ANNEXURE - A

to G.O.Ms. No.160, Finance (Salaries) Department, dated 29-06-2021

THE GUIDELINES FOR IMPLEMENTATION OF NEW HEALTH INSURANCE SCHEME, 2021 FOR EMPLOYEES OF GOVERNMENT DEPARTMENTS, STATE PUBLIC SECTOR UNDERTAKINGS, STATUTORY BOARDS, LOCAL BODIES, STATE GOVERNMENT UNIVERSITIES ETC., AND THEIR ELIGIBLE FAMILY MEMBERS

1. Title and Commencement:-

(1) These Guidelines may be called "The Guidelines for New Health Insurance Scheme, 2021" for Employees of Government Departmentss, Public Sector Units, Co-operatives and Other Institutions / Organisations etc., and their eligible family members.

(2) These Guidelines shall come into force from 01-07-2021 for a block period of four years i.e., upto 30-06-2025.

2. Application:-

(1) The New Health Insurance Scheme, 2021 for Employees of Government Departments, Public Sector Units, Co-operatives and Other Institutions / Organisations etc., will provide health insurance coverage to all the Employees of Government Departments, Public Sector Units, Co-operatives and Other Institutions / Organisations etc., and their eligible family members.

3. Extent of the Scheme:-

The following employees and their eligible family members are covered under the New Health Insurance Scheme, 2021:-

(1) The employees of Government Departments drawing pay in regular time scale of pay including Teaching and Non-Teaching Staff of Aided Educational Institutions.

(2) The employees of willing Organisations / Institutions registered under the Tamil Nadu Registration of Societies Act, 1975 covered under the New Health Insurance Scheme 2016.

(3) The employees of the Tamil Nadu Hindu Religious & Charitable Endowments Boards drawing pay in regular time scale of pay.

(4) The following family members of the employee shall be covered under the New Health Insurance Scheme, 2021:-

(1) Legal Spouse of the Employee;

(2) Children of the Employee – till they get employed or married or attain the age of 25 years whichever is earlier and dependent on the Employee;

(3) Parents of the Employee, in the case of unmarried employee until the Employee get married, in case of a divorced employee not having children, until such employee gets re-married; and

(4) Physically Challenged and Intellectually Disabled Children of the employee without any age restriction, subject to the minimum of the handicap to the extent of 40% as certified by the District Disability Welfare / Rehabilitation Officer and wholly dependent on the employee.

4. Definitions:-

(1) In these guidelines, unless the context otherwise requires,-

(a) **"Accident"** An accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

(b) **"Accreditation Committee"** means Accreditation Committee constituted by the Government headed by the Commissioner of Treasuries and Accounts, having the Director of Medical and Rural Health Services Department or his nominee and an official representative of the Insurance Company as members.

(c) "**Agreement"** means an agreement prescribing the terms and conditions of services, which may be rendered to the beneficiaries under this scheme entered into between the Government and Insurance Company.

(d) "**Authorities concerned"** means the Drawing and Disbursing Officer (DDO), Sub-Treasury Officer (STO) / District Treasury Officer (DTO) / Pay and Accounts Officer (PAO) concerned.

(e) **"Beneficiary"** means Employees and their eligible family members of Government Departments, Public Sector Units, Co-operatives and Other Institutions / Organisations etc., as stated in clause 3 (4) of these guidelines.

(f) **"Cashless facility"** means a facility extended by the Insurance Company (insurer) to the beneficiary (insured) where the payments, of the costs of treatment undergone by the beneficiary (insured) in accordance with the Guidelines (policy terms and conditions), are directly made to the network hospital by the Insurance Company (insurer).

(g) "**Cashless Service by Network Hospital"** means

(i) The beneficiaries are provided with CASHLESS treatment with adequate facilities without the need to pay any deposits right from time of the entry into the hospital, through the commencement of the treatment, the end of treatment till discharge, for all the procedures covered under the Scheme.

(ii) It is envisaged that for each hospitalization the transaction shall be CASHLESS for covered procedures. Enrolled beneficiary will go to hospital and come out without making any payment to the hospital subject to procedure covered and Ceiling Criteria. However, the beneficiary shall meet the Non-Admissible Expenses and shall settle the bill related to these expenses with the Hospital directly.

(h) **"Ceiling Criteria"** means the criterion referred to in clause-10 (3).

(i) **"District Level Empowered Committee"** means District Level Empowered Committee constituted by the Government headed by the District Collector, having the Joint Director of Medical and Rural Health Services Department, the District Treasury Officer and an official representative of the Insurance Company as members.

(j) **"Eligible Medical Expenses"** means such expenses as defined in clause-8 (3).

(k) **"Emergency Care"** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

(l) **"Employee"** means Employees of all the Employees of Government Departments, Public Sector Units, Co-operatives and Other Institutions / Organisations etc.,

(m) **"Family"** includes the Employees and their eligible family members as detailed below:- (i)Legal spouse of the employee;

(ii) Children of the employee – till they get employed or married or attain the age of 25 years whichever is earlier and dependent on the employee;

(iii) The parents of the employee, in the case of unmarried employee until the employee gets married; in case of a divorced Employee not having children, until such employee gets re-married;

(iv) Physically challenged and Intellectually Disabled Children of the employee without any age restriction subject to the minimum of the handicap to the extent of 40% as certified by the District Disability Welfare / Rehabilitation Officer and wholly dependent on the employee.

(n) **"Form"** means the relevant form as may be specified by the Government under these Guidelines;

(o) **"Government"** means Government of Tamil Nadu.

(p) **"Grievance Redressal Officer"** means a Joint Director of Medical and Rural Health Services Department at District Head Quarters.

(q) **"Guidelines"** means the Guidelines for New Health Insurance Scheme, 2021 for the employees of the government departments, organizations etc., and their eligible family members.

(r) **"High Level Empowered Committee"** means High Level Empowered Committee constituted by the Government comprising of the Secretary to Government, Finance Department, Secretary to Government, Health and Family Welfare Department and an official representative nominated by the Insurance Company.

(s) **"Hospital"** means any institution established for in-patient care and day care treatment of illness and / or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56 (1) and the said act or complies with all minimum criteria as under:-

(i) has qualified nursing staff under its employment round the clock;

(ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

(iii) has qualified medical practitioner(s) in charge round the clock;

(iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;

(v) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

(t) **"Hospitalization"** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures / treatments, where such admission could be for a period of less than 24 consecutive hours.

(u) **"ICU (Intensive Care Unit) Charges"** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

(v) **"Insurance Company"** means Public Sector Insurance Company carrying a health insurance business which is registered with Insurance Regulatory and Development
Authority of India (IRDAI).

(w) **"Network Hospital"** means hospitals or health care providers enlisted by Insurance Company / Third Party Authority to provide medical services to a beneficiary by a CASHLESS facilities under this scheme.

(x) **"Non-Admissible Expenses"** means the list of items in **Annexure-IV** of these Guidelines.

(y) **"Non-Network Hospital"** means any hospital, day care centre or other provider that is not a Net Work Hospital.

(z) **"Scheme"** means the New Health Insurance Scheme, 2021 for Employees of Government Departments, Public Sector Units, Co-operatives and Other Institutions / Organisations etc., and their eligible family members;

(aa) **"Spouse"** means a wife / husband of the Employee**;**

(ab) **"Subscription"** means subscription per month prescribed by Government which shall be recovered from the Employee.

(ac) **"State Level Empowered Committee"** means State Level Empowered Committee constituted by the Government headed by the Commissioner of Treasuries and Accounts having the Director of Medical and Rural Health Services as Member Secretary or his nominee and an official representative nominated by the Insurance Company as members.

(ad) **"Tamil Nadu Medical Attendance Rules"** means the rules governing Medical Attendance and Levy of Fees in the Government medical institutions in the State of Tamil Nadu.

(ae) **"Third Party Administrator or TPA"** means any person who is registered under Insurance Regulatory and Development Authority of India (IRDAI) (Third Party Administrators – Health Services) Regulations, 2016, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services.

(2) Words or expressions not defined in these Guidelines but defined in the Chapter-I of the Guidelines on Standardisation in Health Insurance issued in Circular No.IRDA/HLT/REG/CIR/ 146/07/2016, dated 29.07.2016 shall have the same meanings respectively assigned to them in the IRDAI Guidelines.

5. Enrolment:-

(1) The enrolment of the Employees of Government Departments, Public Sector Units, Co-operatives and Other Institutions / Organisations etc., under the Scheme shall be compulsory.

(2) Option to be exercised for certain cases:-

(a) This scheme is compulsory for all employees of the Government Departments etc.,

(b) The employee's contribution shall be recovered from only one of the employee in case both are State Government employees i.e., from the younger of the two.

(c) The option once exercised shall be final.

(d) Those Employees who are eligible for exercising their option had already exercised their option under New Health Insurance Scheme, 2016 need not exercise their option again for this Scheme.

6. Subscriptions to the Scheme:-

A sum of Rs.295/- per month, per employee of Government Departments, Public Sector Units, Co-operatives and Other Institutions/ Organisations etc. shall be deducted from the monthly salary from the month of July, 2021.

7. Objectives:-

The main objectives of the Scheme are: -

(1) to extend the scope of assistance for medical treatments available under the existing Scheme;

(2) to cover more ailments and more hospitals including payment wards of Government Hospitals;

(3) to provide financial assistance upto **Rupees Five Lakh** per employee (including eligible family members) for a block of four years for the approved treatments taken and surgeries undergone as per **Annexure-I**, with provision to pay upto Rs.10.00 lakh for specified approved treatments taken and surgeries undergone as per **Annexure-I A**; and

(4) to provide the assistance for approved medical treatments and surgeries as per **Annexure-I and I A**, on a cashless basis in Network Hospitals **and on reimbursement basis from non-network hospitals for Emergency Care or following an Accident**.

(5) to provide assistance for approved medical treatments and surgeries as per **Annexure-I and Annexure–I A**, on reimbursement basis, from non-network hospitals for non-emergency care, which shall however be restricted to 75% of the applicable package rate for similar treatment or surgery, in a network hospital of the lowest grade.

8. Scope of the Scheme:-

(1) The scope of the Scheme shall be to provide coverage for **Eligible Medical Expenses** incurred by the Beneficiary of this scheme during Hospitalisation for

the treatments and surgeries listed in **Annexure-I and Annexure-I A** to these Guidelines that are undertaken / undergone in Network Hospitals listed in **Annexure-II** as amended from time to time.

(2) The Network Hospitals shall render Cashless Service as defined in clause-4(g) of these Guidelines for the approved treatments and surgeries listed in **Annexure-I and Annexure-I A** to these Guidelines.

(3) **Eligible Medical Expenses** with reference to the Network Hospital shall include all expenses charged by the Hospital upon hospitalization till the date of discharge except Non-Admissible Expenses as listed in **Annexure-IV**. However, with regards cataract surgery, the total assistance shall not exceed Rs.30,000/- per eye and for Hysterectomy (uterus removal surgery) shall not exceed Rs.50,000/-. The room rent shall be restricted to the applicable rent for standard A/c room available in the hospital. Transport charges shall be excluded.

(4) Eligible Medical Expenses with reference to Non-Network Hospital for Emergency Care and following Accident shall include all expenses charged by the hospital except non admissible expenses as listed in **Annexure-IV**. The total claims shall however be restricted to package rates determined based on the recommendations of the Accreditation Committee.

(5) The coverage under the scheme shall also include pre existing illness which have been included in **Annexure–I and Annexure–IA** to these Guidelines.

9. Hospitals to be covered under the Scheme:-

(1) The Hospitals under the Scheme shall include both:-

(a) Pay wards of Government Hospitals; and

(b) Private Hospitals.

(2) All hospitals already accredited under the **New Health Insurance Scheme, 2016** for Government Employees etc., as in **Annexure-II** to these **Guidelines** shall automatically be deemed to be networked hospitals and the Insurance Company shall ensure that they enter into a tie-up with these hospitals within one month of the commencement of the Scheme. Provided that for valid reasons to be adduced by the Insurance Company, Government may, upon recommendation of the Accreditation Committee may agree to approve some reduction in the members of existing Network Hospitals.

(3) At least three institutions (excluding Government Hospitals) each situated at Puducherry, Bengaluru, Thiruvananthapuram and New Delhi shall also be covered.

(4) The Insurance Company shall at all time during the currency of the contract ensure the availability of a minimum of 6 networked hospitals in each district of the State and the availability of a minimum 50 networked hospitals excluding Government Hospitals in the areas under each district cluster as indicated below:-

(a) Northern Cluster:
Chennai, Tiruvallur, Kancheepuram, Chengalpattu, Vellore, Ranippettai, Thirupathur, Tiruvannamalai, Villupuram, Kallakurichi and Cuddalore.

(b) Central Cluster:
Perambalur, Ariyalur, Nagapattinam, Mayiladuthurai, Tiruvarur, Tiruchirapalli, Thanjavur, Pudukottai and Karur.

(c) Western Cluster:
Krishnagiri, Dharmapuri, Salem, Erode, Namakkal, Nilgiris, Coimbatore and Tiruppur.

(d) Southern Cluster:
Madurai, Theni, Sivagangai, Virudhunagar, Dindigul, Ramanathapuram, Tirunelveli, Tenkasi, Kanyakumari and Thoothukudi.

(5) If any district or cluster does not have the number of hospitals as specified above, the successful insurance company can seek specific exemption for that district or cluster and the same will be considered by the Government of Tamil Nadu after verification of the available qualified hospitals in that district or cluster.

(6) The Government Hospitals which were empanelled under CMCHIS will also be included as network hospital under this scheme.

(7) Additions and deletions in the list of approved Network Hospitals and treatment / surgeries, if any for CASHLESS treatment will be done on the recommendation of the Accreditation Committee as and when necessity arises.

(8) The Network Hospitals under this scheme shall extend treatment to the Beneficiaries on a CASHLESS basis.

(9) Insurance Company and Third Party Administrators, wherever applicable, shall ensure that Network Hospitals shall meet with minimum requirements of Standards and Benchmarks for hospitals in the provider network which are prescribed in Chapter-IV of the Guidelines on Standardisation in Health Insurance issued in Circular No.IRDA/HLT/REG/CIR/ 146/07/2016, dated 29.07.2016.

(10) **Banning of Hospitals**:- Where any fraudulent claim becomes directly attributable to a Hospital included in the networked hospitals listed in the **Annexure-II** to the Guidelines, the said Hospital shall be removed and excluded under the Scheme by the Insurance Company and shall be excluded from the list of approved networked hospitals for the purpose of the Scheme.

10. Medical Assistance:-

(1) The Scheme shall provide coverage for the treatments and surgeries **listed in the Annexure-I to these Guidelines** upto a maximum of **Rupees Five Lakh** to employees

of Government Departments, Public Sector Units, Co-operatives and Other Institutions / Organisations etc., and their eligible family members for a block of four years from **01-07-2021 to 30-06-2025** ordinarily in any of the Network Hospital on CASHLESS basis and in case of Emergency Care or following an Accident in a Non-Network Hospital on reimbursement basis. However, the financial assistance shall be enhanced upto **Rupees Ten Lakh for specified treatments and surgeries as in the Annexure-I A to these Guidelines.** Coverage for approved treatments and surgeries in a Non-Network Hospital for Non-emergency care shall be on reimbursement basis, which shall be restricted to 75% of the package rate of similar treatment or surgery in a network hospital of lowest grade. In any case, maximum limit of assistance admissible per employee of the Government Departments etc., shall not exceed **Rupees Ten Lakh.**

(2) Even if the legal spouse / beneficiaries defined in clause 4(e) of these Guidelines is covered under the term "Employee" the total financial assistance for the Employee will be limited to Rupees Five Lakh Only. In such cases the Employees contribution shall be recovered from only one of the Employees as per the option exercised in this regard.

(3) **Ceiling criteria**: The benefit will be on floater basis i.e. the total coverage upto Rupees Five Lakh in respect of all Eligible Medical Expenses incurred towards approved treatments and surgeries as in the **Annexure-I** and upto Rupees Ten Lakh in respect of specified treatments and surgeries as in the **Annexure-I A** to these Guidelines can be availed of individually or collectively by the employees and his / her spouse with eligible dependent / family members during the said block of four years with no restriction on the number of times of availing. In any case, maximum limit of assistance admissible per employees spouse with eligible dependent / family members shall not exceed Rupees Ten Lakh.

11. Settlement of Claims by Insurance Company / Third Party Administrator (TPA):-

(1) The medical assistance shall be on CASHLESS basis for the **Eligible Medical Expenses** incurred subject to the ceiling criteria for approved treatments taken and surgeries undergone during Hospitalisation in any of the empanelled Network Hospitals and no payment for any of the Eligible Medical Expenses need to be made by the Beneficiary. In case, payment has been made by the beneficiaries either at the instance of the hospital or otherwise for any of the Eligible Medical Expenses, including in a case where pre authorization has been sought but wrongly denied or claim under CASHLESS facility has been restricted, the Insurance Company shall be required to make cash reimbursement of the same, subject to the ceiling criteria along with interest at 12% per annum calculated on monthly basis for the period from the date of payment to the hospitals by the beneficiary and the date of reimbursement of Eligible Medical Expenses upon submission of claims by the beneficiary after following the process stated in clause 15 of these Guidelines.

(2) **Non-Network Hospital Claims for emergency care or following an accident**: Eligible Medical Expenses incurred in Non-Network Hospital during Hospitalisation for Emergency Care or following an Accident by the beneficiary shall be reimbursed by the insurance company subject to the ceiling criteria upon submission of claim by the beneficiary or his / her legal heirs to the Grievance Redressal Officer and approval of the District Level Empowered Committee or State Level Empowered Committee or High Level Empowered Committee. The amounts that can be claimed for reimbursement will be limited to package rates, applicable for that approved treatment/surgery listed in Annexure I and IA in a similarly placed Network Hospital based on the recommendations of the Accreditation Committee, as per the process stated in clause-15 these Guidelines.

(3) **Non-Network Hospital Claims for Non-emergency care**: Eligible Medical Expenses incurred in Non-Network Hospital during Hospitalisation for Non-Emergency Care by the beneficiary shall be reimbursed by the insurance company subject to the ceiling criteria upon submission of claim by the beneficiary or his / her legal heirs to the Grievance Redressal Officer and approval of the District Level Empowered Committee or State Level Empowered Committee or High Level Empowered Committee. The amounts that can be claimed for reimbursement will be limited to 75% of the package rate for that approved treatment / surgery listed in Annexure I and IA in lowest grade network hospital, based on the recommendations of the Accreditation Committee, as per the process stated in clause-15 of these Guidelines.

(4) A Insurance Company / Third Party Administrator (TPA) shall render servicing of claims under this scheme by way of pre-authorization of cashless treatment for surgeries or settlement of claim other than CASHLESS claim or both, as per the underlying terms and condition of this scheme and within the framework of the guidelines for settlement of claims.

12. Pre-authorisation by Insurance Company / Third Party Administrator [TPA]:-

(1) The purpose of obtaining pre authorization from Insurance Company / Third Party Administrator (TPA) is to verify if the beneficiary is eligible for financial assistance under the Scheme and whether the proposed treatment or surgery is covered under the Scheme. It is also for the purpose of intimation by the Insurance Company to the Network Hospital that the Hospital should act in accordance with the tripartite agreement between the Insurance Company, Third Party Administrator (TPA) and the Hospital concerned with regards the rates chargeable by the Hospital for various Eligible Medical Expenses.

(2) **In case of Planned Hospitalisation** (to a Network Hospital):

(a) The Network Hospitals empanelled for CASHLESS facility under the Scheme alone shall be approached for availing medical assistance for the approved

treatments and surgeries under this Scheme. The Beneficiary shall approach the Insurance Office of the Network Hospital who is dealing with CASHLESS treatment. In case of difficulty, they can contact the District Level Co-ordinator / District Level Nodal Officer / Toll Free Number / State Level Co-ordinator / State Level Nodal Officer in this regard.

(b) The Identity Card of the employees and their eligible family members etc., issued by the Insurance Company / Third Party Administrator or by production of the copy of Form prescribed in **Annexure-III** shall be produced to the Network Hospitals for availing CASHLESS facility.

(c) Network Hospital shall identify, direct and register all the Beneficiaries holding eligibility card.

(d) The Network Hospital shall send the pre-authorisation request immediately to Insurance Company / Third Party Administrator with ID Card proof or DDO with Authorisation Form for the approved treatments and surgeries to be undertaken so that pre-authorisation approval is given by the Insurance Company / Third Party Administrator.

(e) If the approved treatments and surgeries are covered under this scheme, an approval of pre-authorisation would be issued to the concerned Network Hospital enabling cashless facility for the eligible medical expenses to the incurred subject ceiling criteria.

(f) In case of any deficiency or query, an additional information letter will be sent to the Network Hospital. On retrieval of the said information the request will be processed accordingly.

(g) The Insurance Company / Third Party Administrator shall scrutinize the pre-authorisation requests as per the Guidelines with the help of medical professionals and accord authorization for approved treatments and surgeries to be undertaken within 24 hours for planned hospitalization.

(h) The Insurance Company / Third Party Administrator shall also send an automated SMS to the beneficiaries with the status of the approval and make arrangement to download the approval of pre-authorisation in the designated website of the Insurance Company / Third Party Administrator.

(i) The beneficiary should sign the approval of final authorization letter approved by the insurance company /TPA in which the final authorization amount shall be provided to know the beneficiary.

(j) The following caption shall be indicated in the final authorization letter both in English and Tamil to lodge complaints for any grievance of the beneficiary:

"Any grievance / complaint about Eligible Medical Expenses, the beneficiary shall lodge complaint to the Grievance Redressal Officer (Joint Director of Medial and Rural Health Services) of the concerned district within fifteen days from the date of discharge from the Hospital."

(k) The Network Hospital shall obtain the signature of the beneficiary on the approval of final authorization letter and after obtaining signature, the same shall be sent to the Insurance Company / Third Party Administrator by the network hospital at the time of claim settlement.

(3) **In case of Emergency or Following an Accident (to a Network Hospital):**

(a) In an accidental case or in medical emergency, the approval of the Insurance Company / Third Party Administrator for the approved treatments and surgeries undertaken in the Network Hospitals shall be obtained for settlement on CASHLESS basis by the Network hospitals / Beneficiary during the period commencing from the date of admission in the Network Hospital for the treatments /surgeries as in-patient to the date before discharge from the Network hospitals.

(b) Relaxation of pre-authorisation relating to treatments taken and surgeries undergone in any of the non-network hospitals in case of emergency care or following an accident only shall be allowed.

13. Issue of Identity Cards by Insurance Company/TPA:-

(i) The Insurance Company shall arrange to issue identity cards to cover the beneficiaries with the details of the Employees and their eligible family members of Government Departments etc,. The identity cards will be distributed to the Drawing and Disbursing Officer (DDO) concerned through Sub-Treasury Officer (STO) / District Treasury Officer (DTO) / Pay and Accounts Officer (PAO) concerned. The available data of the Employees and their eligible family members of Government Departments etc., under New Health Insurance Scheme, 2016 on the date of commencement of the Scheme will be made available by the Government of Tamil Nadu through the Commissioner of Treasuries and Accounts, Chennai. The identity cards shall be made available within a period of sixty days from the date of commencement of the Scheme. During the interim period of preparation and distribution of the identity cards, the Insurance Company shall authorise acceptance of the identity cards already issued under NHIS, 2016 as valid identity for the purpose of availing the Scheme. This arrangement will be applicable only for such interim period, till the identity cards are made available.

(ii) The Insurance Company shall arrange to issue identity cards to the existing Employees and their eligible family members of Government Departments etc., under the scope of the Scheme. The DDO shall arrange to furnish the data of such

Employees and their eligible family members of Government Departments etc., as in **Annexure-III.** The data furnished by the State Government shall be the property of the State Government and should not be used for any other purpose without the prior permission of the Government of Tamil Nadu.

14. Procedure to be followed by the Beneficiaries for availing Medical Assistance under this Scheme:

(1) **In case of Planned Hospitalisation**: The Beneficiaries seeking medical assistance under this Scheme shall approach the Network Hospitals only for the approved treatments and surgeries to be undertaken on CASHLESS basis so that pre-authorisation is given by the Insurance Company / Third Party Administrator under the control of the Insurance Company.

(2) **In case of Emergency Care or following an Accident**: The Beneficiary seeking medical assistance under this Scheme shall approach either Network Hospital for the approved treatments and surgeries to be undertaken on CASHLESS basis or Non-Network Hospital for the treatments and surgeries to be undertaken on reimbursement basis. The Beneficiary has to pay the medical expenses first directly to the hospital and then seek cash reimbursement for the approved treatments and surgeries undertaken subject to Eligible Medical Expenses and Ceiling Criteria. There will be no cashless facility applicable in Non-Network Hospital.

(3) The Scheme is that ordinarily the Employees and their eligible family members of Government Departments etc., is required to avail CASHLESS facility in Network Hospital (to the extent of Eligible Medical Expenses and Ceiling Criteria under the Scheme) and pay for non-medical expenses directly to the hospital.

(4) In case, Employees or their eligible family members of Government Departments etc., undergo emergency treatments / surgeries not covered under this Scheme in either Network Hospital or Non-Network Hospital, **no claim can be filed under the Health Insurance Scheme**. However, they shall be eligible for claim to the extent permissible under the Tamil Nadu Medical Attendance Rules and the **G.O.Ms.No.1023, Health and Family Welfare Department, dated 17-06-1980**. It may be noted that the Tamil Nadu Medical Attendance Rules requires that treatment in private hospitals should not be resorted to except in cases of emergencies. Clause 2(3) of the aforesaid G.O. states that in genuine cases of emergency, the claims will be restricted to the expenditure that would have been incurred had the patient taken treatment in a Government hospital excepting diet charges. For claims under Tamil Nadu Medical Attendance Rules, the beneficiaries shall apply to authority in the department in which the Government Employees are working.

15. Redressal of Grievances and Reimbursement of payment:

(1) Claims under clause-11 of these Guidelines for reimbursement of payments made by beneficiary to Hospital for Eligible Medical Expenses shall be submitted by the beneficiaries to the Grievance Redressal Officer (Joint Director of Medical and Rural Health Services) along with relevant documents and bills.

(2) Reimbursement claims can be submitted to Grievance Redressal Officer through registered post or in Person.

(3) Claim Documents should be sent to Grievance Redressal Officer within 30 days from the Date of Discharge.

(4) Claim Forms prescribed by Insurance Company / TPA can be downloaded from designated website of the Insurance Company / TPA.

(5) Documents that need to submit for a hospitalisation reimbursement claim are:-

(a) Original completely filled in Claim Form.

(b) Covering letter stating complete address, contact numbers and email address (if available), along with Schedule of Expenses.

(c) Copy of the ID card or copy of Form prescribed in **Annexure-III** or ID card issued under NHIS, 2016 (if any).

(d) Copy of Discharge Summary.

(e) Copy of Hospital final bill.

(f) Numbered receipts for payments made to the hospital [at the time of submission of original submission].

(g) Copy of Complete breakup of the hospital bill.

(h) Copy of Investigations done with the respective reports.

(6) The original documents should be kept in safe custody of the Employees and their eligible family members of Government Departments etc., as these shall be handed over to the Insurance Company at later stage.

(7) The Grievance Redressal Officer shall examine the claims to verify if the claims relate only to Eligible Medical Expenses and recommend to the District Level Empowered Committee for reimbursement of such sums of money that relate to Eligible Medical Expenses. In case of claims relating to Non-Network Hospital, he shall examine and submit to the District Level Empowered Committee with his opinion as to whether the claim relates to Emergency Care or treatment / surgery undergone following an Accident or non-emergency

care. The Grievance Redressal Officer shall submit his report with his opinion to District Level Empowered Committee within a period of one month from the date of receipt of claim from the Beneficiary.

(8) The District Level Empowered Committee shall examine claims with reference to the recommendations and opinions of the Grievance Redressal Officer and approve all such sums for reimbursement that it finds to be Eligible Medical Expenses, satisfying the requirements of clause-11of these Guidelines within a period of one month from the date of receipt of the report from the Grievance Redressal Officer.

(9) Appeal against the claims of the District Level Empowered Committee shall lie with the State Level Empowered Committee within a period of one month from the date of receipt of copy of the Proceedings of the Committee.

(10) The sums determined by the District Level Empowered Committee / State Level Empowered Committee in any case not exceeding the applicable package rates specified in clause-11 of these guidelines. to be reimbursable shall be paid by the Insurance Company to the Beneficiary within a period of one month from the date of receipt of copy of the Proceedings of the Committee.

(11) In case, claim is denied, it should be ensured that the denial letter is sent quoting the reason for denial of claim to the Beneficiary.

(12) Any claim in deviation of the above procedure for reimbursement is liable to be rejected.

(13) Any grievance / dispute arising out of the implementation of the Scheme remaining unresolved by the State Level Empowered Committee shall be preferred within fifteen days of award of State Level Empowered Committee to the High Level Empowered Committee.

(14) The Civil Courts situated in Chennai shall have exclusive jurisdiction over any grievance / dispute remaining unresolved by the above procedure.

(15) Nothing aforesaid, shall prejudice the rights of the Government of Tamil Nadu to approach any other forum for dispute resolution permissible under Law.

(16) The list of address of Grievance Redressal Officers and the address of District Level Empowered Committee, State Level Empowered Committee and High Level Empowered Committee are listed in Annexure – VII & VIII to these guidelines.

16. Payment of Premium to Insurance Company:-

(1) For the first year (starting from the date of commencement of the Scheme) the premium will be initially calculated based on the number of Employees of

Government Departments etc., in position in the Government of Tamil Nadu as on **31-03-2021**. Of this amount, 95% will be paid as adhoc payment on the date of commencement of the Scheme. Actual annual premium will be paid at the beginning of the Second Year based on the updated database provided by the Insurance Company as on starting from the date of commencement of the Scheme after adjusting the 95% of adhoc payment paid at the beginning of the first year.

(2) During the 2nd, 3rd and 4th years 95% of the adhoc payment of annual premium will be paid as per the data provided by the Insurance Company after the exclusion of Employees of Government Departments etc., who died in harness during the previous year at the commencement of that year.

(3) For the Second and Third year, actual annual premium will be paid at the beginning of the Third and Fourth year based on the data provided by the Insurance Company as on beginning of the Third and Fourth year after adjusting the 95% of adhoc payment paid at the beginning of the Second and Third year.

(4) For the Fourth year, the actual annual premium will be paid on or after end of the Fourth year based on the actual data provided by the Insurance Company after adjusting the 95% of adhoc payment paid at the beginning of Fourth year for final settlement.

(5) Annual premium will be calculated on pro-rata basis for the new Employees of the Government departments etc., after the beginning of every year.

(6) After providing 20% of the premium paid towards the company's administrative cost, if there is any surplus after the claims experience on the premium (excluding GST) at the end of the policy period, of the balance 80% after providing for outstanding claims if any, 90% of the leftover surplus will be refunded to the Government within 30 days after the expiry of the policy year. If the claims experience on the premium is more than 100%, the excess above 100% may be compensated from out of the refunded amount remitted by the Insurance Company in the block of 4 years.

(7) The Commissioner of Treasuries and Accounts will pay the insurance premium to the Insurance Company.

17. Implementation Procedure:-

(1) The Government of Tamil Nadu will provide database of existing Employees of the Government Departments etc., and their eligible family members of and the basic details as in the format in **Annexure–III** to these Guidelines to be covered under the Scheme.

(2) The Insurance Company shall provide specified health insurance cover at a particular "premium" that covers Eligible Medical Expenses.

(3) The Insurance Company shall prepare and distribute identification cards to all the Employees of Government Departments etc., within sixty days of handing over of data by the Department.

(4) The Scheme will be implemented by the Commissioner of Treasuries and Accounts, Chennai and the premium payable will be released through the Commissioner of Treasuries and Accounts. The DDOs /PAOs/ Treasury Officers / Sub-Treasury Officers shall be responsible to arrange to delete the identity cards of such of those Employees of Government Departments etc., who die in harness. In such cases, the identity cards shall be surrendered.

(5) The Insurance Company shall ensure that the Employees of Government Departments etc., and their eligible family members defined in these Guidelines are treated without having to make any cash payment for any of the Eligible Medical Expenses subject to the Ceiling Criteria upto a limit of **Rupees Five Lakh** in respect of treatments taken and surgeries undergone listed in the **Annexure-I** to these Guidelines and upto **Rupees Ten Lakh** in respect of specified treatments taken and surgeries undergone listed in the **Annexure-I A** to these Guidelines in the empanelled Network Hospitals.

(6) The Insurance Company shall furnish a quarterly / half yearly / annual report on the amount disbursed on CASHLESS facility and reimbursement basis by treatments and surgeries wise to the Commissioner of Treasuries and Accounts. After scrutinizing the report, the Commissioner of Treasuries and Accounts shall furnish the report to the Government in Finance (Health Insurance) Department for monitoring the scheme at Government level.

(7) The Scheme may be administered through the Third Party Administrators. The Insurance Company / Third Party
Administrators should have one office unit in each district.

(8) The Network Hospital will raise the bill on the Insurance Company. The Insurance Company shall process the claim and ensure the settlement of the claims expeditiously so as to provide the services to the Beneficiaries by the hospital without fail. In case of any failure in services from the Hospitals due to pending bills, the Insurance Company will be held responsible by the Government.

(9) The agreement shall be entered into between the Government of Tamil Nadu and the successful Insurance Company.

18. Performance Monitoring:-

Performance of the Insurance Company / Third Party Administrator shall be monitored regularly based on the following parameters:–

- Timely pre-authorization.
- Timely claim settlement.
- Complaints redressal.
- Claim ratio.
- Any other parameters.

19. Online Management Information System (MIS) and 24 Hours Pre-authorization:-

(1) The Insurance Company should post enough dedicated staff, so as to ensure free flow of daily MIS and ensure that progress of scheme is reported to the Commissioner of Treasuries and Accounts in the desired format on a real-time basis.

(2) The Insurance Company should establish proper networking for quick and error-free processing of pre-authorizations.

(3) The pre-authorization has to be done round the clock which will be scrutinized by Commissioner of Treasuries and Accounts / Government periodically and pre-authorization shall be done within 24 hours.

(4) A provision for emergency intimation and approval should also be established.

20. Publicity:-

(1) The Insurance Company / Third Party Administrator on its part should ensure that proper publicity is given to the Scheme in all possible ways.

(2) This will include distribution of brochures at the time of issue of Identity Cards and display boards in Network Hospitals.

(3) They shall also effectively use services of State Level Nodal Officer and District Level Nodal Officer for this purpose.

21. Appointment of Nodal Officers / Co-ordinators at State and District Levels:-

(1) The Insurance Company / Third Party Administrator needs to appoint one Chief Nodal Officer / Chief Coordinator at State Level and one Nodal Officer each at all Districts and other places to facilitate admission, treatment and CASHLESS transaction to the Beneficiary. The Insurance Company / Third Party Administrator shall also appoint one nodal officer in each of the 50 most frequented private hospitals among the network hospitals. This nodal officer shall compulsorily be present in the hospital during regular working hours.

(2) The Nodal Officers / Coordinators should help hospitals in pre-authorization, claim settlement and follow-up.

(3) They should also ensure proper reception and care in the hospitals and send regular Management Information System
(MIS).

(4) Insurance Company shall provide all Nodal Officers / Coordinators with cell phone having CUG connectivity with SMS based reporting framework for effective and instant communication.

(5) They shall follow the Guidelines of Government / instructions of the Commissioner of Treasuries and Accounts / Government in this regard.

22. Penalty:-

(1) Deficiency in services – Failure to provide services as required by terms of Scheme will attract penalty as may be determined by the Government, subject to the minimum of five times the amount of the expenditure incurred by the Government of Tamil Nadu or beneficiary due to non compliance.

(2) Failure to process pre-authorisation within 24 hours from the time of submission will attract the Penalty of payment of entire expenditure incurred by the hospital towards the treatment of beneficiary.

(3) In addition to this, fine will be levied by the Government upto 100% of claim amount on each occasion on failure of processing pre-authorisation within the stipulated time.

(4) The Insurance Company shall also streamline the administration for facilitating hassle-free treatments for employees under the scheme. Penalty would be imposed in case patients are refused treatment in Network hospitals and if additional levies are imposed for items covered in the package rates, ensuring CASHLESS treatment to the employees.

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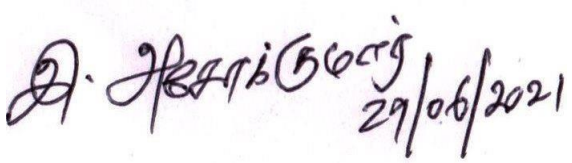

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