIAT, JAMMU.**



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Introduction

Objects & Reasons:- 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 overcome these unnecessary hassles faced by the employees during the course of 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 quality medical health care (Group Medclaim Insurance Policy) to its serving and retired Government employees (Gazetted and Non Gazetted)/ Employees of State PSUs, Autonomous Bodies, Local Bodies, Universities, Pensioners and their 5 dependent family members. In this behalf as a part of Employee friendly measure, a customized Health Insurance policy outlined herein is being introduced to provide the quality health care facilities to the aforesaid beneficiaries.

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CHIEF MINISTER'S GROUP MEDICLAIM INSURANCE POLICY

1. Name of the Scheme: This Scheme shall be called as Chief Minister's Group Mediclaim Insurance Policy for all Government employees and employees of PSUs /Autonomous Bodies/Local Bodies/Universities and Pensioners.

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

- a) All Gazetted/Non Gazetted Employees of State Government, PSUs, Autonomous Bodies, Local Bodies and Universities on mandatory basis.
- b) **Optional:** For all categories of Pensioners, 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 (5) shall be covered under this Scheme on compulsory basis. The Scheme/Policy shall be optional for other categories as defined above at para 1(b) above.

3. Definitions: Unless context otherwise provides,

- I. **"Government"** means Government of Jammu and Kashmir.
- II. **"Government Servant"** means an employee working in Permanent/Quasi Permanent /Temporary basis appointed in the regular scale of pay.

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III. The term "pensioner" in the instant policy product would also mean and include the categories of "family Pensioners", as well as "ex-legislators," who are pensioners. The family unit for Pensioners will mean, the Pensioner himself and his/her spouse and children fully dependent upon him/her, if any.

IV. "Family unit" for Government Employees / PSU / Autonomous Bodies / Local Bodies / Universities / and all other categories of employees shall mean family unit comprising employee and his/her 5 dependent family members. Provided that in case of women employees, the family shall include father-in-law and mother-in-law also in case they are residing with such employee. 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, and he/she shall be provided all benefits under the instant policy and shall not be counted as a separate member. The child shall be treated as part of the mother. Verification for the new born shall be done by any of the existing family members who are getting the benefits under the policy. Member shall be required to enroll new born child at the time of renewal of the policy prior to expiry of the policy. In the first pregnancy, if twins are born then the Insurance coverage shall not extend in the case of second pregnancy. However, in second pregnancy, if twins are born then both shall be covered till the expiry of the current policy. Congenital diseases of new born child shall be covered.

V. New Employees As regards the new incumbents the coverage in the Insurance Scheme is compulsory. The data of such employees shall 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 shall be covered in the Insurance Scheme from the date of joining. The family unit for the New Employees shall remain the same as applicable to the existing employees. They shall be charged premia on pro rata basis.

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

VII. "Identification of Family" Beneficiaries shall be identified by a "Health Insurance Card having Unique Identification No" issued by the Insurer to all beneficiaries, which shall contain all personal details, medical history, policy limits etc. of the Policy. This Card shall be used in and outside the State to access Health Insurance Benefits.

VIII. "Dependent" means the Employee's family members i.e. husband, wife, parents including step mother/father, sons, daughters, step sons, step daughters, adopted Sons/daughters, brother/sisters who are wholly dependent on the employee.

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

1. Son - Till he starts earning or attains the age of 40 years, whichever is earlier;
2. Daughters-Till she starts earning or gets married, irrespective of age limit, whichever is earlier. Also, Dependent daughters, who are divorced/abandoned or separated from their husband including widowed daughters – irrespective of age limit.
3. Sisters- Dependent Sisters, who are 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 40 fully depended and residing with the beneficiary.
6. Dependent Parents – up to 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) Divorced sisters.
 - c) Handicapped brothers/sisters

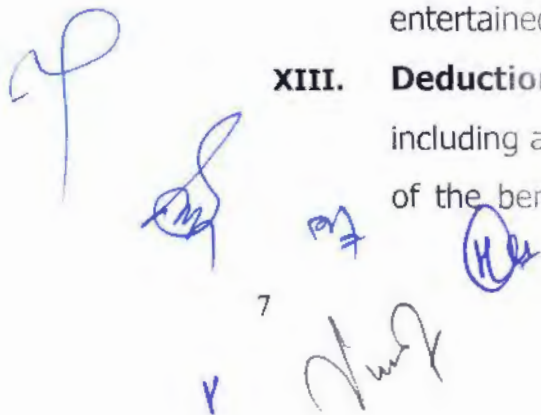
ii) **Deletion from Family is allowed in following contingencies:**

- 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.

- IX. "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 Empanelled Hospital/Nursing Home/Day Care Unit.
- X. "Plan Period"** 03 years from the date of inception of policy.
- XI. "Renewal of the policy"** The Scheme/Policy Shall be renewed with the incumbent Insurance Company subject to the satisfactory performance on all parameters of the Scheme.
- XII. "Mode of Premium"** The mode of payment of premium to the successful Insurance Company in lump sum or in instalments shall be decided by the State Government. Any claim for increase in premium rates during the policy period on account of any reason whatsoever shall not be entertained.
- XIII. Deduction of the Premium:** The amount of premium including applicable taxes, shall be deducted from the salaries of the beneficiaries and same shall be remitted against the



proper Head of Accounts by the concerned DDO. The details in this behalf shall be notified separately at the time of launch of the Scheme. However, in case of PSUs/Autonomous Bodies /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: a.** In case both husband and wife or any other family member are Govt. Employee(s) or pensioner(s), the premium shall be payable by any one of them only.
- b.** If the parents or one of the parents of an employee, who are/is pensioners/pensioner, fall within the employee plus dependents' cap of 1+5, they are not required to pay the premium separately and take out a separate policy. However, if the employee and his dependents, which include his family plus his pensioner parents, exceed the above cap, one of the pensioner parents can take out a separate policy for himself or herself and his or her dependents.

XIV. Payment of Premium:

As the policy shall 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 shall be payable to the Insurer only in respect of the beneficiaries who have been enrolled and in whose case premia have been deducted from their salaries. In all other cases, the Government shall not be liable to pay premium to the Insurer.

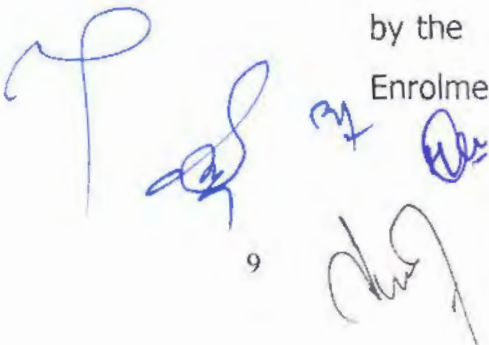


- b) However, if any intended beneficiary could not submit/deposit his enrolment form to the concerned Agency for some reasons, he/she shall submit the same within 30 days of the inception of the Policy/Scheme. The above date can be extended by the Government in exceptional circumstances.
- c) The concerned Insurance Company/Brokerage Agency shall upload on the portal all the off-line enrolment forms received from DDOs/Treasuries/PSUs/Autonomous Bodies etc. and keep them online for any correction by the beneficiaries up to 30 days.
- d) Insurer shall provide the details of enrolment of the beneficiaries in a prescribed format to the Government on fortnightly/monthly basis, or at intervals to be decided by the Government.
- e) Reconciliation of premia paid to the Insurance Company shall be carried out at the end of the year or such other time as the Government may deem appropriate.

xv. "Refund/Adjustment of Premium" In case of excess/shortage of premia paid to the Insurance Company, the same shall be refunded by the Insurance Company after the expiry of the policy period or shall be adjusted at the time of renewal of the Policy by the State Government.

xvi. Enrolment & its Process

All the beneficiaries shall follow the circular instructions issued by the Finance Department in letter and spirit regarding the Enrolment & the subsequent processes under the Policy.



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- a) Insurance Company shall issue Health Insurance Cards having Unique Identification Number on the basis of information received of the beneficiaries for enrolment. Such Health Insurance 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 15 days. At the time of delivering the Health Insurance Card, the Insurer shall provide a booklet indicating the list of the Empanelled Hospitals, list of other than empanelled Hospitals covered under the reimbursement mode, the availability of benefits under the Scheme and the names and details of the contact person/persons, and toll-free number(s) of call center. The company shall in parallel also convey UHID No. to each beneficiary through SMS.
- b) In case of emergency, till the Health Insurance Card is available the company shall provide the treatment to the beneficiaries in the empanelled hospitals on production of identity card or Adhaar card or UHID issued by the Insurance Company to the beneficiaries.

Note: The Insurer will have to necessarily complete the following activities before the inception of the policy and issuance of Health Insurance Cards:-

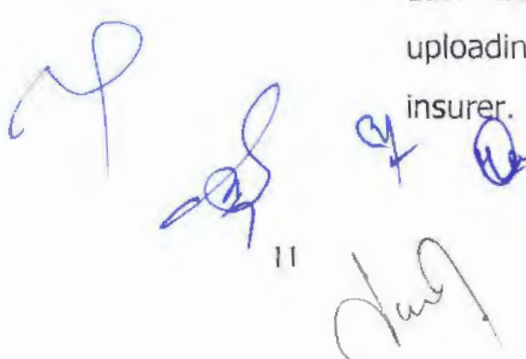
1. During the empanelment of the Hospitals/Nursing Homes/Day Care Clinics, care should be taken that all the prominent Hospitals in the country such as Apollo Group of Hospitals, Batra Group Of Hospitals, Fortis Group of Hospitals, Max Group of Hospitals, Narayan Group of Hospitals, Tata Group of Hospitals

Mediciti (Medhanta) Hospitals, Ganga Ram Hospital etc, having presence all across the country must be included in the list of network hospitals. Further, the hospitals which are empanelled under J&K Medical Attendance cum Allowances Rules 1990 within and outside of the State must also be included in the Network of Hospitals. The list of the same is necessary to be kept available on the web portal and official websites of Government. The Company shall provide a web-based application, to Head of Departments/official websites /beneficiaries to enable the beneficiaries to access their relevant information on the said website.

2. Setting up of District KIOSK Offices, in all districts of the state.
3. Prepare the user guide containing all important information.

XVII. Health Insurance Cards issued by the Insurer.

The Health Insurance Cards having Unique Identification Number 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 empanelled/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.

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- XVIII. "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 05 years and duly licensed by the Insurance Regulatory and Development Authority (IRDA) of India for Group Medclaim Insurance Policy (Health Insurance).
- XIX. 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.
- XX. 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.

Further, the said website designed by the Insurer shall have District/State wise Enrolment status, Claims, Treatments rendered, Hospitals Data which shall be uploaded by the Insurance Company on periodical basis. Insurer shall provide MIS reports related to enrolment, admissions, preauthorization, claim settlement, grievance reporting and its resolution besides the other service related report as required by Govt. /Nodal Agency time to time on a regular basis as agreed between the Parties. The said website shall also have soft copies of all health cards, list of empanelled hospitals along with their contact no. and

location address. Stage wise tracking facility for claims and grievances should also be made.

XXI. Call Centre Services

The Insurer shall provide a dedicated telephone services free of cost for the guidance of beneficiaries. 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. Under the above 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) Maintaining the data of receiving the calls and response on the system.
- j) The Insurer shall 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.

XXII. Language: The Insurer shall provide services to the Insured Persons in English, Urdu and local languages.

XXIII. "TPA" means Third Party Administrator, which in this policy shall be mandated and nominated by the Successful Insurance Company in consultation with Ms. Trinity Reinsurance Broker Pvt. Ltd. duly licensed by IRDA. TPA is engaged in the business of formulating and administering 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.

XXIV. "Facility/Treatment" The Company has to provide cashless facilities to the beneficiaries in all the 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. The company shall ensure that the hospital do not impose any hidden charges on the beneficiaries. 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 the treatment of Life consuming diseases if diagnosed after inception of the policy, including domiciliary expenses, shall be reimbursed by the Insurance Company.

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

- (a)** In case of any organ transplant, expenses incurred on the Donor shall also be payable under the scheme.
- (b)** In case a beneficiary meets with an Accident/suffers from 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 shall reimburse the full amount incurred on such treatment to the beneficiary directly within 30 days. After the discharge, the beneficiary shall be allowed the follow up treatment in the said hospital as advised by the doctors or any network hospital.
- (c) Psychiatric diseases:** Expenses for treatment of psychiatric and psychosomatic diseases shall be payable subject to hospitalization. However, Intentional self inflicted injury and/or suicide shall remain out of scope of policy coverage.

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- (d) **Taxes and other Charges:** All Taxes, Surcharges, Service Charges Registration charges, Admission Charges, Nursing, and Administration charges shall be payable by the Insurance Company.
- (e) Rental Charges for External and or durable Medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Bi-PAP, Infusion pump etc. shall be covered under the Scheme.
- (f) **Physiotherapy charges:** Physiotherapy charges shall be covered for the period specified by the Medical Practitioner even if taken at home.
- (g) A General body check up, including tests if necessary as recommended by the consulting doctor, in any empanelled /designated hospital(s)/or designated diagnostic centers for employees and his /her enrolled dependent family members, once in a policy year subject to a ceiling of Rs 1000/- shall be covered under this policy on cashless basis.

XXVI. 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.

XXVII. Pre & Post hospitalization benefit: Expenses 30 days prior to Pre-Hospitalization and 60 days after Post-Hospitalization, shall be payable by the Insurance Company on cashless basis /reimbursement. However, this condition shall not be applicable to the patients who require their follow up treatment even after 60 days.

XXVIII. Critical disease: For the purpose of this Scheme Cancer including Leukaemia, Stroke, Paralysis, By Pass Surgery, Major Organ Transplant, End Stage Liver Disease, Heart Attack, Kidney Failure, Heart Valve Replacement Surgery etc. shall be treated as critical diseases.

XXIX. "Day care Treatment" refers to medical treatment, and/or surgical procedure which are undertaken under General or Local Anesthesia in a Hospital/Day care centre in less than 24 hours because of technological advancement. All new kinds of approved advanced medical procedures such as laser surgery, stem cell therapy for treatment of a disease is payable on hospitalization /day care surgery. 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. Lithotripsy (kidney stone removal).
4. All Orthopedics day care procedures.
5. Tonsillectomy.
6. Dilation & Curettage.
7. Dental surgery following an accident
8. Surgery of Hydrocele
9. Surgery of Prostrate
10. Few Gastrointestinal Surgery
11. Genital Surgery
12. All day care Urology procedures.

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

34. Septoplasty.
35. Varicose Vein Ligation.
36. Paranoid Schizophrenia.
37. Circumcision for only two children born after the inception of the policy.
38. 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).
39. Laparoscopic therapeutic surgeries that can be done in day care.
40. Identified surgeries under General Anesthesia or any procedure mutually agreed upon between insurer and health care provider.
41. All other genuine day care procedures/investigations shall also be covered.

Expenses incurred on treatment taken in the empanelled Hospitals/ Nursing Homes /Day Care Clinics by the beneficiaries suffering from such disabilities as blindness, low vision, leprosy-cured, hearing impairment, locomotors disability etc. shall also be payable irrespective of age.

XXX. Maternity benefit

- This shall mean treatment taken in an Empanelled Hospital/ Nursing Home arising from childbirth,

including Normal Delivery/Caesarean Section including miscarriage or abortion induced by accident or other medical emergency.

- This benefit shall 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.

XXXI. "Empanelled 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 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 be deemed to have been included in the list of network hospitals. In case any facility/treatment is not available in the empanelled hospital of the Insurance Company, expenses shall be borne by the Insurance Company wherever the treatment is available. The list of Empanelled Hospitals once approved shall not be subject to any change during the currency of the policy, without approval of the Government.

XXXII. Eligible Health Service Providers The Policy aims to provide quality and affordable Health care services to all the

beneficiaries. The Company shall, as such, follow prescribed National Accreditation Board for Hospitals & Healthcare Providers (NABH) Accreditation/JCI/ACHS (Australia) as minimum eligibility criteria for empanelment of both Public and Private 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.

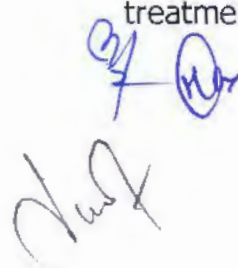
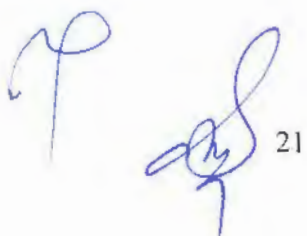
- ii) **Specialty hospitals** (the list of specialties given below) Hospitals having less than 100 beds can apply as a specialty hospital -provided they have at least 25 beds earmarked for each specialty applied for with at least 15 additional beds – Thus, under this category a single specialty hospital should 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 100 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 to avoid any confusion once Scheme is implemented.
 - a) The "Package Rates" shall mean and include lump sum cost of inpatient treatment/day care/diagnostic procedures from the time of admission to discharge

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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 as to the package rates, the package rate for a particular procedure shall be inclusive of all sub-procedures and all related procedures. 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 in the hospital shall be enforced, if, the extension in stay is due to infection as a consequence of surgical procedure or due to any improper procedure.
- d) Cost of implants shall be payable in addition to package rates as per ceiling rates for such implants or as per actuals. In case there are no prescribed ceiling rates, the decision of the doctor advising implants shall be binding in this regard.

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- e) Cost of external equipment required for treatment as listed in Scheme shall be payable also as an additional benefit.

XXXIII. Cashless Access Service: It means a facility extended by the Insurance Company to the Insured person where the costs involved in the treatment undergone by the Insured person in accordance with the policy terms, are directly made by the Insurer to the empanelled hospital. The Insurer has to ensure that all beneficiaries 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 the services are covered under the Scheme.

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

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 shall be paid by the Insurance Company under operating policy in which beneficiary was admitted.

XXXIV. Documents required for Reimbursement of the Claims

The claim shall be supported with the following documents and submitted within the prescribed time limit.

- a) Completed claim form
- b) Original bills, payment receipts, medical history of the

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patient recorded, discharge certificate/ summary from the hospital etc.

- c) Original cash-memo from the hospital(s)/chemist(s) supported by proper prescription
- d) Original payment receipt, investigation test reports etc. supported by the prescription from attending medical practitioner
- e) Attending medical practitioner's certificate regarding diagnosis and bill receipts etc.
- f) Surgeon's original certificate stating diagnosis and nature of operation performed along with bills/receipts etc.

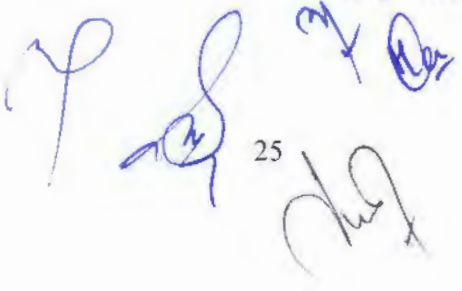
XXXV. Claim Settlement

Reimbursement claims shall be paid within 15 days after receipt of all related documents from insured person.

XXXVI. Internal congenital anomaly means congenital anomaly not existing in the visible and accessible parts of the body is called Internal Congenital Anomaly. Expenses for treatment of congenital Internal diseases, defects, anomalies shall be covered under the scheme.

4. RUN-OFF PERIOD

A Run-Off period of two months shall be allowed in case of cancellation/non-renewal of the policy. Expenses incurred by the beneficiaries, who are under treatment in the emplaned hospitals and where the patient is under treatment the policy is either



cancelled or expire shall be payable for two months beyond such cancellation/expiry of the policy.

5. REPUDIATION OF CLAIMS

In case of any claim is found untenable, the Insurer shall communicate reasons to the Trinity Reinsurance Pvt. Ltd. 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.

6. 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) 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

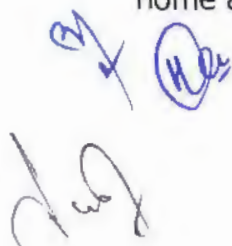
or of aesthetic treatment of any description and Plastic Surgery other than as may be necessitated due to an accident or as a part of any illness

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



7. **Corporate Buffer:** Corporate Buffer of Rs 10 Crore shall be maintained under the Policy to meet out hospitalization expenses incurred for the treatment of any of the Insured beneficiary, where the respective family has already utilized the entire available sum insured. The details of utilization of this buffer shall be separately devised.

8. **Redressal Cell for Beneficiaries:** It shall be the responsibility of the successful Insurance Company and Ms Trinity Insurance Broker Agency particularly to establish grievance mechanism for immediate redressal of the grievances of the complainants. As per the Agreement the Broker Agency shall establish full-fledged and effective grievance redressal mechanism with the following objectives:-

- Delays must be handled in a time bound manner.
- Effective escalation matrix must be operational at all times.
- Grievances shall be segregated by their nature and solutions must be identified so as to prevent repetition.
- All grievances shall be routed through call centre or mobile Application. Responsibility shall be defined for non compliance of grievances redressal and TAT.
- The redressal of grievances of the beneficiaries shall be the sole responsibility of the Trinity.


9. **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 shall be settled in the following way: There shall be three tier dispute resolution mechanism to address all disputes arising during the implementation of the Policy as under:

1. At the first tier, the disputes shall be resolved by a mechanism put in place by Broker and Insurer, which will be appropriately framed by the two entities and notified on on the relevant website.
2. If any dispute remains unresolved at the first tier, it shall be posed to the 2nd tier, which shall again have representatives from Trinity and Insurer. However, this time, the resolution mechanism shall be overseen by higher officers of the two organizations.
3. If any dispute is still not resolved at the Second tier, then there will be a third tier involving representatives of Broker, Insurer and State Finance Department where such dispute shall be brought for appropriate resolution. The decision of the third tier shall be binding on all the concerned.
4. In the event of a dispute between the Government and the Insurer, the matter shall be referred to a sole arbitrator who shall be jointly appointed by parties involved, 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.

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5. The law governing the arbitration shall be the Arbitration and Conciliation Act, 1996, as amended or re-enacted from time to time.
6. The proceedings of arbitration shall be conducted in the English language.
7. The arbitration shall be held in Jammu / Srinagar (J&K) only.

10. AGREEMENTS:

- 1) A tripartite brief Service Level Agreements (SLAs)/MOUs having all the terms and conditions binding on all the three parties shall be signed between State Government, Brokerage Firm and Insurance Company.
- 2) Insurer will also enter into SLAs/MOUs with other intermediaries for ensuring compliance including penalty clauses.

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

The Agreement shall take effect from 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 the State Government terminating the Agreement, on the basis of review of the performance of the INSURER before the same period. The Government shall 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.

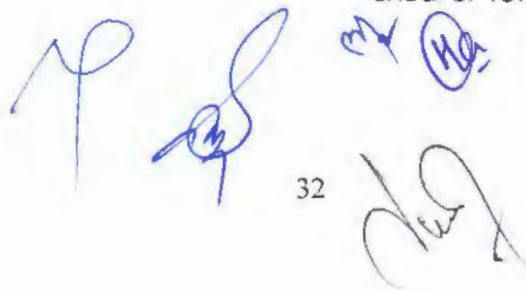
12. The Agreement may be terminated:

- 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 shall 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 act as per clause above, the Insurer shall 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 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 claim to it.

13. PERFORMANCE PARAMETERS AND PENALTY CLAUSE:

Insurer is required to perform multiple activities in performance of their obligations arising out of the contract with 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 suitable penalty shall be imposed on the Insurer for the period of delay.



Handwritten signatures and initials in blue ink, including a large signature on the left, a signature with a circled 'M' in the middle, and a signature with a circled 'H' on the right.

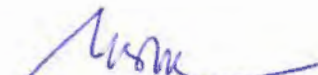
14. NODAL AGENCY:

- 1) The Finance Department, J&K Civil Secretariat shall be the Nodal Agency for the implementation of this Group Medclaim Insurance Policy.
- 2) Nodal Cell at the Finance Department level shall monitor data related regular enrolments, empanelment of hospitals, authorization status, claims status, utilization statistics, network hospital status and the website maintained by the Insurer.

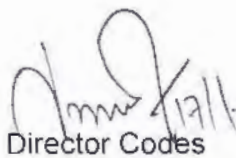
15. MEDICAL AUDIT: The Insurance Company shall also carry out inspection of hospitals, investigations, on the spot verification of inpatient admissions, periodic medical audits, to ensure proper care and counselling for the patient at network hospital by coordinating with hospital authorities, feedback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



1. Jt. Director (Resources)
Finance Department
(Member)



2. Additional Secretary
Finance Department
(Member)



Director Codes
Finance Department
(Chairman)