

DRAFT

**CENTRAL GOVERNMENT EMPLOYEES AND PENSIONERS HEALTH
INSURANCE SCHEME (CGEPHIS)**

1. NAME OF THE SCHEME:

The name of the proposed scheme is “**Central Government Employees & Pensioners Health Insurance Scheme (CGEPHIS)**”.

2. BENEFICIARIES:

All personnel of the Central Government including All India Service officers, serving, newly recruited, retired / retiring and others who are covered under the existing CGHS (Central Government Health Services) and under CS (MA) [Central Services (Medical Attendance) Rules] Rules shall be offered Health Insurance Scheme on voluntary or on compulsory basis as indicated below:

1. CGEPHIS shall be compulsory to new Central Government Employees who would be joining service after the introduction of the Health Insurance Scheme.
2. CGEPHIS shall be compulsory to new Central Government retirees who would be retiring from the service after the introduction of the Insurance Scheme.
3. CGEPHIS would be available on voluntary basis for the following:
 - a. Existing Central Government Employees and Pensioners who are already CGHS beneficiaries. In this case they have to opt out of **CGHS** scheme. They will also have the option of choosing both CGHS and Insurance policy. In such case the total insurance premium has to be borne by the member.
 - b. Existing Central Government Employees and Pensioners who are not CGHS beneficiaries but are covered under CS (MA)

Rules. Pensioners are however not covered under CS(MA) Rules.

3. TARGET GROUP:

All personnel of the Central Government including All India Service officers, serving and retired, and others who are covered under the existing CGHS and under CS (MA) Rules shall be offered the Health Insurance Scheme. **It is estimated that approximately 17 lakh serving employees and 7 lakh pensioners** shall be offered this Scheme on compulsory / optional basis.

4. 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 Empanelled Hospitals/ Nursing Homes (24 hours admission clause) within the country, arising out of either illness/disease/injury and or sickness.

NOTE:

In case of organ transplant, the expenses incurred for the Donor are also payable under the scheme.

- 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.
- c) Pre & Post hospitalization benefit:** Benefit up to 30 days Pre Hospitalization & up to 60 days Post Hospitalization respectively which would cover all expenses related to treatment of the sickness for which hospitalization was done.
- d) Domiciliary Hospitalization:** The Scheme would also cover Domiciliary Hospitalization where the medical treatment for such illness/disease /injury requires as in-patient treatment at empanelled 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 empanelled Hospitals/Nursing home within that area.

Note: Pre and Post hospitalization benefit under this section would not be covered.

e) 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 (less than 24 hours hospitalization) for such identified procedures. OPD services shall not be part of Day Care facilities.

1. Eye Surgery
2. Lithotripsy (kidney stone removal)
3. Tonsillectomy
4. D&C
5. Dental surgery following an accident
6. Surgery of Hydrocele
7. Surgery of Prostrate
8. Few Gastrointestinal Surgery
9. Genital Surgery
10. Surgery of Nose/Throat / Ear
11. Surgery of Urinary System
12. Dialysis
13. Chemotherapy
14. Radiotherapy
15. Treatment related to dog bite/snake bite etc.
16. Treatment of fractures/dislocation, Contracture releases and minor reconstructive procedures of limbs which otherwise require hospitalization
17. Laparoscopic therapeutic surgeries that can be done in day care

18. Identified surgeries under General Anesthesia or any procedure mutually agreed upon between insurer and health care provider.

Note: Insurers will provide the exhaustive list of Day care procedures.

f) The expenses incurred for treatment taken in empanelled Hospitals/ Nursing Homes /Day Care Clinics by the beneficiaries suffering from **such disabilities** as defined in “Section 2 (i) of the person with disabilities (equal opportunities, protection of rights and full participation) Act, 1995 (No: 1 of 1996)” 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.

g) 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 empanelled 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, twins are born than the benefit will cease for second pregnancy. However, in second pregnancy 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.

5. FAMILY SIZE:

1. Serving/Retired Employees: Self, Spouse, Two dependent children and **up to Two** Dependent Parents. 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 CGEPHIS 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 CGEPHIS benefits.

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

2. Any additional dependent member in addition to above [Sr. No. 5 (1)] can be covered under the Scheme by paying the fixed amount of premium. This additional full premium shall be borne by the beneficiary.

3. All Members (Serving/Retired Employees) shall be insured till they are the member of the scheme unless withdrawn from the Scheme.

A. Age limit of dependent for the purposes of CGHS and CS (MA)

Rules 1944 includes:-

1. **Son** - Till he starts earning or attains the age of 25 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** – As per condition of eligibility.

B. Income limit for dependency of family members – If monthly income from all sources of income is less than Rs. 3,500/- per month plus dearness allowance of the family member, then the following would be entitled to be treated as dependant on the employee:

1. Parents
2. Sisters
3. Widowed Sisters/Widow Daughter –in-law.
4. Widowed / Divorced / Separated Daughters,
5. Brothers
6. Step mother
7. Children.

NOTE:

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

C.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 CGEPHIS beneficiary (requiring inclusion of spouse's name), or

b) Parents becoming dependants.

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)

D.New Employees/Retirees

a) As regards the new incumbents/pensioners the coverage in the insurance scheme is compulsory. The data of such employees/pensioners will be collected from the various departments.

b) The Pay and Account Offices of all the Ministries/Departments would provide the data to the insurer. Each of the New Employee/Pensioners of the Ministry/Department would be provided with the enrolment form which needs to be filled in and submitted to the respective Ministry which will consolidate all the forms and forward the same to the Nodal Officer/Ministry on monthly basis.

c) The said employees would have to be covered in the Insurance Scheme from the date of joining/retirement. 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.

6. 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 CGEPHIS members. This card would be used across the country to access Health Insurance Benefits. The photograph embedded in the chip of the Smart Card will be taken as the proof for determining the eligibility of the beneficiaries.

7. 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 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 lakh can be availed by one individual or collectively by all members of the family.

B. BUFFER / CORPORATE SUM INSURED:

An additional Sum Insured of **Rs.25 Crore** 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 lakhs**. Insurer is required to inform the Nodal Agency with the details on case to case basis.

8. PAYMENT OF PREMIUM:

As the policy would be renewed every year, there is an element of uncertainty in the level of premiums depending upon the actual number of enrolment and claims submitted and the inflow into the fund.

To ensure a certain degree of stability in premiums at least for a period of 3 to 5 years, Insurers will quote the premium for various ranges.

- I.** These numbers will consist of both serving and retired employees.
- II.** 1, 00,000 persons shall be taken as assured beneficiaries for the first year to calculate the estimated premium to be paid to the insurer.
- III.** If the number of beneficiaries exceeds the first slab, in such case the premium shall be adjusted retrospectively according to eligible stage in which beneficiaries number will fall.
- IV.** L-1 will be considered from the first slab of 1, 00,000 assured beneficiaries. However, in next slabs, best lowest offer shall be

picked up from the financial quotes given by the bidder in their financial bid and shall ask the L-1 to match the same.

- V. Loading needs to be quoted by the insurer based on the claim ratio mentioned below. However, slab wise best lowest loading offer shall be picked up from the financial quotes given by the bidders in their financial bid and shall ask the L-1 to match the same.

<u>Claim Ratio %</u>	<u>Loading %</u>
• Up to 100%	: Nil
• 101 to 120%	: %
• 121 to 140%	: %
• 141 to 160%	: %
• 161 to 180%	: %
• Above 180%	: %

NOTE:

- a) This includes the Management cost, intermediary cost and burning cost (claims paid and outstanding) etc. If claim ratio is less, the premium can be taken care by **refund clause mentioned at Sr. No. 9.**
- b) This premium will be paid to the Insurers for the beneficiaries to be enrolled during the policy period in case of new joiners / retirees and exiting employees/pensioners. This premium will also take care of the members inadvertence missed for any reasons.
- c) The enrolment period shall be for 180 days in the case of retired employees from the date of introduction of the Scheme. In this case, full premium shall be paid. No enrolment shall be allowed after 180 days from the date of introduction of the Scheme.
- d) In the case of new joiners and new retirees, the enrolment will continue throughout the year. In this case, premium will be paid on pro rata basis based on monthly calculation.
- e) Insurer will submit the details of the beneficiaries, in case the premium paid is utilized to the extent of 90%, enabling the GOI to

release the provisional premium to take care of the enrolment of beneficiaries for the remaining period of policy.

- f) Insurer will submit the statement along with the details of enrolment in a prescribed format to the agency on fortnightly/monthly basis.
- g) Reconciliation of premium paid to the insurance company would be carried out at the end of the year.

9. REFUND OF PREMIUM/ADJUSTMENT OF PREMIUM:

If there is a surplus after the pure claims experience on the premium (excluding Service Tax) at the end of the policy period, after providing 20% of the premium paid towards the Company's administrative cost, in the balance 80% after providing for claims payment and outstanding claims, 90% of the left over surplus will be refunded by the insure to the Central Government/Nodal agency within 30 days after the expiry of the policy period or shall be adjusted with renewal premium.

10. ELIGIBLE HEALTH SERVICES PROVIDERS:

Both Public and Private Health Providers which provide hospitalization and/or a Day Care Services would be eligible for inclusion under the CGEPHIS, subject to such requirements for empanelment as agreed between the Central Government and Insurers.

CGEPHIS 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 interested to join the CGEPHIS 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 (ISQua) as minimum eligibility criteria for empanelment of hospitals. In addition 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, Paediatrics, 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 150 or more beds with treatment facilities in at least three of following Super Specialties in addition to Cardiology& Cardio-thoracic Surgery and Specialized Orthopaedic 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).

NOTE - A:

- a) Such Hospitals/Nursing Homes/Day Care Clinics that obtained entry level pre accreditation certificate from NABH would also be eligible for empanelment under CGEPHIS.
- b) The Hospitals/Nursing Homes/Day Care Clinics which are already empanelled under CGHS, if, desires to be get empanelled under CHEPHIS and are not accredited by **NABH/JCI/ACHS/ ISQua** are required to apply for NABH accreditation within two months from the date of empanelment under the Scheme as per criteria mentioned below at “**A**” (Criteria for Empanelment of Private Hospitals/Nursing Homes/Day Care Clinics in addition to the NABH /JCI / ACHS / ISQua/ NABL criteria). A certificate confirming to apply with NABH within the stipulated period should be given by the hospital while getting empanelled under CGEPHIS.
- c) Any Hospitals/Nursing Homes/Day Care Clinics not applying to NABH within stipulated period shall be automatically de-paneled from the Scheme.
- d) In addition, the empanelled Hospitals/Nursing Homes/Day Care Clinics having in-house diagnostic Laboratories or using the linked diagnostic laboratories shall also apply for National Accreditation Board for Testing & Calibration Laboratories (**NABL**) certification of the Laboratory as per condition.

Note - B:

- 1) Hospitals/Nursing Homes/Day Care Clinics that have already applied for /accredited under NABH/JCI/NABL shall inform the office of Insurer with supportive document.

- 2) Those applying to NABH/JCI for accreditation to join the CGEPHIS shall also agree to the CGHS package rates and to the clause 11-A and 11-B mentioned below.

A. Criteria for Empanelment of Hospitals/Nursing Homes/Day Care Clinics in addition to the NABH /JCI / ACHS / ISQua/ NABL criteria.

- i. Fully equipped and engaged in providing Medical and/ or Surgical facilities. The facility should have an operational pharmacy and diagnostic services. In case health provider does not have an operational pharmacy and diagnostic services, they should be able to link with the same in close vicinity so as to provide 'cash less' service to the patient.
- ii. Those Hospitals/Nursing Homes/Day Care Clinics undertaking surgical operations should have a fully equipped Operating Theatre of their own.
- iii. Fully qualified doctors and nursing staff under its employment round the clock.
- iv. Agreeing to the cost of packages for each identified procedures as approved under the CGHS scheme.
 - a) These package rates shall mean and include lump sum cost of inpatient treatment/day care/diagnostic procedures for which CGEPHIS 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 an illustrative one 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 CGHS ceiling rates for defined implants or as per actual, in case there is no CGHS prescribed ceiling rates.
- e)** Cost of External Equipments required for treatment as listed in CGHS scheme **(Appendix - A)** is payable in addition to package rates as per CGHS ceiling rates for defined External Equipments or as per actual, in case there is no CGHS prescribed ceiling rates.
- f)** Expenses incurred for treatment of new born baby are separately payable in addition to delivery charges to mother.
- g) Package rates envisage duration of indoor treatment as follows:**
 - Upto 12 days: for Specialized (super specialty) Treatment.
 - Upto 7 days: for other Major surgeries.
 - Upto 3 days: for Laparoscopic surgeries/ Normal delivery.
 - 1 day: for Day Care/ Minor surgeries

h) Entitlements for various types of wards: CGHS beneficiaries are entitled to facilities of private, semi-private or general ward depending on their pay drawn in pay band/ pension. These entitlements are amended from time to time and the latest order in this regards needs to be followed. The entitlement is as follows:-

S.No.	Pay drawn in pay band/Basic Pension	Entitlement
1.	Upto Rs. 13,950/-	General Ward
2.	Rs. 13,960/- to 19,530/-	Semi-Private Ward
3.	Rs. 19,540/- and above	Private Ward

1. Private ward is defined as a hospital room where single patient is accommodated and which has an attached toilet (lavatory and bath). The room should have furnishings like wardrobe, dressing table, bed-side table, sofa set, carpet, etc. as well as a bed for attendant. The room has to be air-conditioned.

2. Semi Private Ward is defined as a hospital room where two to three patients are accommodated and which has attached toilet facilities and necessary furnishings.

3. General ward is defined as a hall that accommodates four to ten patients.

NOTE:

a) Treatment in higher Category of accommodation than the entitled category is not permissible.

b) The package would cover the entire cost of treatment of the patient from date of admission to his/ her discharge from hospital and any complication while in hospital, making the transaction truly cashless to the patient as per CGHS package rates.

c) The applicable CGHS rates under the Scheme would be for the policy period and shall not be amended during the currency of

the policy. Rates for such procedures which are not in the CGHS list, can only be considered, if, finalized during the policy period.

- d)** Procedures will be subject to Cashless services and a pre-authorization procedure, as per **Clause – 11**.
- e)** Districts may be clubbed under respective State/Zones by the Central Government for the application of CGHS package rates.
- v)** Maintaining the necessary records as required and the Insurer or his representative/Central Government/Nodal Agency will have an access to the records of the insured patient.
- vi)** Allowing the Insurer or his representative / Central Government / Nodal Agency to visit, carry out the inspection as and deemed fit.
- vii)** The Private Empanelled Hospitals/Nursing Homes/Day Care Clinics **be legally responsible for user authentication**.
- viii)** Telephone, Fax, Scanner and have atleast 256 KBPS broadband internet connectivity. Each empanelled Hospital/Nursing Home/Day Care Clinics shall possess a Personal Computer with 2 smart card readers. These empanelled Hospitals/Nursing Homes/Day Care Clinics must have the capacity to submit all claims / bills in electronic format to the Bill Clearing Agency and must also have dedicated equipment, software and connectivity for such electronic submission. **NIC concurrence is required.**

B. Additional Benefits to be Provided by Empanelled 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 CGEPHIS beneficiaries:

- 1)** Free OPD consultation including pre and post hospitalization consultation.

- 2) Has to display its status of being a preferred provider of CGEPHIS at the reception/admission desks and to keep the displays and other materials supplied by the Insurer for the ease of beneficiaries, Central Government and Insurer.
- 3) Agrees to provide a separate help desk headed by paramedical for providing the necessary assistance round the clock to the CGEPHIS beneficiary.

C. Delisting of hospitals:

Empanelled Hospitals/Nursing Homes/Day Care Clinics would be de-listed by the Insurer from the CGEPHIS network, if, it is found that guidelines of the Scheme are not followed by them and services offered are not satisfactory as per laid down standards.

11. CASHLESS ACCESS SERVICE:

The Insurer has to ensure that all CGEPHIS 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 along with subject to responsibilities of the Insurer as detailed in this clause is collectively referred to as the “**Cashless Access Service.**”

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, i.e., not specifically excluded under the scheme.

A. Pre-Authorization for Cashless Access in case of Emergency/Planned Hospitalization for Listed /Non Listed packaged procedures:

Packaged procedures would mean the rates for various procedures approved by the CGHS 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.

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:

Request for Authorization shall be forwarded by the Empanelled Hospitals/Nursing Homes/Day Care Clinics after obtaining due details from the treating doctor in the prescribed format i.e. **“Request for Authorization Letter” (RAL)**. The RAL needs to electronically send to the 24-hour Authorization /Cashless department of the Insurer along with contact details of treating physician, as it would ease the process. The medical team of Insurer would get in touch with treating physician, if necessary.

- a. The RAL (Request for Authorization Letter) should reach the Authorization Department of Insurer within 6 hrs of admission in case of emergency or within 3 days prior to the expected date of admission, in case of planned admission.
- b. In failure of the above “clause a”, the clarification for the delay needs to be forwarded along with RAL by the Empanelled Hospitals/Nursing Homes/Day Care Clinics.
- c. **Treatment code is required** to be selected from the packaged procedures and mentioned in RAL in case of listed procedure.
- d. The RAL form should be dully filled **in all cases** with clearly **mentioned Yes or No**. There should be **no nil, or blanks**, which will help in providing the outcome at the earliest. Along with RAL copies of diagnostic test reports should also be forwarded electronically or the case may be.
- e. If, given medical data is not sufficient for the medical team of Authorization Department to confirm the eligibility, it will be responsibility of the Empanelled Hospitals/Nursing Homes/Day Care

Clinics to provide the complete details without any further delay, failing which it would be treated as violation of the norms.

- f.** 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.
- g.** Insurer guarantees payment only after receipt of RAL and the necessary medical details. Only after Insurer has ascertained the rates as per CGHS prescribed rates and or negotiated the packages (if no rates are fixed by CGHS), with provider, shall issue the Authorization Letter (AL). This shall be completed within 12 hours of receiving the RAL and response shall be sent by the insurer.
- h.** In case the ailment is not covered, insurer can deny the authorization. In such case it would be the responsibility of the Empanelled Hospitals/Nursing Homes/Day Care Clinics to inform the beneficiary accordingly.
- i.** The Insurer needs to file a report to Nodal Agency explaining reasons for denial of every such claim on day to day basis.
- j.** Authorization letter [AL] will mention the authorization number and the amount guaranteed as a CGHS package rates and negotiated rates for such procedure for which package has not been fixed earlier. Empanelled Hospitals/Nursing Homes/Day Care Clinics must see that these rules are strictly followed.
- k.** The guarantee of payment is given only for the necessary treatment cost of the ailment covered and mentioned in the request for Authorization letter (RAL) for hospitalization.
- l.** The entry on the Smart Card at the time of admission as well at discharge would record the authorization number as well as package amount for listed procedure and agreed package amount by the Empanelled Hospitals/Nursing Homes/Day Care Clinics and Insurer in case of non listed procedure. Negotiated package would be entered

manually by the hospital since this would not be available in the package list on the computer.

- m.** Having carried out these activities, 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 officials / departments as may be authorized by the MoHFW.

B. Business Contingency Plan (BCP) (Off Line Procedure)

In the event on-line system becoming inoperative for any reason, the insurer shall resort to the Business Contingency Plan by default (BCP).

On visit to an Empanelled Hospitals/Nursing Homes/Day Care Clinics, the beneficiary's details shall be verified. Once the identity of the beneficiary and/ or his/her family member is established by verifying the Photo Smart Card manually (**Xerox copy of the Smart Card shall be kept by the Empanelled Hospitals/Nursing Homes/Day Care Clinics for record purpose**) following procedure shall be followed for providing the health care facility listed/not listed in packages in addition to procedure **envisaged at Para 11 A:**

- a.** A manual pre-authorization form filled up and faxed to Insurer within 6 hours of admission along with copy of diagnostic reports.
- b.** The same shall be authorized within a turnaround time of not more than 12 hours.
- c.** Cashless treatment shall be given accordingly, without charging any money from the beneficiary.
- d.** On completion of treatment discharge documents are signed.
- e.** Having carried out these activities, 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 officials / departments as may be authorized by the MoHFW.

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

12. RUN-OFF PERIOD

A Run-Off period of one month 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 one month after the expiry of policy period, all such claims will be honored.

14. 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 Central / Nodal Agency for this purpose with a copy to the Beneficiary. All such claims shall be reviewed by the **Central Government** on monthly /quarterly basis.

15. ENROLMENT:

The enrolment of the beneficiaries would be undertaken by the Insurance Company selected by Central Government/Nodal Agency. The Insurer shall enroll the beneficiaries as per procedure laid down below and shall issue Photo Smart cards as per Central Government specifications and handover the same to the CGEPHIS beneficiaries.

- (a) The enrolment period in the first year shall be for 180 days in the case of retired employees and 60 days in case of serving employee.** However, in the case of new joinees and new retirees the enrolment will continue throughout the year.
- (b)** Insured will have the option to change the details regarding dependent beneficiary in the smart card; however the total number of dependents cannot be more than the number fixed at the time of renewal at designated district Kiosk setup by the insurer within 60 days prior to the expiry period of the policy.
- (c)** The Insurer will arrange for preparation of the Photo Smart Card as per the Guidelines provided.

- (d)** At the time of delivering the smart card, the Insurer shall provide a booklet along with Photo Smart Card to the CGEPHIS 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 centre. To prevent damage to the smart card, a plastic jacket should be provided to keep the smart card.
- (e)** If the smart card is lost within the policy period then beneficiary can get a new card issued at the designated District Kiosk, by paying to the insurer, a pre-defined fee agreed by Central government/ Nodal Agency.
- (f)** To address the problems of incorrectness, functionality of cards etc and enrolment could not be done by the beneficiary for any reason; the same would be done at designated district kiosk by the insurer.
- (g)** Advance publicity shall be given by the Insurer and Central Government/Nodal Agency on Pan India basis.
- (h)** Insurance Company would carry out enrolment at agreed designated District office of the Insurer in case of Pensioners and scan document will be given for the purpose on the spot. In case of Serving Employees the data will be collected from Head of Department level. In both the cases photo Smart Cards along with the enrollment kit shall be sent by the insurers directly to the insured persons at their respective mailing addresses at insurer's cost.
- (i)** Insurance Company will also provide a web-based application, which would be available to Head of Departments of the Ministries/Departments. The empanelled Hospitals/Nursing Homes/Day Care Clinics and the beneficiaries shall have the access to the website to see their relevant information.
- (j)** Nodal Agency at the Health Ministry will also monitor data related to Insurance plan like enrolment etc through this website.
- (k)** The Scheme as well as the enrolment form would be put up on the web-site of the various Ministries/Departments on a permanent basis.

- (1) Any Employee / Pensioner who opts for the Insurance Scheme shall remain the member of the scheme with future renewals automatically awarded unless he/she opts out of the scheme. The beneficiary is required to submit the declaration to the MOH&FW for **discontinuation from the Scheme 90 days prior to expiry of the policy**. In such cases the benefits shall cease on the expiry of the policy.

ENROLMENT PROCESS

The process of enrolment shall be as under:

A. Serving Employees:

1. Departments and offices will call for options from employees to join voluntary CGEPHIS with or without existing CGHS/CS (MA) benefits.
2. Head of Department of the Administrative Ministry/Department would be the contact point for the Insurance Companies.
3. Enrolment forms giving details about self and family and authorization to the department for recovery of premium on a monthly basis would be consolidated by the Administrative Ministry/Department. The data of the beneficiary and dependent members to be covered along with 2 recent passport size photo and copy of enrolment form will be forwarded to Insurance Company on monthly basis.
4. Insurance Company will issue Smart Cards on the basis of information received of the beneficiaries for enrolment.
5. Such Smart Cards along with the enrollment kit shall be sent by the insurers directly to the insured persons at their respective mailing addresses at insurer's cost within 7 days.

B. Retired Employees:

1. In case of Retired Employees, wide publicity of the Scheme should be given through various media sources like advertisement in local newspapers, Cable network etc.
2. A notice would be posted in the pension paying branches (approximately 30,000 in numbers) / post offices giving details of proposed Scheme.

3. Information can also be disseminated through pensioners associations and other related agencies.
4. Enrolment forms would be made available with Pension Paying Branches/ Post Offices as well as on the website of the Departments/ Ministries.
5. The enrolment process for the pensioners shall continue as per schedule agreed by the Government/Nodal Agency. Insurer in consultation with the Central Government/Nodal Agency/shall chalk out the enrolment programme by identifying enrolment stations at Insurers district offices during fixed period to complete the task in scheduled time.
6. Retired employees opting for the scheme would fill up the enrolment form giving details relating to self and dependent members along with the proof of self and dependents as per CGEPHIS Guide Line along with 2 recent passport size photos each at Insurers district offices for enrolment under the scheme along with his /her **first contribution** by cheque only.
7. The enrolment form would be accompanied by authorisation form to the pension paying agency to debit contribution of his/her future premium for the purpose of continuing as a member of the Insurance Scheme.
8. Insurance companies will issue scanned Photo document to pensioners on the basis of information received at the time of enrolment of the beneficiaries. Photo Smart Cards along with the enrollment kit shall be sent by the insurers directly to the insured persons at their respective mailing addresses at insurer's cost.
9. Copy of enrolment form along with the authorization form would be sent to **Central Pension Accounting Office** for preparation of the data. Central Pension Accounting Office will pass on the authorization form of the pensioners to the respective pension paying units for deduction of premium for future renewals.

10. Limited access to the database available with the Central Pension Accounting Office/ MOHFW would be available to the Insurance Company.

B. For Future Employees and Pensioners:

- a. All future employees and future pensioners shall necessarily be covered under CGEPHIS.
- b. At the time of their entry into or retiring from service they are required to carry out certain documentary formalities at their respective places of posting and the ministry. Enrollment into CGEPHIS shall be dovetailed to such activities and the documentation for the same shall be made an integral part of the entry / exit exercise.
- c. The insurer shall have to provide enrolment forms (printed as well as soft versions) at all such locations.
- d. Employee shall fill up form enrolment form, authorization form for deducting the contribution and submit 2 recent passport size photographs of the family each (individual) to DDO/ Nodal Officer.
- e. Insurer shall arrange to collect the enrolment form & family photograph from the respective DDOs/ Nodal Officers under acknowledgement.
- f. After required processing, all relevant data shall be uploaded on the server and smart cards shall be issued by the insurers.
- g. Such Smart Cards along with the enrolment kit shall be sent by the insurers directly to the insured persons at their respective mailing addresses at insurer's cost.
- h. The insurance cover shall be effective from the date of joining or retirement of an employee.
- i. All these activities shall have to be uploaded on the insured's server on a read-only access, a link, shall be provided to the officials / departments as may be authorized by the MoHFW.

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

- Empanelment of the Hospitals/Nursing Homes/Day Care Clinics
- Setting up of District Kiosk
- Prepare the enrollment kit and get it approved by the Government.

16. SPECIFICATIONS FOR SMART CARDS AND SOFTWARE: NIC concurrence is required.

The Smart Cards to be used must have the valid Compliance Certificate from National Informatics Centre, New Delhi. The specifications of the smart card are listed as below.

- Microprocessor based Integrated Circuit(s) card with Contacts, with minimum 64 Kbytes available EEPROM.
 - Compliant with **ISO/IEC 7816-1,2,3** and **SCOSTA 1.2b/SCOSTA-CL 1.2** with all latest errata and addendum (ref. <http://scosta.gov.in>).
 - Must have a valid SCOSTA or SCOSTA-CL Compliance Certificate from NIC.
 - Supply Voltage 3V or 5V – nominal.
 - Protocol T=0 or T=1.
 - Data Retention minimum 10 years.
 - Write cycles minimum 300,000 numbers.
 - Chip Temperature Range -25 to +70 Degree Celsius.
 - Operating Temperature Range -25 to +55 Degree Celsius.
 - Composite layered Construction of PETG (middle layer) and PVC (outer layers). Ratio of PETG and PVC content should be 50% each.
 - Surface – Glossy with pre printed content as provided by Department.
- a.** Smart Card shall be the property of the Central Government and shall be insurer-neutral. The insurer shall have no proprietary rights over it and, therefore, shall not be entitled to place its name, logo etc. on the same.

- b.** The Smart Card Chip Memory File System and Layout shall be provided by MoH/NIC.
- c.** The Smart Card Visual Zone layout shall be designed by the shortlisted bidder and approved by MoH.
- d.** Insurer shall provide following Smart Card related software and services,
 - i.** Smart Card Sourcing as per the specifications given above.
 - ii.** Smart Card Personalization as per the Layout provided by MoH.
 - iii.** Smart Card Key Management System as per MoH/NIC wetted architecture.
 - iv.** Developing all Smart Card based Transaction applications as per MoH/NIC wetted architecture.
- e.** The card shall universal acceptability, across the country, by all empanelled hospitals / nursing homes/Day care clinics in the insurer's panel.
- f.** To address the problems of incorrectness and functionality of cards, the insurers shall be required to open kiosks in all major cities as may be advised by the MoHFW.
- g.** Preparation of transaction systems, mechanism for data transfer, and establishment of district kiosks and uploading of MIS on the websites advised by the MoHFW shall be the responsibility of the insurer.

17. 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:

A. Hospitalization Benefits:

1) Conditions that do not require hospitalization:

- a) Condition that do not require hospitalization. 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 primarily for evaluation / diagnostic purposes only during the hospitalized period. Expenses on vitamins and tonics etc unless forming part of treatment for injury or disease as certified by the attending physician. Expenses on telephone, tonics, cosmetics / toiletries, etc.

2. Any dental treatment or surgery which is corrective, cosmetic or of aesthetic procedure, including wears and tears etc. unless arising from disease or injury which requires hospitalization for treatment including following dental treatment which indicates that the teeth are the real source of disturbance.

- a) Jaw bone disease treatment
- b) Wholesale removal of teeth
- c) Surgical operations needed for removal of Odontomes and impacted wisdom tooth
- d) Gum boils under oral surgery.
- e) Treatment of pyorrhea and Gingivitis may also be reimbursed as it is covered under the term “Gum treatment”.
- f) Extraction,
- g) Scaling and Gum treatment
- h) Filling of teeth
- i) Root Canal treatment.

3) Congenital external diseases etc: Congenital External Diseases or Defects or Anomalies, Convalescence, General Debility, “Run Down” condition or Rest Cure.

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

5) 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. Cost of Spectacles / Contact Lens.

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

7) 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.

8) External and/or durable Medical/Non-medical equipment of any kind used for diagnosis and/or treatment except covered under CGHS scheme.

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.

18. INFRASTRUCTURE OF INSURER

Insurer shall establish an exclusive Project Office at convenient place for coordination with the Central Government/Nodal agency at the National level. The project office shall coordinate with Central Government/Nodal

Agency on a daily basis and ensure effective implementation of CGEPHI Scheme. Accordingly, Insurer will also have the dedicated unit at Zonal/State and district level.

The Project Manager shall be appointed within 7 days and the project office shall be placed by the Insurer at New Delhi within 30 days of signing of the contract having sufficient people with appropriate qualification and experience to perform various functions.

19. 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.
- b)** The information shall be available on real time basis on Insurers Website and shall also be uploaded on central server for MoHFW's use and analysis and uploading on its web portal. For this purpose to provide for a Central Govt. Server under MoHFW where real-time data pertaining to District/State wise Enrolment status, Claims, Treatments rendered, Hospitals Data etc can be uploaded by the Insurance Company on periodical basis. Claims, Treatment data etc shall automatically updated on the Insurer state server as & when the details are punched at Hospital level.
- c)** Insurer will also upload such data required by MOHFW.

20. CALL CENTER SERVICES

The Insurer shall provide dedicated telephone services for the guidance and benefit of the CGEHIS 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 Information

The Insurer shall operate a Call Centre 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. 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 CGEPHIS.
- c)** General guidance on the CGEPHIS.
- 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.

II. Language

The Insurer undertakes to provide services to the Insured Persons

in English and local languages.

III. Toll Free Number/Fax Number

- a) The Insurer will operate a dedicated National Toll Free number with a facility of a minimum of 10 lines. The cost of operating of the number shall be borne solely by the Insurer. The toll free numbers will be restricted only to the incoming calls of the clients only. Outward facilities from those numbers will be barred to prevent misuse.
- b) The Insurer will operate a dedicated National Toll Free Fax. The cost of operating of the number shall be borne solely by the Insurer.

IV. Insurer to inform Beneficiaries

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.

21. 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 Health Care Provider/Care Provider 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 Central Government

A dispute between the Central 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.

- The law governing the arbitration shall be the Arbitration and Conciliation Act, 1996 as amended or re-enacted from time to time.
- The proceedings of arbitration shall be conducted in the English language.
- The arbitration shall be held in New Delhi, India.

22. AGREEMENTS:

- a) Service Level Agreements (SLAs)/MOUs shall be signed with Insurance Companies and proper mechanism for ensuring compliance established including penalty clauses.
- b) Insurer will also enter into SLAs/MOUs with other intermediaries for ensuring compliance established including penalty clauses.

23. TERM & TERMINATION OF AGREEMENT BETWEEN INSURER & CENTRAL 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 Central Government to terminate the Agreement, on the basis of review of the performance of the INSURER before the same period. The Central 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 Central Government at the bidding and implementation stage of the Scheme; and
- h) Such other factors as the Central Government deems fit.

The Agreement may be terminated:

- a) By the Central 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:

- a. The Insurer will pay back to the Central 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.
- b. If the insurer fails to do as per clause above, the insurer will pay the Central Government, the total package amount for all the cases for which preauthorization has been given, but claim not settled.
- c. In addition to above the Insurer shall pay interest at the rate of 12% 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.
- d. The Central 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.

24. 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 CGEPHIS 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 as specified percentage on total premium shall be payable by them to the Govt. of India for the period of delay.

25. NODAL MINISTRY:

- a) The Ministry of Health & Family Welfare would be the Nodal Agency for the implementation of CGEPHIS.
- b) A Coordination Committee having the representatives from Ministry of Health & Family Welfare, Ministry of Finance and Department of Administrative Reforms & Public Grievances for monitoring the implementation of the Scheme on a regular basis.
- c) Nodal Cell at the Health Ministry 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.

26. 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.
