PUNJAB GOVERNMENT EMPLOYEE'S & PENSIONERS HEALTH INSURANCE SCHEME

THE SALIENT FEATURES OF PUNJAB GOVERNMENT EMPLOYEES AND PENSIONERS HEALTH INSURANCE SCHEME

1. BENEFICIARIES:

All personnel of the **Punjab Government including All India Service officers, Serving, Newly Recruited, Retired and Retiring** who are covered under the existing Punjab Medical Attendant Rules [CS(MA) Rules, 1940] shall be offered **Health Insurance Scheme on compulsory or on optional basis as indicated below:**

a. **PGEPHIS** shall be **compulsory to all serving Punjab Government Employees and Pensioners** (herein after referred to as "Serving Employees and pensioners") who are presently covered under the existing Punjab Medical Attendant Rules [CS (MA) Rules, 1940].

Serving Employees and Pensioners shall have to mandatorily submit their Enrollment Form within the duration of Enrollment Period. In an event of their failure to get enrolled under the Scheme during the Enrollment Period, they shall be able to get enrolled in the subsequent renewal/ policy plan period of PGEPHIS. No fresh enrollment of the Serving Employees and Pensioners shall be allowed after the date of expiry of Enrollment Period except for any exceptional circumstances, under which coverage as well as payment of premium of such employees/pensioners shall be allowed on pro-rata basis (herein after referred to as employee/pensioner under exceptional circumstances).

b. **PGEPHIS** shall also be **compulsory to new Punjab Government Employees** who would be joining after the date of expiry of Enrollment Period of the scheme (hereinafter referred to as "New Employees"). The enrollment of new employees, who join after the date of after the date of expiry of Enrollment Period, shall continue throughout the policy plan period. The coverage as well as payment of premium of new employees shall be on pro rata basis, for the remaining period of policy plan period from the date of their joining in the service. In an event a new employee avails hospitalization during the intervening period between his/her date of joining in the service and his/her enrollment, the new employee shall be entitled to receive treatment at the provider network on the reimbursement basis as per the package rates defined under the Scheme, subject to submission of bills/ claim within prescribed time period.

c. PGEPHIS would be available on **voluntary**/ **optional basis** for the following categories:

- All IAS & IPS officers serving in the State- serving and retired who are covered under the existing Punjab Medical Attendant Rules [CS(MA) Rules, 1940].
- Serving & Ex-MLAs,

- Serving and Ex-Judicial officers including judges of Punjab & Haryana High Court,

In order to enroll under PGEPHIS, the beneficiaries falling under the category for which the scheme is available on optional basis, if covered under the existing Medical Attendant Rules, will have to opt out of the current reimbursement system, if applicable. Those who wish to opt for PGEPHIS shall exercise their option/ choice at the time of filling the Enrollment Form within the stipulated Enrollment Period. Those who do not opt for PGEPHIS during the duration of Enrollment Period, shall be able to exercise their option in the subsequent renewal/ policy plan period of PGEPHIS. No fresh enrollment of the beneficiaries falling under categories, for which the scheme is available on optional basis, shall be allowed after the date of expiry of Enrollment Period.

2. TARGET GROUP/ STATUS

Category	Applicability	Premium Liability
Serving Employees & Pensioners	Compulsory	State
After the closer of enrollment period New employees and employees/pensioners under exceptional circumstances.	Compulsory	State (On pro rata basis)
All India Service officers, Serving & Ex-MLAs, Serving and Ex-Judicial officers including judges of Punjab & Haryana High Court	Optional	State

Note :

In case husband and wife both are in Punjab Government job or one of them is retiree from Punjab Government, either one of them is eligible for the scheme. However, in case any employee/pensioner is taking medical reimbursement (as a dependent of spouse) from other source, he/she will not be eligible under the PGEPHIS.

3. INSURANCE COVERAGE:

The PGEPHIS will cover the indoor/ daycare entitlements as specified under the State Services(Medical Attendant Rules) [CS(MA)] Rules, 1940, except for exclusions and other things specified in PGEPHIS.

a) In-patient benefits – The Insurance Scheme shall pay all expenses incurred in course of medical treatment availed by the beneficiaries in the empanelled hospitals/ nursing homes (24 hours admission clause) within the country, arising out of any 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: Benefits up to 7 days Pre Hospitalization & up to 30 days Post Hospitalization respectively which would cover all expenses related to treatment of the sickness for which hospitalization was done. The beneficiary shall avail this benefit on cashless basis in empanelled hospitals. The pre and post hospitalization investigations shall be covered at CGHS Rates.

Coverage of Chronic Diseases: Medical reimbursement of bills against chronic diseases, that are covered under the existing Punjab Medical Attendant Rules [CS (MA) Rules, 1940] shall be admissible as long as either the patient is treated as indoor patient or as outdoor patient having valid "**Complicated chronic disease certificate". Complicated chronic disease certificate"** has to be issued by State Government Medical Colleges, PGIMER Chandigarh, AIIMS Delhi and GMCH Chandigarh. The beneficiary shall avail this benefit on cashless basis from designated stores and hospitals in every district and block of Punjab and Chandigarh.

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.

- Eye Surgery
- Lithotripsy (kidney stone removal)
- Tonsillectomy
- D&C
- Dental surgery following an accident
- Surgery of Hydrocele
- Surgery of Prostrate
- Few Gastrointestinal Surgery
- Genital Surgery
- Surgery of Nose/Throat / Ear
- Surgery of Urinary System
- Dialysis
- Parenteral Chemotherapy
- Radiotherapy
- Treatment related to dog bite/snake bite etc.
- Treatment of fractures/dislocation, Contracture releases and minor reconstructive procedures of limbs which otherwise require hospitalization
- Laparoscopic therapeutic surgeries that can be done in day care
- Identified surgeries under General Anesthesia or any procedure mutually agreed upon between Insurer/ TPA and Nodal Department.
- Coronary Angiography/ cardiac interventions done on daycare basis.

g) Maternity and Newborn Benefits:

a. Maternity benefit

- 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.

- 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

Newborn child (single/twins) to an insured mother would be covered from day one up to the expiry of the current policy plan period 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 the eligibility of the member as per definition of the family as defined under Punjab Medical Attendant Rule [CS (MA) Rules, 1940].

- 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.

- Congenital diseases of newborn child shall be covered.

h) The exclusions under the PGEPHIS shall be made available on reimbursement basis to the employees / pensioners as per existing policy and State Services (Medical Attendant Rules) [CS(MA)] Rules, 1940 as amended from time to time through Treasury route.

i) Any treatment taken abroad will not be covered under PGEPHIS. Any employee / pensioner will have to take overseas insurance cover before going abroad. Premium of such insurance cover will be borne by employee/pensioner. In case, any employee is going on Government tour, premium of such overseas insurance will be borne by the State Government.

j) Robotic Surgeries, Cochlear Implantation, liver transplantation and Stem Cell surgeries shall not be covered on cashless basis under the scheme. The employee/ pensioner will seek reimbursement as per the existing pattern to the extent of the State Medical Reimbursement Policy and procedures as per his/her entitlement under State Services (Medical Attendent Rules)[CS(MA)] rules, 1940

4. A. FAMILY SIZE:

a. The Scheme shall cover a family and dependents as defined under Punjab Medical Attendant Rules [CS (MA) Rules, 1940]. 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 PGEPHIS 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 PGEPHIS benefits.

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

b. All Members shall be insured till they are the member of the scheme unless withdrawn from the Scheme.

B. Age limit of dependent for the purposes of PGEPHIS includes:-

Age Limit of dependents shall be as defined under existing Punjab Medical Attendance Rules [CS (MA) Rules, 1940].

C. Income limit for dependency of family members –

Income Limit **for dependency of family members** shall be as defined under existing Punjab Medical Attendance Rules [CS (MA) Rules, 1940].

NOTE:

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

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

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

- Marriage of the PGEPHIS beneficiary (requiring inclusion of spouse's name), or
- 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)

E. New Employees

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

b) The respective department of the new employee would provide the data to the insurer. Each of the New Employee shall fill up the enrollment form and submit one recent passport size photograph of each of his/her

eligible family member including himself/herself to be enrolled, to the DDO of his/her department within 7 days of joining into the service.

c) In an event a new employee avails hospitalization during the intervening period between his/her date of joining in the service and his/her enrollment, the new employee shall be entitled to receive treatment at the provider network on the reimbursement basis as per the package rates defined under the Scheme, subject to submission of bills/ claim within prescribed time period.

c) The said employees would have to be covered in the Insurance Scheme from the date of joining. Thus for them the inclusion in the policy will be made by making payment of the pre defined monthly pro-rata premium rate which would be less than the yearly premium, if their date of joining into the service falls after the date of start of the policy.

5. IDENTIFICATION OF FAMILY:

Beneficiaries shall be identified by a "Photo ID Card" issued by the insurer/ TPA to all the beneficiaries which would contain Unique Health Identification Number (UHID No.) and all relevant details of the PGEPHIS members. This card would be used at the Provider Network to access 'Health Insurance Benefits. The photograph printed on the ID will be taken as the proof for determining the eligibility of the beneficiaries.

6. SUM INSURED AND BUFFER / CORPORATE SUM INSURED:

A. BASE SUM INSURED:

The Scheme shall provide coverage for meeting all expenses relating to hospitalization of beneficiary members up to Rs. 3,00,000/- per family per year in any of the Empanelled Hospital/Nursing Home/Day Care Unit subject to prescribed rates on cashless basis through Photo ID Cards. The benefit shall be available to each and every member of the family on floater basis i.e. the total cover of Rs. 3.00 lakh can be availed by one individual or collectively by all members of the family. In an event the sum insured of Rs 3 lacs per family is exhausted, the coverage of the family shall be met through the Buffer Sum Insured of Rs 25 Crore available to each and every beneficiary of the group, on group floater basis, to be maintained by the Insurance Company.

In an event the Buffer Sum Insured of Rs 25 crores gets completely exhausted, the cashless reimbursement more than Rs 3.00 lacs will not be available to any employee/ pensioner and the over and above expenses shall be met by the State Government as per the extent of the medical reimbursement policy and procedures. In such circumstances, the Insurance Company will inform the employee/pensioner that further treatment shall not be available on cashless but reimbursement basis as per existing pattern at PGI/ AIIMS rates and the employee/pensioner will seek the reimbursement over and above Rs. 3.00 lacs as per existing pattern to the extent of the medical reimbursement policy and procedures. The concerned DDO will seek the reimbursement from concerned Civil Surgeon/Directorate of Health & Family Welfare who will examine the bill as

per the entitlement of the claimant as per State Services (Medical Attendant Rules) [CS(MA)] Rules, 1940. If that particular bill(s) as per the entitlement(s) is less than Rs. 3.00 lacs then no amount will be reimbursed to the employee and if the bill(s) is more than Rs. 3.00 lacs then additional amount will be reimbursed to the employee through Treasury Route.

B. BUFFER / CORPORATE SUM INSURED:

An additional Sum Insured of Rs. 25 Crore shall be provided by the Insurer as Buffer/Corporate Floater. This will be used in case hospitalization expenses of a family exceed the base sum insured of Rs 3.00 lakhs. Insurer is required to inform the Nodal Department with the details on case to case basis electronically.

7. PAYMENT OF PREMIUM:

In case of serving employees/pensioners and mentioned as a opted category, the premium of the main member as well as dependent(s) (as defined in the State Services (Medical Attendant Rules) [CS(MA)] Rules, 1940) will be paid by the State Government.

8. ENROLLMENT PERIOD:

a) The enrolment period shall start with immediate effect from the date of notification of the Scheme and will be completed by 31-12-2015, except for i) "new employees", who shall be eligible to get covered under PGEPHIS after the date expiry of the enrollment period, w.e.f their date of joining into the service and ii) "employees/pensioners under exceptional circumstances", who shall be eligible to get covered under PGEPHIS after the expiry of the enrollment period and policy of employees/pensioners under exceptional circumstances" shall start after 30 days from the date of submissions of their enrollment form to the insurance company.

   Every employee/ pensioner will ensure his/her enrolment along with dependants before 15-12-2015 enabling the Insurance Company to deliver the enrolled insurance cards upto 31.12.15.

b) The insurance policy coverage/ Policy Plan Period shall commence from 1st January 2016 and will expire on midnight 12.00 am of 31-12-2016.

c) Beneficiaries under optional category as well as serving employees and pensioners, shall have to submit their enrollment forms through their DDOs within the enrollment period. Enrollment of such beneficiaries shall not be allowed after the expiry of the enrollment period.

d) The Scheme shall provide health insurance coverage to all the beneficiaries who submit their enrollment form within the enrollment period for a Policy Plan Period of twelve months initially.

e) In the case of new employees (employees joining after the expiry of enrollment period) and Employees/Pensioner under exceptional circumstances, the enrolment will continue throughout the policy plan period. In this case, coverage as well as payment of premium shall be allowed on pro-rata basis.

9. PERIOD OF INSURANCE AND PERIOD OF CONTRACT:

The Scheme will be introduced from the date agreed by the Punjab Government/ PHSC. The period of Insurance Contract will be effective from the date/ date of signing of SLA and shall expire three months after the date of expiry of policy plan period or at completion of all the obligations of the insurance company, whichever is later; subject to renewal of policy on yearly basis based on parameters fixed by the Punjab Government/ PHSC at its absolute discretion. Without prejudice to the unconditional and independent right of the Punjab government/ PHSC to take any suitable legal or other remedial measure, the Punjab Government/ / PHSC reserves the right to terminate the contract if the policy is not renewed in the subsequent year with the same Insurance Company, for any reasons whatsoever.

In case the contract is terminated after the expiry of the Policy Plan Period, the Insurer shall continue to remain liable for making payments in respect of all the claims lodged with it or the TPA in respect of all the claims/ invoices of Provider Network and Beneficiaries on or before the date of expiry of the policy plan period.

10. PROVIDER NETWORK:

10.1 The hospitals in Punjab, Chandigarh and NCR area (Gurgaon, Noida and Delhi), that shall be included for providing medical facilities to the Beneficiaries under the Scheme shall be identified by the Insurer or by the TPA appointed by the Insurer, as per the prescribed minimum qualifying criteria of the hospitals and shall be empanelled by the TPA after seeking prior approval from the State Government/ PHSC. The Government Hospitals, Government Medical College, / Research Institutes located in Punjab, Chandigarh and NCR area (Gurgaon, Noida and Delhi) shall be automatically included in the Provider Network.

10.2 Modus Operandi to be followed for treatment at various Network Hospitals for all types of treatment shall be as under:

i) **For private hospitals in Punjab, Chandigarh &Panchkula** : Rates shall be determined in accordance with the PGEPHIS Schedule of Rates. For treatments that have not been mentioned in the PGEPHIS rates, the rates applicable shall be either CGHS Rates or negotiated rates with the hospital whichever is less.

ii) **For Govt. hospitals in Punjab & Chandigarh :** Rates shall be determined in accordance with the PGEPHIS Schedule of Rates, fixed by the Nodal Department/ State Government. For treatments that have not been mentioned in the PGEPHIS rates, the rates shall be internal rates of the respective Govt. Hospital. The treatment provided shall be essentially on cashless basis, however in cases where cashless services has not been rendered by the hospital, due to any reasons whatsoever; the beneficiary shall be eligible for reimbursement, subject to submission of the claim to the TPA within 30 days from the date of discharge from the hospital. The

reimbursement shall be made at Govt Hospital rates or PGEPHIS Rates, whichever is less.

iii) **For PGIMER, GMCH-32 and State Medical Colleges:** The Internal rates of respective hospital/institution shall be applicable. The treatment availed by the beneficiary shall be on reimbursement basis, subject to submission of the claim to the TPA within 30 days from the date of discharge from the hospital. The reimbursement shall be made at respective Govt Hospital rates, where treatment is taken or PGEPHIS Rates, whichever is less.

iv) **For private hospitals in NCR area (Gurgaon, Noida and Delhi):** The CGHS-New Delhi rate shall be applicable. The treatment availed by the beneficiary shall be on reimbursement basis, subject to submission of the claim to the TPA within 30 days from the date of discharge from the hospital.

The treatment provided shall be essentially on cashless basis, however in cases where cashless services has not been rendered by the hospital, due to any reasons whatsoever; the beneficiary shall be eligible for reimbursement at the CGHS rates or the hospital rates, whichever is less, subject to submission of the claim to the TPA within 30 days from the date of discharge from the hospital.

v) **For Govt. hospitals in NCR area (Gurgaon, Noida and Delhi):** The internal rates of the respective Govt. hospital shall be applicable. The treatment availed by the beneficiary shall be on reimbursement basis, subject to submission of the claim to the TPA within 30 days from the date of discharge from the hospital. . The reimbursement shall be made at the respective Govt Hospital rates, where treatment is taken or PGEPHIS Rates, whichever is less.

vi) **For Private Hospitals in remaining parts of the country:** The reimbursement to the beneficiary against the claim of the treatment availed in the private hospital located anywhere in India except Punjab, Chandigarh and NCR area (Gurgaon, Noida and Delhi), shall be made in accordance with the PGEPHIS rates, irrespective of the actual expenditure incurred by the beneficiary. For treatments that have not been mentioned in the PGEPHIS rate list, the reimbursement shall be made in accordance with the PGIMER Rates, Chandigarh.

vii) **For Govt Hospitals in remaining parts of the country:** The reimbursement to the beneficiary against the claim of the treatment availed in the Govt hospital located anywhere in India except Punjab, Chandigarh and NCR area (Gurgaon, Noida and Delhi), shall be made in accordance with the internal rates of the respective Govt. hospital OR PGEPHIS rates, whichever is lower.

10.3 A) Both Public and Private Health Providers which provide hospitalization and/or a Day Care Services would be eligible for

inclusion under the PGEPHIS, subject to such requirements for empanelment as agreed between the Punjab Government/ PHSC and Insurers. PGEPHIS aspires to provide to all its beneficiaries high quality medical care services that are affordable. The private hospitals shall be empanelled by the TPA/ Insurer, for providing cashless treatment, in Punjab, Chandigarh and NCR area (Gurgaon, Noida and Delhi). The Hospitals/Nursing Homes/Day Care Clinics interested to join the PGEPHIS should be preferably 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. Such Hospitals/Nursing Homes/Day Care Clinics should comply with the following minimum qualifying criteria:

- Should have at least 25-bed indoor treatment capacity along with full fledged Operation Theatre and Intensive Care Unit. Eye Hospitals catering to OPD procedures such as cataract and other eye surgeries, which are covered under the Scheme, may have less than 25 beds.

- Should have atleast three permanent M.B.B.S doctors and at least one postgraduate doctor (M.D/M.S) on its roll. The Hospital should also have atleast one DM/ MCh Doctor for the each super speciality catered to by the Hospital.

- Should have atleast three permanent trained nurses, who are registered with nursing council of India, on its roll.

- Should have facility of in-house pharmacy and pathological lab or tie-ups for pathological tests/pharmacies to ensure completely cashless treatment of the Beneficiaries.

- Should have the facility of 24 hrs nursing staff/medical staff consisting of fully qualified doctor(s), round the clock and 24hrs admission facility.

- Shall agree to the rates/duration of stay for various procedures as mentioned in PGEPHIS Schedule of Rates.

- Shall install necessary infrastructure such as computer, fax machine, software, hardware at its own cost etc for implementing e-preauthorization and facilitating online transmission of radiological images/ modalities and identify minimum two coordinators to coordinate with patient, treating doctor, TPA and billing department of the hospital.

- Shall provide preferred and priority admission to the beneficiaries and ensure that hospitalization of the members is completely cashless i.e. arrange for funds for the medicines/investigations not available with the hospital or have necessary tie-up with the diagnostic centers/pharmacies for the facilities not available in the hospitals.

B) General purpose hospital having 25 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, Imaging facilities , in house laboratory facilities and Blood Bank.

C) Specialty hospitals (specialties list given below) Hospitals having less than 50 beds can apply as a specialty hospital -provided they have at least 10 beds earmarked for the specialty applied for with at least 15 additional beds – Thus under this category a single specialty hospital would have at least 25 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
- Gynaecology and Obstetrics

D) 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.

E) Cancer hospitals having minimum of 50 beds and all treatment facilities for cancer including radiotherapy (approved by BARC / AERB). Already empanelled hospitals for Cancer treatment in the State will continue to be empanelled hospitals.

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 PGEPHIS.

b) The Hospitals/Nursing Homes/Day Care Clinics which are already empanelled under CGHS in Punjab, if, desires to be get empanelled under PHEPHIS shall be eligible for empanelment under the Scheme.

c) 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.

d) The diagnostic labs setup in the district hospitals under PPP mode shall be covered under the scheme.

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 PGEPHIS shall also agree to the PGEPHIS package rates and to the clause 10.4-A and 10.4-B mentioned below.

10.4 (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 ltie-up 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 PGEPHIS scheme.

a) These package rates shall mean and include lump sum cost of inpatient treatment/day care/diagnostic procedures for which PGEPHIS 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, IRC charges of listed investigations, Anesthesia charges, Preanesthetic 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 Punjab Medical Attendance Rules for defined implants or as per actual, in case there is no prescribed ceiling rates.

e) Cost of External Equipments required for treatment as permissible under PMA Rules is payable in addition to package rates subject to ceiling rates for defined External Equipments under Punjab Medical Attendance Rules or as per actual, in case there is no 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:** Beneficiaries shall be 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:-

Sr.No.	Group of Employee	Entitlement
1	Group-D	General Ward
2	Group-B&C	Semi-Private Ward
3	Group-A	Private Ward

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 PGEPHIS package rates.

c) The applicable PGEPHIS 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 PGEPHIS list, can only be considered, if, finalized during the policy period.

d) Procedures will be subject to Cashless services and a preauthorization procedure, as per Clause – 12.

v) Maintaining the necessary records as required and the Insurer or its representative/State Government/Nodal Department will have an access to the records of the insured patient.

vi) Allowing the Insurer or its representative / State Government / Nodal Department 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) Has to display its status of being a preferred provider of PGEPHIS at the reception/admission desks and to keep the displays and other materials supplied by the Insurer for the ease of beneficiaries, State Government and Insurer.

ix) Agrees to provide a separate help desk headed by paramedical for providing the necessary assistance round the clock to the PGEPHIS beneficiary.

x) These empanelled Hospitals/Nursing Homes must have the capacity to submit all claims / bills in electronic format to the Insurance Company, and must also have/ should be ready to establish at its own cost, the dedicated equipment, software and connectivity for such electronic submission.

xi) The provider should have suitable backup arrangements, so that in the event of any unforeseen situations, the affected portion of the data should be retrievable in totality.

xii) In case the PGEPHIS approved rates are more than what is being charged for same procedure from other (non- PGEPHIS) patients or institutions, then the hospital has to offer the same reduced rates for the said procedure by allowing appropriate discount to PGEPHIS.

xiii) The Hospital agrees that any liability arising due to any default or negligence in providing or performance of the medical services shall be borne exclusively by the hospital that shall alone be responsible for the defect and / or deficiencies in rendering such services.

10.5 (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 PGEPHIS beneficiaries:

i) Free pre and post hospitalization consultation under pre and post hospitalization cover period.

ii) PGEPHIS rates for diagnostic tests done under under pre and post hospitalization cover period.

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11. DELISTING OF HOSPITALS:

Empanelled Hospitals/Nursing Homes/Day Care Clinics would be delisted by the Insurer from the PGEPHIS network after the approval for the same has been accorded by the State Govt./ PHSC, 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. Based on recommendation of the Insurer, the Nodal Department shall initiate disciplinary proceedings against erring NWHs for the following reasons: (i) Infrastructure deficiencies (ii) Equipment deficiencies (iii) Man power deficiencies (iv) Service deficiencies (v) Violation of service contract agreement vi) Misconduct/ fraudulent activity. Nodal Department shall have the rights to approve one or more of the following disciplinary actions at its sole discretion:

(i) Withholding of payments: Cashless treatment is the bedrock and the primary non-negotiable of this Scheme. Any violation of this condition shall result in immediate withholding of entire payments of the hospital. Payments shall be released only after the hospital repays the patient and takes corrective measures.

A particular claim may also be withheld in case of any service deficiency in management of any case and the payment may be released based on the expert opinion obtained by the Govt. or after rectification.

(ii) Levy of penalty: In cases where all the payments have been released to the NWHs, a penalty shall be levied on the NWH for violations attracting disciplinary action.

(iii) Suspension: The NWH shall be liable to be suspended in all cases of violations of agreement.

(iv) De-empanelment of specialities: The NWH can be de- empanelled for a particular speciality in case of service deficiencies in that particular speciality or completely as per the discretion of the State Govt/ Nodal Department.

(v) Delisting: The NWH shall be delisted for repeated violation of service contract agreement and other service deficiencies for a period of not less than one year.

12. CASHLESS ACCESS SERVICE:

The TPA/ Insurer has to ensure that all PGEPHIS 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 of the Services as covered under the Scheme. The service provided by the Insurer along with the 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 ID 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 State Govt. for PGEPHIS. It would be the responsibility of the TPA/ Insurer to have all empanelled hospitals/nursing homes/ day care clinics agreed to the same. 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 TPA along with contact details of treating physician, through e-preauthorization mode. The medical team of TPA would get in touch with treating physician, if necessary.

a. The RAL (Request for Authorization Letter) should reach the Authorization Department of TPA from the time of admission to not later than 24 hrs of admission, in case of emergency or within 3 days prior to the expected date of admission, to within 6 hrs of admission and not later than 12 hrs of admission incase of planned admission. The RAL form should be dully filled in all cases. 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 and radiological images should also be forwarded electronically.

b. Upon failure of compliance of the provisions 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. 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, upon receipt of any query/ demand of any additional information from the TPA, to provide the complete details without any further delay, failing which it would be treated as violation of the norms.

d. 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.

e. i) Insurer guarantees payment only after receipt of RAL and the necessary medical details. Only after TPA has ascertained the rates as per PGEPHIS prescribed rates and or negotiated the packages (if no rates are fixed by PGEPHIS), with provider, TPA shall issue the Authorization Letter (AL)/ Additional Information/ request/ Denial Letter/ Query Letter, as the case may be.

ii) The TPA shall process the RAL within 2 hours of its receipt at its end and shall send to the Provider Hospital, either an Authorization Letter or a Denial Letter or any other letter seeking additional information as required for concluding the admissibility of the case, not later than 2 hours from the time of the receipt of the RAL at its end.

iii) In the event of asking for some additional information and no response being received from the Provider Hospital, the TPA/Insurer shall ensure that the required information is obtained from the treating doctor or the Beneficiary or the Network Hospital through any other mode of communication including those other than e-RAL for enabling it to take the final decision. The report of the IRC shall be mandatorily taken by the TPA in Cardiac cases and Joint Replacement cases in case of the admissions taking place in Network Hospitals. However under no circumstances, in emergency cardiac cases, the issuance of authorization shall be withheld for want of IRC Report, which can be obtained later to rule out any discrepancy in cardiac angiogram or any other report received from the Network Hospital , for which an explanation may be sought from the Network Hospital In cases of planned admissions in Network Hospitals, where any radiological investigation/ diagnostic modality that can be reported by IRC is conducted, the report of the IRC may be taken on case to case basis. The report of IRC shall not be taken by the TPA in cases of admissions taking place in Government Hospitals.

iv) The TPA after receipt of RAL from the Network Hospital on its web portal shall immediately send Requisition Letter to the IRC, not later than 60 minutes after the receipt of the RAL, intimating the name, card number and CCN Number of the beneficiary, to seek report of the IRC as per the format contained in the SLA.

v) In case of payment of expenses by the Beneficiary to the hospital because of non resolution of query of the hospital or delay in issuance of authorization letter to the hospital, the Insurer shall unconditionally and without any demur make the reimbursement of the hospitalization expenses incurred by the Beneficiary at the actual rates charged by the hospital, irrespective of the package rates, not exceeding the maximum limit of Rs. 3 lacs of the Sum Insured.

vi) In an event a Member goes to a Provider Hospital and inspite of showing his/her ID card to the hospital authorities within stipulated time period, is denied cashless hospitalization by the hospital, for any reason whatsoever, including but not limited to, denial by the Hospital at its own end without receiving any denial from the TPA or the wrongful denial by the TPA or delay in issuance of authorization by the TPA for any reasons or any other circumstances whatsoever and no fault lies with the Member, he/ she may submit his/ her claim to the TPA as per the check list for reimbursement within 60 days of date of discharge from the hospital. In such cases, the TPA/Insurer shall extend full cooperation to the Beneficiary and depending upon merit/ genuineness of the case, determine the admissibility of the claim within the purview of the Scheme and settle the claim within 15 days of receipt of the claim, in accordance with terms and conditions of the Scheme.

f. In case the ailment is not covered, TPA 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. The TPA shall clearly mention explicit and justifiable reasons for the denial of cashless access in the Denial Letter issued to the Network Hospital or to the Beneficiary. The TPA shall deny the cashless treatment to any Beneficiary, only if the respective treatment/ procedure is not admissible as per the terms and conditions laid in the Scheme. The TPA shall not, under any circumstances whatsoever, deny cashless treatment to the Beneficiary on account of non receipt/ delayed receipt of the query response from the Provider Hospital. The TPA shall exercise its own independent discretion, taking into account all clinical parameters/ conditions/

eligibility terms and conditions, along with the report of IRC, wherever applicable, to decide upon the admissibility of the case. No case shall be rejected by the TPA/ Insurer, solely based upon the reporting of the IRC. IRC shall not be allowed to decide upon the rejection or admissibility of any RAL received from the Network Hospital. IRC shall only provide interpretations/ findings on radiological image/ modality sent to it by the Insurer/ Network Hospital, establish radiological extent of disease, point out discrepancies, if any, between its own report and report of the Network hospital and provide grading on the extent of the disease as interpreted radiologically.

g. The TPA/ Insurer needs to file a report to Nodal Department explaining reasons for denial of every such claim on day to day basis.

h. Authorization letter [AL] shall be numbered, signed and stamped by the Doctor of the TPA. It shall mention the name of the treatment or medical procedure for which the amount has been authorized and the amount guaranteed as a PGEPHIS 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.

i. 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.

J. In case of non listed procedure, the Empanelled Hospitals/Nursing Homes 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

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 under operating policy in which beneficiary was admitted.

13. CLAIM SETTLEMENT:

The Empanelled Hospital/Nursing Home shall be reimbursed the cost of treatment as per PGEPHIS Package Rates with hospitals. The Insurance Company shall settle the claims of the Hospitals/Nursing Homes within 15 days of receipt of the complete bills along with the discharge summary of the patient. The claim settlement progress will be scrutinized and reviewed by the State Government/ PHSC .

14. REPUDIATION OF CLAIMS:

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

15. RIGHT OF APPEAL AND REOPENING OF CLAIM:

The Empanelled Hospitals/Nursing Homes shall have a right of appeal to Nodal Department against the TPA/ Insurer, if, the Health Care Provider feels that the

claim is payable. The Nodal Department can direct the Insurer/ TPA to re-open the claim, if, proper and relevant documents as required are submitted.

16. REVIEW OF PAID CLAIMS:

The Nodal Department will have the right to reopen a settled claim and to direct the TPA/ Insurer to settle for an appropriate amount within a period of 3 months of payment of the claim. The TPA and insurer further agree to provide access to the PHSC their records for this purpose. All the claims settled by the Insurer to the Empanelled Hospitals/Nursing Homes based on the bills received from the hospitals in conformity with the PGEPHIS package rate arrived at and also based on the pre-authorization given by the Insurer/ TPA will be reckoned as final and will not be subject to any reopening by any authority except the Nodal Department

17. ENROLMENT:

The enrolment of the beneficiaries would be undertaken by the Insurance Company selected by State Government/Nodal Department. The Insurer shall enroll the beneficiaries as per procedure laid down below and shall issue Photo ID cards to all the PGEPHIS beneficiaries.

(a) No fresh enrollment of serving employees or pensioners will take place after the date of expiry of Enrollment Period. However, in the case of new employees, whose date of joining falls after the date of the expiry of the enrollment period and Employees/Pensioner under exceptional circumstances, the enrolment will continue throughout the year. Beneficiaries falling under optional category who did not opt for the Scheme in the first year, shall be eligible to opt in the subsequent renewals.

The Scheme shall provide health insurance coverage for a Policy Plan Period of twelve months to all the beneficiaries who have got enrolled under the Scheme within the Enrollment Period. Though the date of start of policy of the new employees and Employees/Pensioner under exceptional circumstances shall, vary from member to member, depending upon the date of joining of such member/ date of enrolling under the scheme. The date of expiry of policy shall be co-terminus for all the beneficiaries.

(b) Insured will have the option to change the details regarding dependent beneficiary in the ID card; however the total number of dependents cannot be more than the number fixed at the time of next renewal of the Scheme,

(c) The Insurer will arrange for preparation of the Photo ID Card as per the Guidelines provided.

(d) At the time of delivering the card, the Insurer shall provide a booklet/ Guide Book along with Photo ID Card to the PGEPHIS 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. The insurer shall also make available the soft copy of guide book on its website, that can be downloaded by the beneficiary, in case required.

(e) To address the problems of incorrectness, functionality of cards etc and if enrolment of the beneficiary could not be done for any reason, inspite of submission of the Enrollment Form to the Insurance Company; the same would be done at by the TPA within 15 days of receipt of any such complaint.

(f) Photo ID Cards along with the Guide Book shall be handed over by the Insurance Company to the DDOs for onward delivery to the employee/ pensioner.

(g) Insurance Company will also provide a web-based enrollment application/ employees registration platform/e-enrollment module. The enrollment forms for the employees/pensioners and option/enrollment form for the employees/ pensioners under optional category will be available after the designated date, on the website "www.pbhealth.gov.in" along with the procedure to fill such forms. A copy of the forms will be made available to all the DDOs. The forms can be filled online as well as offline but have to be submitted in hardcopy through DDO to Insurance Company. The Insurance Company will collect the filled forms from DDO and handover the Insurance Cards of the main member and dependent(s) to the DDO for onward delivery to the employee/pensioner. The insurance Company shall provide right to print ID Card to the DDO of the department. DDO, however won't have any rights to make any amendments/ modifications/ alterations in the enrollment database of the employees. Every employee/pensioner will be notified regarding enrollment with Unique Health Identification Numbers. In case of misplacement of the card/non availability of the card, this Unique Health Identification Numbers can be used for taking treatment in the designated hospitals.

The empanelled Hospitals/Nursing Homes/Day Care Clinics and the beneficiaries shall have the access to the dedicated website to see their relevant information.

(h) Nodal Department at the State Health Department will also monitor data related to Insurance plan like enrolment etc through this website.

(j) The beneficiaries falling under the category of compulsory enrollment shall remain the member of the scheme with future renewals automatically awarded. The beneficiaries falling under the category of optional enrollment, if wish to opt out of the scheme, shall be required to submit the declaration to the Department of Health & Family Welfare Punjab for discontinuation from the Scheme at the time of next renewal of the Scheme . In such cases the benefits shall cease on the expiry of the policy.

18. ENROLMENT PROCESS:

The process of enrolment shall be as under:

A. Serving Employees:

1. Departments and offices will notify the employees to join compulsory PGEPHIS without existing Medical reimbursement under PMA rules.

2. DDO would be the contact point for the Insurance Companies and shall be responsible for validating the enrollment forms filled by the employees and forwarding it to the Insurance Company.

3. Enrolment forms giving details about self and family and options given by employees/ pensioners falling under optional category would be consolidated by the Administrative Department/ respective Department. The data of the beneficiary and dependent members to be covered along with 1 recent passport size colored photo of each member , has to be provided in the

enrolment form, which will be collected by the Insurance Company from the DDOs of various departments on weekly/monthly basis during the enrollment period.

4. Insurance Company will issue Photo ID Cards on the basis of information received in the Enrolment Form filled by the beneficiaries, received through DDOs.

5. Such Photo Id Cards along with the guide book shall be handed over to the respective DDO of the employee for onward delivery to the employees within 15 days of receipt of filled Enrollment Form and not later than 5 days prior to the commencement date of the Policy Plan Period, by the Insurance Company.

B. Pensioners

1. In case of pensioners, wide publicity of the Scheme should be given through various media sources like advertisement in local newspapers, Cable network etc.

2. The notification of the Scheme will be available on the website "www.pbhealth.gov.in" giving details of the proposed Scheme.

3. Information can also be disseminated through pensioners associations and other related agencies.

4. Enrolment forms, along with the procedure to fill such forms, could be downloaded/ filled online through the website "www.pbhealth.gov.in" along with the procedure to fill such forms.

5. Pensioners would fill up the enrolment form giving details relating to self and dependent members along with 1 recent passport size photos of each member. The forms can be filled online as well as offline but have to be submitted in hardcopy through DDO to Insurance Company. The Insurance Company will collect the filled forms from the DDOs.

6. Photo Id Cards of the pensioners along with the guide book shall be handed over to the respective DDO, where he/ she was last serving, for onward delivery to the pensioner, within 15 days of receipt of filled Enrollment Form and not later than 5 days prior to the commencement date of the Policy Plan Period, by the Insurance Company.

C. For New Employees:

a. All New Employees shall be compulsorily covered under PGEPHIS.

b. At the time of their entry into service they are required to carry out required documentary formalities related to enrolment under the Scheme at their respective places of posting.

c. `Employee shall fill up form enrolment form, providing 1 resent passport size photographs of the family each (individual) and submit the filled Enrolment Form to the DDO of his/ her Department within 7 days of joining into the service.

e. Insurer shall arrange to collect the enrolment form & family photograph from the respective DDOs under acknowledgement, after receiving intimation from the DDO.

f. After required processing of the Enrolment Form at the Insurer's/ TPA's end, ID card shall be issued by the insurer and handed over to the to the DDO for onward delivery to the new employee.

g. The insurance cover shall be effective from the date of joining of an employee.

Note: The Insurer will have to complete the following activities before the start of the Policy Plan Period:

- ·Empanelment of the Hospitals/Nursing Homes/Day Care Clinics.
- Setting up of Project Office/ District Offices ·
- Setting up of adequate infrastructure required for the implementation of the Scheme.

19. 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 accident which requires hospitalization for treatment.

3) Congenital external diseases etc: Congenital External Diseases or defects or Anomalies.

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 PGEPHIS scheme.

B. Maternity Benefit Exclusion Clauses:

1. 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.

2. 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.

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

20. CALL CENTER SERVICES:

I. Toll Free Number

State wide toll free medical helpline number "104" shall be available to all the beneficiaries for taking any information/ clarification regarding enrollment, benefits available under the Scheme, exclusions, list of enrolled private as well as government hospitals, process to be followed for lodging claim with Insurance Company or with State Government and for redressal of any complaint regarding enrollment, treatment, exclusions, benefits etc available under the Scheme. The complaint will be redressed in a time bound manner.

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 TPA/ Insurance Company:

1) District level Grievance Redressal committee

Grievance Redressal committee shall be set up in each District for all possible Redressal of grievance of beneficiaries/Health provider by the Insurer. The committee will constitute following members:

i. Deputy Commissioner,

ii Civil Surgeon

iii Deputy Medical Commissioner

iv Representative of Insurance Company

The Committee will resolve the Grievance with in 30 days from the date of receiving the application. Any Party, if not satisfied with the decision of the committee, can reached to the State Level Committee.

- **State level Grievance Redressal committee:**

The next level of Grievance Redressal will be State Level SGRC consisting having following members.

I Principal Secretary, Health & Family Welfare Punjab

ii Managing Director, PHSC

iii Director Health Services, Punjab

iv State Representative of Insurance Company

v Nodal Officer, PGEPHIS

The Committee will resolve the Grievance with in 30 days from the date of receiving the application. The Decision of the Committee Shall be final & binding to all the parties.

b. Dispute between TPA/ Insurance Company and the State Government

A dispute between the State Government /Nodal Department and Insurance TPA/ Company shall be referred to the respective Chairmen/ CEO's/CMD's of the Nodal Department 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 Chandigarh, Punjab.

22. NODAL DEPARTMENT:

a) The Punjab health System Corporation would be the Nodal Department for the implementation of PGEPHIS.

b) A Coordination Committee having the representatives from The Department of Health & Family Welfare, Punjab, Finance, Planning, Pensioner Welfare and Department of Administrative Reforms & Public Grievances for monitoring the implementation of the Scheme on a regular basis.

c) The Punjab health System Corporation will monitor data related plan like enrolment, empanelment of hospitals, authorization status, claims status,

Note: Any liability arising due to any default or negligence in providing or performance of the Insurance Services shall be borne exclusively by the Insurer who shall alone be responsible for the defect and / or deficiencies in rendering such services. The complete financial and legal liabilities, if any, arising consequent to the operationalization of the Scheme or the Policy, shall rest exclusively and unconditionally with the Insurance Company.

23. OPERATIONAL TERMS AND CONDITIONS APPLICABLE TO THE REIMBURSEMENT CLAIMS.

- All hospitals of the Punjab Health Systems Corporation (PHSC), Civil Hospitals, Government Hospitals and Government Medical Colleges/ Research Institutes located in the State of Punjab and Chandigarh and Govt Hospitals in New Delhi shall be automatically included in the list of Provider Hospitals where the beneficiaries can avail medical services as covered under the terms and conditions of the Scheme. In an event, the aforesaid hospitals fail to provide cashless treatment, beneficiary shall be entitled to avail reimbursement of his/her claim, subject to the submission of claim within 30 days from the date of discharge from the hospital.

- The reimbursement to the beneficiary against the claim of the treatment availed in the private hospital located anywhere in India except Punjab, Chandigarh and NCR area (Gurgaon, Noida and Delhi), shall be made in accordance with the PGEPHIS rates, irrespective of the actual expenditure incurred by the beneficiary, subject to the submission of claim within 30 days from the date of discharge from the hospital. For treatments that have not been mentioned in the PGEPHIS rate list, the reimbursement shall be made in accordance with the PGIMER Rates, Chandigarh.

- The treatment in PGIMER, GMCH-32 and State Medical Colleges of Punjab and Government Hospitals in NCR area (Gurgaon, Noida and Delhi) will be covered at Govt. Hospital rates as applicable in such Govt. Hospitals or PGEPHIS Rates, whichever is less. The consumables, medicines/investigations that are not available in Govt. Hospital and are purchased by the beneficiary from outside shall also be reimbursed by the TPA to the Beneficiary, at the PGEPHIS Rates or the rates as billed by outside source, whichever is less.

- The beneficiaries shall bear all the expenses incurred on treatment/hospitalization in the Govt. Hospitals, where the treatment is not available on cashless basis and shall later claim for reimbursement from the TPA, within 30 days from the date of discharge from the Govt. Hospital.

- Benefits up to 7 days Pre Hospitalization & up to 30 days Post Hospitalization respectively which would cover all expenses related to treatment of the sickness for which hospitalization was done shall be covered on cashless basis at PGEPHIS Rates, in empanelled private hospitals in Chandigarh, Punjab and Panchkula; on reimbursement basis in Government Hospitals at respective Govt Hospital rates or PGEPHIS Rates, whichever is less; on reimbursement basis in the private hospitals in remaining parts of the country at PGEPHIS rates or the rates as billed by the private hospital, whichever is less, subject to the submission of bills to the TPA within 60 days of the date of discharge from the hospital.

- Medical reimbursement of bills against chronic diseases, that are covered under the existing Punjab Medical Attendance Rules, shall be admissible as long as either the patient is treated as indoor patient or as out door patient having valid "Complicated chronic disease certificate". Treatment can be had from any hospital/Nursing Home/clinic located anywhere in India. Complicated chronic disease certificate" has to be issued by State Government Medical Colleges, PGIMER Chandigarh, AIIMS Delhi and GMCH Chandigarh. The beneficiary shall avail this benefit on cashless basis in designated stores and empanelled hospitals in all the districts of Punjab and Chandigarh.

24. CHECKLIST FOR REIMBURSEMENT CLAIMS:

1 Copy of Photo I.D. Card.

2 Original Hospital bill with bill breakup details, Pharmacy bills with prescriptions.

3 Original reports with Laboratory Bills, and prescription for investigations.

4 Original Radiological Investigation reports with images,

5 Original or attested Discharge summary of the hospital with Date and Time of admission & discharge mentioned in it.

6 Claim form signed by the patient or the claimant.

7 Death certificate in death cases.

8 For the medicines purchased, the bills in original and prescription by the treating doctor/ hospital.

9 FIR or MLC report in accident, if the case has been registered with Local police station.

10 Bar codes, Batch Number and Invoices for the stents, implants, catheters etc.

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