

SCOPE OF WORK

SCHEDULE: - 01

GROUP INSURANCE POLICY FOR THE CONTRACTUAL EMPLOYEES OF NATIONAL HEALTH MISSION, ASSAM AND THEIR DEPENDANT FAMILY MEMBERS

1. NAME OF THE SCHEME : The name of the proposed scheme is Group Mediclaim Insurance Policy for the contractual employees of the NHM, Assam.

2.BENEFICIARIES : All employees of the NHM, Assam including the parents, spouse & up to two Children of the employees are eligible to be covered.

3. INSURANCE COVERAGE:

(A) In-patient benefits – The insurance Scheme shall pay expenses (subject to policy limitations) incurred in course of medical treatment availed by the beneficiaries in a registered hospitals/nursing Homes within the country, arising out of either illness/disease/injury and/or sickness. The treatment must require at least 24-hour hospitalization. The selected Insurance Company must have empanelled hospitals/nursing homes and it should be available cashless treatment (subject to policy limitations) can be availed.

(B) Coverage of Pre-existing diseases – Pre-existing diseases, if any, shall be covered from day one under this insurance scheme. For example, a person suffering from any disease or already having implants and/or any internal congenital disease prior to the inception of the policy shall also be covered in this scheme.

(C) Post hospitalization benefit – All expenses (subject to policy limitations) during the post-hospitalization period of up to 60 days required due to the treatment of the sickness for which hospitalization was done would be covered in this scheme.

(D) Day Care procedures – Given the advances made in the treatment techniques, many medical treatments, formerly requiring hospitalization, can now be treated on a day care basis. The scheme would also provide for day care facilities (which require less than 24 hours hospitalization) for such identified procedures. However, OPD services shall not be part of Day Care facilities. Day care facilities would be available for the following medical treatment:

1. Eye Surgery
2. Lithotripsy (kidney stone removal)
3. Tonsillectomy
4. Dental surgery following an accident
5. Surgery of Hydrocele

6. Surgery of Prostate
7. Few Gastrointestinal Surgery
8. Genital Surgery
9. Surgery of Nose/Throat/Ear
10. Surgery of Urinary System
11. Dialysis
12. Chemotherapy
13. Radiotherapy
14. Treatment related to dog bite/snake bite etc.
15. Treatment of fractures/dislocation, Contracture releases and minor reconstructive procedures of limbs which otherwise require hospitalization.
16. Laparoscopic therapeutic surgeries that can be done in day care
17. Identified surgeries under General Anesthesia or any procedure mutually agreed upon between insurer and health care provider.

NOTE : The For OPD treatment or any other treatments which do not require any hospitalization, the existing reimbursement system should be available.

MATERNITY AND NEWBORN BENEFITS

A. Maternity Benefit

- (a) Includes maternity related procedure/treatments arising from pregnancy onwards (including both normal delivery & Caesarean section, including miscarriage or abortion induced by accident or other medical emergency) treated in a registered hospital/ nursing home.
- (b) This benefit would be limited to only first two living children in respect of Dependent Spouse/Female Employee as per CS(MA) rule.
- (c) The new born baby will be covered by the insurance policy immediately after birth without any waiting period. The parents/guardians of the baby must report the birth of the child to appropriate NHM, Assam authority at the earliest.
- (d) The cost of maternity procedure is limited to Rs. 25,000/-for normal delivery and 60,000/-for Caesarean delivery.

B. Newborn Benefit

- (a) Newborn child (single/twins) to an insured mother would be covered under the scheme from day one for the expenses (subject to policy limitations) incurred for treatment taken in registered Hospitals/Nursing Homes/Day Care Clinics as an in-patient and will be treated as a part of the mother.
- (b) If, in first pregnancy, twins are born then the benefit stand ceases for second pregnancy. However, if in second pregnancy twins are born then both the children will be covered.

- (c) Congenital diseases of new born child shall also be covered under this scheme.

4. CONCESSIONS FOR FAMILY:

A. Definition – ‘Family’ means employee’s –

- (a) Parents of the employee including stepmother and stepfather.
- (b) Husband/Wife including more than one spouse (as per government rule) and also judicially separated wife.
- (c) Parents and Stepmother – In case of adoption, only the adoptive and not the real parents will be covered. If the adoptive father has more than one wife, the first wife only will be covered.
- (d) A female employee has a choice to include either her parents or her parents-in-law. Option exercised can be changed only once during the service period.
- (e) Children including legally adopted children, stepchildren and children taken as wards subject to the following conditions:

Unmarried Son: Till he starts earning or attains the age of 21 years, whichever is earlier.

Daughter: Till she starts earning or gets married, whichever is earlier, irrespective of age limit (18th years)

Son suffering from permanent disability of any kind (physical or mental): No age limit.

- (f) Widowed daughters and dependent divorced/separated daughters irrespective of age limit.

- (g) Sisters including unmarried/divorced/abandoned or separated from husband/ widowed sisters – irrespective of age limit.

- (h) Minor brothers.

B. Dependency

There are no income limit for dependency of the family members for consideration of the claim.

NOTE: The definition of dependent shall be governed as per guidelines issued by the Central Government from time to time.

C. Addition & Deletion of Family Members during the Running Policy

- (a) **Addition to the family is allowed in following contingencies during the policy:**

- (1) Marriage of the beneficiary (requiring inclusion of spouse’s name), or

- (2) Parents becoming dependants

(b) Deletion from Family is applicable in following contingencies:

- (1) Death of covered beneficiary
- (2) Divorce of the spouse
- (3) Member becoming ineligible (on condition of dependency)

D. New Employees

As regards to the new incumbents, the coverage in the group insurance scheme should be mandatory and starts from the date of joining.

5. IDENTIFICATION OF FAMILY: Beneficiaries shall be identified by a “Photo Smart Card” issued by the insurer. This card would be used across the country to access Health Insurance Benefits. The photograph embedded in the Card will be taken as the proof for determining the eligibility of the beneficiaries.

6. SUM INSURED AND BUFFER/CORPORATE SUM INSURED:

(a) Sum Insured : The Scheme shall provide coverage for meeting all expenses relating to hospitalization of beneficiary members up to Rs. 5,00,000/-per family per year in any of the registered empanelled Hospital/Nursing Home/Day Care Unit subject to stated limits on cashless basis through smart cards. The benefit shall be available to each and every member of the family on floater basis i.e. the total reimbursement of Rs.5,00,000/-(Rupees five lakhs) can be availed either by one individual or collectively by all members of the family.

(b) Buffer/Corporate Sum Insured : An additional Sum Insured of Rs. 5,00,000/- lakhs shall be provided by the Insurer as Buffer/Corporate Floater in case hospitalization expenses of a family (per illness or annual) exceed the original sum insured of Rs. 5,00,000/-. Insurer is required to inform the NHM, Assam authority with the details on case to case basis and only the NHM, Assam authority will decide the distribution and disbursement of the buffer corporate sum insured. For this ,the employee must submit the application to the Mission Director through proper channel.

(c) Limitations:

(i) Room Rent Limit : 1% of Sum Insured per day, however if admitted in all types of ICU (including ventilator) limit is 5% of sum insured per day. Over all limit under this head: 25% of Sum Insured per illness.

(ii) Surgeon, Anesthetist, Medical Practitioner, Consultants Special fees, Maximum Limit per illness-25% of sum Insured.

(iii) Anesthesia, Blood, Oxygen, OT charge, Surgical appliances, Medicines, Drugs, Diagnostic Material & X-Ray, Dialysis, Chemotherapy, Retinopathy, Cost of Pacemaker, Artificial Limbs and cost of stent and implant. Maximum limit per illness – 50% of Sum Insured.

(iv) Hospitalization expenses of person donating an organ during the course of organ transplant will also be payable subject to the limitation (iii) above as applicable to the insured person.

(v) Reimbursement of Ambulance charges: Maximum Rs. 10000/-(subject to actual) in a policy year may be reimbursed for ambulance to be used. This benefit is available only for shifting patient from residence to hospital if admitted to ICU or Emergency Ward or from one hospital to another.

In the rarest of rare cases, the limitation in respect of (i), (ii) and (iii) above may be relaxed as advised by the appropriate NHM Authority.

Death Benefit:

A rider facility with one time settlement to the nominee of deceased of Rs. 5,00,000/- as death benefit is to be provided.

Permanent disability/ Partial disability benefit:

7. PROCEDURE FOR AVAILING CASHLESS ACCESS SERVICES IN EMPANELLED HOSPITAL/ NURSING HOME:

1 Claims in respect of Cashless Access Services will be through the list of the network/empanelled Hospitals/Nursing Homes.

2 Cashless services for all planned medical treatment are subject to pre-admission authorization.

3 In case of emergency, the TPA (Third Party Administration) should be contacted immediately after admission preferably through the hospital/ nursing home.

4 Both for items (2) and (3) above, the TPA shall, upon getting the related medical information from the insured persons/network provider, verify that the person is eligible to claim under the policy and after satisfying itself will issue a pre-authorization letter/guarantee of payment letter to the Hospital/Nursing Home mentioning the sum guaranteed as payable for the ailment for which the person is seeking to be admitted as a patient.

5 Pre-authorization for Cashless Access Services in Empanelled Hospital/Nursing Home is within the authority of TPA and will be given after verification of required documents pertaining to treatment of

the insured to the satisfaction of TPA. Any inconvenience regarding the items above should be brought to the notice of appropriate NHM authority at the earliest.

6 Pre-authorization for cashless treatment may still require deposition of an initial sum in the network/ empanelled hospital/ nursing home. This deposit usually caters for the cost of non-admissible items/charges with respect to reimbursement by the insurance company.

7 Empanelled Hospitals/Nursing Homes where admission will be processed without any deposit (cashless in absolute term). Empanelled Hospitals/Nursing Homes should cover all types of specialization, super-specialty treatment facility and it should be distributed throughout the state and country.

8 Claims for hospitalization in non-network or non-empanelled hospital will be reimbursed by the Insurance Company after submitting the claim documents to the TPA.

9. Claim Documents for non-Cashless Services: Claim document which includes all hospital receipts and bills in original, Cash memos, reports, discharge certificates, filled claim form etc. should be submitted to the insurance company or TPA within 60 days from the date of discharge from the Hospital and where Post-hospitalization treatment is not completed, it shall be within 30 days from the date of completion of Post-hospitalization treatment.

The claim documents must include:

- (a) Original bills, receipts and discharge certificate/card from the hospital
- (b) Original Cash memo from the hospital(s)/chemist(s) supported by proper prescription
- (c) Original receipts, pathological and other test reports from a pathologist/radiologist including film etc. supported by the note from attending medical practitioner/surgeon demanding such tests
- (d) Certificates and bills, receipts from attending Consultants/ Anesthetists/ Specialist
- (e) Surgeon's original certificate stating diagnosis and nature of operation performed along with bills/receipts etc.

Timeline:

- 1 Reimbursement claims to be settled within 25 days of submission of complete documents.
- 2 Status of claims will be updated within 7 days.
- 3 After receiving the request of the Insured person settlement advice/certificate is to be issued by the TPA within 10 days of settlement of claim.

4 Waiver of this condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances which the Insured was placed it was not possible from him/her or any other persons to give such notice or file claim within the prescribed time limit.

9. Special Services to be provided by TPA to NHM

- (1) TPA will set up Help Desk at Guwahati.
- (2) Claim cheque to be issued in favour of employee
- (3) List of non-admissible items is to be provided by the TPA.
- (4) TPA will provide 24 x 7 exclusive Helpline phone number for NHM.
- (5) Empanelled Hospital/Nursing Home to be included in the network of TPA.
- (6) Photographs to be collected at the Help Desk.
- (7) Any name which is not in the list to be referred to NHM Authority.

SUMMARY OF THE TAILORMADE GROUP MEDICLAIM POLICY

Scope of the Insurance Coverage Scheme

- The Mediclaim Policy reimburses expenses incurred due to a Disease, Illness or Accident.
- The Mediclaim Policy stipulates that a claim is admissible when the insured is admitted in a Hospital/Nursing Home for a minimum period of 24 hours for the treatment.
- 24 hours clause not applicable if the treatment completed with-in a day/or day care procedure due to advancement of technology (for details kindly refer clause 3D of the scheme).
- Claims regarding the indoor treatment other than the Network Hospital even in the Govt. Hospital will be reimbursed by the Insurance Company. However, the cashless facility will not be available in such case.
- The treatments in the Government Hospitals are inexpensive and it is highly unlikely it would exceed Rs.5.00 lakhs per family limit in one year. In case of such events additional payment can be adjusted from the Buffer/Corporate Floater fund.

It may also be noted that as per CS(MA) rules cost for Angiography/ Angioplasty / CABG / Pacemaker / Cataract / Knee replacement / Hip replacement/ Renal Diseases/ Dialysis/ Blood Transfusion/ Bypass surgery etc. are reimbursed as per the package rate which is much less than the present Insurance Scheme.

The insurance policy covers treatment costs for a number of private or semi-private hospitals most of whose charges are generally either not payable or payable to a very limited extent as per CS(MA) rules.

4. How will employees ascertain that the TPA would cooperate and respond efficiently?

- A Standing Committee may be constituted to review the performance of the TPA. Feedback from individuals availing medical insurance will be solicited. TPA will provide 24 x 7 exclusive helpline number for NHM.
5. What will be the time limit for reimbursement?
- All claims will be settled within 25 days of submission of complete documents. Status of the claim will be updated within 7 days.
6. Can anyone draw medical advance for treatment in the hospital/Nursing Home/Government Hospital where cashless facility is not available?
- An employee can appeal to the competent authority for the medical advance. Depending upon the merit of the case authority may approve the advance.
7. Is there an option to remain in the CS(MA) indoor treatment ?
- The new system incorporate all the features of the CS(MA) rules. However, if any one feels may remain in the old system.

HOW TO AVAIL THE MEDICAL INSURANCE FACILITY

PLANNED ADMISSION

Insured should inform the TPA at least 3 working days prior to hospitalization along with the Doctor's advice for Hospitalization.

TPA issues an authorization/detail letter to Hospital/Nursing Home for covered service as per policy terms & conditions.

Cashless treatment is extended by registered Hospital based on TPA's authorization letter.

At the time of discharge insured signs the claim form; all the relevant bills & all original documents including photocopy of ID Card will be kept by the network hospital. Some payment may be necessary to cover the cost of non-admissible items required during treatment.

EMERGENCY ADMISSION

Insured approaches registered hospital & submits the copy of ID Card.

Network hospital forwards request letter to the TPA.

TPA will issue the authorization as per the policy terms & conditions.

At the time of discharge insured signs the claim form and all the relevant bills & all original documents including the photocopy of the ID Card will be kept by the registered hospital. Some payment may be necessary to cover the cost of non-admissible items required during treatment.

Treatment as non-Cashless basis

Insured get treatments from registered hospital and nursing homes. Inform the TPA as soon as possible.

At the time of discharge insured pays for all bills, collect all reports, bills, receipts in original.

With next 10 days insured submits claim form along with admission advice, all treatment related bills, receipts, prescriptions, cash memos, discharge certificates etc. to TPA or insurance company. The claim will be settled by the insurance company within 25 days and the status of the claim will be intimated within 7 days of application for reimbursement.

REIMBURSEMENT OF POST HOSPITALISATION EXPENSES

As per the policy the expenses incurred upto 60 days after discharge related to disease for which insured have been hospitalized is entitled to get reimbursement. Original prescription & bill/receipt related to this should be submitted to the TPA along with all other documents. Please note that once fitness certificate has been issued by the Doctor, insured is not entitled to any reimbursement of expenses incurred beyond fitness date.

AVAILING SERVICES AT NON-NETWORK HOSPITAL

- Insured is required to intimate TPA at least 3-4 days prior to hospitalization or within 24 hours in case of emergency hospitalization.
- Intimation should be in writing and the following points should be mentioned in it :

(a) Name of the Patient

(b) Date of Hospitalization

(c) Name of the Hospital & Name of the Doctor

The patient party should pay the entire treatment cost and after discharge submits the complete claim form along with all the documents to the TPA's Help Desk.

IMPORTANT

1. Please provide all documents in original
2. Please keep a photocopy of all relevant documents for record.
3. Claim-Form can be obtained from

- TPA's Website
- TPA's Help Desk
- Insurance Company

6. Co-operate with TPA for early processing and settlement of claim.

At the time of discharge insured signs the claim form and all the relevant bills & all original documents including the photocopy of the ID Card will be kept by the registered hospital. Some payment may be necessary to cover the cost of non-admissible items required during treatment.

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