Chhattisgarh State Power Company Contributory Cashless Health Scheme

(Consolidated up to the 5th amendment dated 31 October 2025)
(Network Hospital list updated up to 31 October 2025)

Abstract

The Board of Directors of the Chhattisgarh State Power Transmission Company approved the "Chhattisgarh State Power Company Contributory Cashless Health Scheme (CSPCHS)", to meet the requirements of regular employees and pensioners of the Chhattisgarh State Power Companies considering the provisions of the prevailing reimbursement-based medical scheme.

The scheme commenced on 01st October 2023, and after periodic review 5 amendments have been made in the scheme and further amendments can be made as per requirement in future.

This scheme is optional, meaning that regular employees/pensioners have the choice to join the Contributory Cashless Health Scheme by paying a monthly contribution, if they so wish.

The important provisions of the scheme are as follows:-

1.Beneficiary:-

All Regular employees, pensioners of three State Power Companies, who have opted the scheme alongwith their spouse (who are not receiving fixed medical allowance or medical facilities from their employer, employed if any), as well as their following dependent family members are beneficiaries under this scheme:

a) For regular employees/family pensioners- Parents or parents-in-law living with them.

b) Sons up to the age of 25 years, unmarried daughters, and physically or mentally disabled children (maximum of two surviving children; in the case of twins, the third child will also be considered).

c) The above family members will be considered dependent only if their annual income is less than or equal to total amount of minimum pension including Dearness Relief payable during the previous financial year (i.e.₹1,65,000 for year 2024-25)

2. Scheme period, options, benefits and contribution:-

S.N.	Scheme Period	Option	Benefit: Monetary limit for Cashless and Reimburshment expenses	Contribution per month
1	First Tenure (01-10-23 to 30-09-24) and Second Tenure (01-10-24 to 30-09-25)	1	Rs. 10 Lakhs	1,000
		2	Rs. 5 Lakhs	500
2	Third Tenure (01-10-25 to 30-09-26)	1	Rs. 10 Lakhs	1,200
		2	Rs. 5 Lakhs	600

3. Family floter :-

Medical facilities on a cashless or reimbursement basis shall be extended to all beneficiaries in accordance with the option selected by them, namely coverage of ₹10 lakh under Option-1 or ₹5 lakh under Option-2, for a scheme period of one year on a family-floater basis. For each subsequent annual scheme period, the beneficiaries shall continue to receive medical facilities on a cashless or reimbursement basis under the option already selected—₹10 lakh under Option-1 or ₹5 lakh under Option-2—upon continuation of the prescribed annual contribution.

4. Network Hospital:-

Network hospitals have been classified into five categories as follows:

- Category 1 – Hospitals have agreement at PCHS rates
- Category 2 – Government, charitable, and public sector undertaking (PSU) hospitals
- Category 3 – Hospitals have agreement with the Power Company at non-CGHS rates
- Category 4 – Hospitals have agreement with the ISA group company at non-CGHS rates
- Category 5 – Hospitals for Ayurveda, Yoga, and Naturopathy treatment

5. Medical Facilities available under the Cashless Health Scheme (CSPCHS):-

5.1 Generally, the following medical facilities shall be available on a cashless basis as per the rules:

5.1.1 Allopathic treatment/diagnostic facilities during hospitalization – In the event of any illness or accident, all expenses (such as doctor/surgeon fees, medicines—including those required after discharge—diagnostic charges, pathology charges, nursing charges, room/ICU/ICCU charges, ambulance charges, etc.) incurred for Allopathic treatment/diagnostic procedures during hospitalization in network hospitals (Category-1, Category-3, and Category-4) shall be admissible as per the provisions of the scheme.

5.1.2 Allopathic Day-Care Treatment/Diagnostic Facilities

All expenses incurred for Day-care surgeries/procedures (including those day-care medical treatments that are included in the day-care list due to advancements in technology) in network hospitals (Category-1, Category-3, and Category-4) shall be admissible under the scheme.

5.1.3 Online OPD (Outpatient) Consultation Facility

Efforts will be made to provide the facility of online consultation, each family enrolled under the cashless health scheme, shall be entitled for to six online consultations in every quarter through the *Mor Bijli Company* mobile app.Unused consultations shall not be carried forward to the next quarter.The expenses for online consultations shall be admissible at CGHS rates as per the provisions of the scheme.

5.2 The following medical facilities shall generally be available on a non-cashless (reimbursement) basis:-

5.2.1 Pre and Post hospitalization (15 days prior to the date of admission and up to 30 days after the date of discharge) expenses incurred on medicines, diagnostic tests, and treatment relating to the same illness for which the beneficiary was hospitalized shall be covered under the scheme.

In the case of physiotherapy, expenses incurred for physiotherapy treatment taken from a physiotherapy practitioner registered with the State Government, for up to 60 days after discharge, shall be admissible under the scheme.

Where physiotherapy has been postponed due to plaster expenses incurred for up to 60 days from the day following the removal of the plaster shall also be covered under the above provisions.

5.2.2 Reibursement facility for the expenses incurred by the beneficiary in the case of hospitalization for Ayurvedic, Yoga, or Naturopathy treatment, 50% of the actual expenses incurred on treatment/diagnostic procedures, or ₹15,000 per beneficiary (for Option-1) or ₹10,000 per beneficiary (for Option-2), whichever is lower, shall be admissible. This facility shall be available only once to each beneficiary during the annual period of the scheme.

5.2.3 Reibursement facility for the expenses incurred by the beneficiary for the purchase of necessary medical equipment (as detailed in point No. 13) for the use of the beneficiary, as advised by the treating specialist during or after the treatment undertaken as per the provisions of the scheme (up to the prescribed limit, if any).

5.2.4 Reibursement facility for the expenses incurred by the beneficiary as per the scheme provision for treatment/diagnostic procedures under In-Patient Department (IPD), Day-Care, or Preventive Health Check-up in hospitals/Investigation Centre, where cashless medical facilities are not available.

6. Ward Entitlement:

6.1 All beneficiaries (whether they have opted for Option-1 or Option-2) shall be entitled to a Private Ward for treatment in all hospitals (whether included in the network hospital list or not).

6.2 In network hospitals, ICU/ICCU charges shall be admissible as per the contract/agreement, whereas in non-network hospitals, such charges shall be admissible as per CGHS rates.

7. Medicines :

7.1 In cashless cases:

In CGHS, package rates pricribed for some surgical procedure etc. include medicine expences, whereas in the case of medical management, medicine expeses are billed separately alongwith item wise billing for others, as per CGHS rate (as applicable). In the cases where package rates are not applicable, the medicines (excluding medicines covered under the Drug Price Control Order) whose Maximum Retail Price (MRP) for single-dose is more than Rs. ₹ 5,000, the Implementation Support Agency (ISA) shall try to secure at least a 20% discount on the MRP of such medicines after verifying its actual market price through online medicine sellers or other sources. For all other medicines (excluding medicines covered under the Drug Price Control Order), the ISA shall make efforts to obtain at least a 10% discount on the MRP of such medicines.

If the hospital is unable to provide the 20% discount, payment may be made based on the maximum available discount on online medicine sellers' websites; however, the ISA must attach the necessary supporting documents in the claim settlement file to justify this.

In other words, for medicine bills raised by hospitals based on MRP (under the CGHS Code US003–Drug), the ISA shall make full efforts to secure a minimum 10% / 20% discount on the MRP, as applicable.

7.2 In reimbursement cases:

Beneficiaries enrolled under the cashless scheme are expected to make efforts to purchase medicines that are frequently required during day-care/other treatments from online medicine sellers. For such medicines (excluding medicines covered under the Drug Price Control Order) whose Maximum Retail Price (MRP) for single-dose is more than Rs. 5,000, the beneficiary should verify the actual market price through online medicine sellers or other sources and try to obtain at least a 20% discount on the MRP.

For all other medicines (excluding medicines covered under the Drug Price Control Order), the beneficiary should try to obtain at least a 10% discount on the MRP.

Accordingly, reimbursement of expenses for medicines purchased from medical stores by the beneficiary for treatment shall be made as follows—

a) The actual amount spent, or
b) The amount assessed after applying the applicable minimum 10% or 20% discount on the Maximum Retail Price (MRP) of the medicines,

Whichever of the above (a) or (b) is lower shall be admissible for reimbursement.

Note: 1) If a medicine (excluding medicines covered under the Drug Price Control Order) is used more than once and its Maximum Retail Price (MRP) for single-dose is more than Rs. 5,000, then a minimum 20% discount on the MRP shall be applicable. For all other medicines (excluding those covered under the Drug Price Control Order), a minimum 10% discount on the MRP shall be applicable.

2) In case of any dispute regarding the applicability of the 10% / 20% discount on the purchase of medicines (excluding medicines covered under the Drug Price Control Order), payment may be made based on the maximum discount available

on the websites of online medicine sellers, provided that the ISA attaches the necessary supporting documents in the claim settlement file.

7.3 Under CGHS, there is only one code "US003" specified for medicines (Drugs), which may be re-classified as follows:

US003_01_DPC – Medicines that fall under the Drug Price Control Order (DPCO).

US003_02_20% – Medicines whose Maximum Retail Price (MRP) for single dose is more than Rs. 5,000 and whose billing is required to be done separately, in addition to the CGHS-prescribed package.

US003_02_10% – All other medicines (excluding those covered above) whose billing is required to be done separately, in addition to the CGHS-prescribed package.

8. Eye Treatment

8.1 The beneficiaries shall be entitled to cashless/reimbursement facilities for cataract treatment, limited to a maximum of two eyes per family during each scheme year, as per the following provisions of the scheme.

The charges for cataract surgery, intraocular lenses(IOL) and other related investigations (which are not included in package rate as per CGHS) shall be payable up to the maximum limits prescribed under the CGHS rates.

The expenses towards the intraocular lenses (IOL) used in cataract surgery shall be admissible as per purchase invoice of the lens provided by the hospital subject to the maximum rate prescribed for the respective lens under CGHS.

Further, the hospital/beneficiary must submit the GST-paid purchase bill, batch number and the lens sticker duly signed and sealed by the operating surgeon.

However, If these documents are not provided, approval for the lens cost may be given after applying a 35% discount on the MRP of the lens in exceptional cases.

8.2 Each beneficiary shall be permitted to receive a maximum of three (3) intravitreal injections per eye during each scheme year.
Eye hospitals shall be paid the charges for intravitreal injections after applying a minimum 20% discount on the injection's MRP, and 25% of the total payable amount shall be borne by the beneficiary as co-payment.
In addition to this, the procedure charges for administering the injection shall be payable separately as per CGHS rates.

Example:
If a beneficiary is administered an injection with an MRP of ₹15,000 and the hospital does not offer more than the minimum required 20% discount, the admissible amount for this item shall be ₹12,000. Out of this, ₹9,000 shall be paid to the hospital by the Power Company through M/s Vidal, and the remaining ₹3,000 shall be paid directly by the beneficiary to the hospital.

8.3 All other treatment of eyes shall be admisable as per the CGHS rates and conditions.

9. Dental Treatment:

Except for treatments of a cosmetic nature, certain following dental treatment/investigation shall be covered under the scheme as Day-Care treatments**,** and the expenditure for such treatment/investigation shall be admissible as per CGHS rates.

SN	Details of Dental Treatment	CGHS Code	CGHS Rate (City wise)					
			Non-NABH			NABH		
			X City	Y City	Z city	X City	Y City	Z city
1	Orthopantomogram (OPG)	DI003	425	383	340	500	450	400
2	Teeth Cleaning (Scaling)	DP002	850	765	680	1000	900	800
3	Tooth Extraction (Simple)	DP010	340	306	272	400	360	320
4	Tooth Extraction (Complicated)	DP011	680	612	544	800	720	640
5	R.C.T. – Single-Rooted Tooth	DP030	1700	1530	1360	2000	1800	1600
6	R.C.T. – Multi-Rooted Tooth	DP031	2550	2295	2040	3000	2700	2400
7	Crown – Metal with Ceramic Facing	DP045	2550	2295	2040	3000	2700	2400
8	X-ray of a Single Tooth	DI001	170	153	136	200	180	160
9	Consultation Fee – Payable Once	CN001	350	350	350	350	350	350

a) Beneficiaries covered under the scheme will receive treatment as day care at the above-mentioned rates. For the beneficiaries who have opted for Option-1, the maximum permissible expenditure is Rs.15,000 per family (family floater) per policy year and for beneficiaries who have opted for Option-2, the maximum permissible expenditure is Rs. 10,000 per family (family floater) per policy year.

b) If the estimated expenditure on dental treatment of regular employees (beneficiaries) is likely to exceed the above-prescribed limit, such beneficiaries shall have the option to avail treatment up to the prescribed limit on a cashless basis and undergo the remaining treatment as per the prevailing procedure by obtaining OPD permission (referral) and can submit a reimbursement claim for such expenses through the office of the Controlling Officer as per applicable rules.

c) During treatment, all beneficiaries may obtain the required medicines from the Power Company's dispensary on the basis of the treating doctor's prescription. No separate permission/referral will be required for this. If medicines are purchased from outside, the cost will have to be borne by the beneficiary, and such expenditure will not be reimbursable under the scheme.

d) Beneficiaries who are unable to avail the cashless facility for dental treatment may submit a claim to the I.S.A. for reimbursement of dental treatment expenses, subject to the prescribed limits.

10. Ambulance Expenses

10.1 Ambulance Expenses – ambulance services expenses are allowed as under

a) In case of a normal ambulance, the actual amount spent, or ₹1,000 plus an amount calculated at the rate of ₹15 per kilometer, whichever is less, shall be addminisable**,** subject to an overall maximum limit of ₹10,000**.**

b) Critical Care Unit (CCU) Ambulance Charges
For a Critical Care Unit–equipped ambulance, the actual amount spent, or ₹1,000 plus an amount calculated at the rate of ₹30 per kilometer, whichever is less, shall be addminisable, subject to an overall maximum limit of ₹25,000. In special cases CMEC may also recommend the admissible amount.

c) The concerned beneficiary is required to submit a certificate issued by the treating doctor regarding the need for ambulance service.

10.2 If the patient's condition is critical and they cannot travel by a regular commercial flight, and if the family members take the patient for further treatment through an air ambulance, then in such a situation, 50% of the amount spent on air ambulance charges will be reimbursable, within the limits available as per the selected option.

If a regular employee is unable to receive reimbursement of even 50% of the air ambulance charges due to exhaustion of the cashless treatment/reimbursement limit, then the case will be referred to the Central Medical Expert Committee (CMEC) for reimbursement of remaining of that 50% of the air ambulance charges.

Based on the recommendations of the Central Medical Expert Committee (CMEC), the decision taken by the competent authority regarding reimbursement of the remaining amount will be binding on all**.**

If, for any reason, the Central Medical Expert Committee (CMEC) or the competent authority decides not to reimburse the remaining amount, then the reimbursement already made earlier under this category will remain unaffected.

11 Preventive Health Check-up:

11.1 Beneficiaries whose age is more than 35 years on the date of the check-up will be eligible to receive the preventive health check-up facility as following:-

SN	Test and Investigations	For age above 35 to 45	For age > 45		City wise Category			
			Female	Male	Non-NABL		NABL	
					Y City	Z city	Y City	Z city
1	Complete Blood Count with ESR	✓	✓	✓	230	204	270	240
2	Sugar Fasting & PP	✓	✓	✓	31	27	36	32
3	Kidney (Renal) Function Test (RFT)	✓	✓	✓	383	340	450	400
4	Liver Function Test (LFT)	✓	✓	✓	383	340	450	400
5	Uric Acid	✓	✓	✓	115	102	135	120
6	Thyroid test - T3 T4 TSH	✓	✓	✓	344	306	405	360
7	Suger - HbA1c	✓	✓	✓	230	204	270	240
8	Lipid Profile (Closrestrol etc)	✓	✓	✓	375	333	441	392
9	Vitamin B12	✓	✓	✓	459	408	540	480
10	Vitamin D3	✓	✓	✓	765	680	900	800
11	Urine R&M	✓	✓	✓	77	68	90	80
12	Heart - ECG	x x x x x	✓	✓	134	119	158	140
13	Heart - ECHO		✓	✓	1128	1003	1328	1180
14	Heart –Trade Mill Test (TMT)		✓	✓	857	762	1008	896
15	Chest X-Ray, PA view		✓	✓	176	156	207	184
16	Sonography USG whole Abdomen		✓	✓	612	544	720	640
17	Cancer marker - Mammography		✓	x x x	1052	935	1238	1100
18	Cancer marker -PAP Smear		✓	x x x	306	272	360	320
19	Cancer marker - PSA		x x x	✓	363	323	428	380
20	Cancer marker -Fit Stool test		✓	✓	77	68	90	80
21	Consultation fee	✓	✓	✓	350	350	350	350

NABL means National Accreditation Board for Laboratories.

11.2 This facility will be available once in a block of two scheme year after the commencement of the scheme.

For example **–** A beneficiary is eligible for one preventive health check-up at any time during a block of two consecutive scheme year**,** i.e**.,** from 01 October 2023 to 30 September 2025**.**

Similarly, the beneficiary will again be eligible for one preventive health check-up at any time during the next block of two consecutive scheme year, i.e., from 01 October 2025 to 30 September 2027**.**

11.3 If the preventive health check-up facility is not available on a cashless basis, the beneficiary may submit a claim once in a block of two scheme years through the ISA for reimbursement of expenses incurred for the preventive health check-up. The reimbursement will be admissible as per the prescribed CGHS rates.

11.4 If all the above tests/investigations are not available at the same time in a one diagnostic centre/hospital, the prescribed tests/investigations may be conducted at different diagnostic centres/hospitals. However, for reimbursement, the claim will be accepted only once (for one beneficiary in a two-year block period for all the investigations carried out).

For all the investigation for which a single claim is being submitted, the maximum gap between the investigation must not exceed three months.

11.5 If the CGHS rates for any investigation are revised, then the total payable amount under the above package will be automatically changed accordingly.

12. Modern/Advance Treatment

Expenses for Modern/Advance treatments, such as liver/kidney/heart/stem cell transplants, immunotherapy, robotic surgery, etc. are included in the scheme as per the rules. Since CGHS rates are not prescribed/available for modern treatments like robotic surgeries, immunotherapy for cancer, and high-end diagnostics, therefore the co-pay will be applicable for such treatments/ investigation as following:-.

1) If the treatment is taken in Category-1 or Category-2 or Category-3 hospitals, or in a non-network hospital, then 25% of the approved bill amount, calculated against the total treatment cost (including the cost of medicines with 10%/20% applicable discount) shall be payable by the beneficiary as co-pay.

2) If the treatment is taken in Category-4 listed hospitals, then the beneficiary shall pay the co-pay amount as 30% against the approved bill for the total treatment cost (including the cost of medicines with applicable 10%/20% discount).

Generally, the following investigation are included under High-End Diagnostics:

i. Brain Perfusion Imaging
ii. CT-Guided Biopsy
iii. CT Urography
iv. Digital Subtraction Angiography (DSA)
v. Liver Biopsy
vi. Magnetic Resonance Cholangio-Pancreatography (MRCP)
vii. Renogram
viii. Other tests that fall under this category

13 Medical Equipment/Implant:

Medical equipment (payable only once in five years to a beneficiary) is included in the scheme as per CGHS rates. However, for payment, it is mandatory to submit the MRP wrapper with barcode certificate .

List of Medical Equipment/Implant

S.N.	Description	Ceiling Rates
1	Oxyzen Concentrator	Rs. 45,000+GST
2	CPAP	Rs. 45,000+GST
3	BIPAP (earlier Bi-Level CPAP)	RS. 68,000+GST
4	Bi-Level Ventilator System	RS. 1,05,000+GST
5	Single Chamber Cardiac Pacemaker without rate response	Rs. 34,840+GST
6	Single Chamber Cardiac Pacemaker with rate response	Rs. 44,928+GST
7	Dual Chamber Cardiac Pacemaker	Rs. 83,200+GST
8	Rotablator Burr	Rs. 23,920+GST
9	Drug Eluting Coronary Stents (DCGI & FDA approved, DCGI & CE approved, for DCGI approved)	Rs. 23,625/-
10	Bare metal coronary stents (Cobalt Stents including coated and other stents) (DCGI & FDA approved, DCGI & CE approved, for DCGI approved)	Rs. 12,000/-
11	Bare metal stainless steel stents	Rs. 10,000/-

Note – 1) If the CGHS rates for any above medical equipment/implant changes, then the above-mentioned rates will also be revised accordingly.

2) Apart from the above, if any beneficiary needs/requires any other medical equipment or implant for treatment, the expenses for those will also be permissible as per CGHS rates.

14. Other provisions of the Cashless Health Scheme (CSPCHS) are as following:-

14.1 Generally, treatment of all diseases of the beneficiaries, including pre-existing diseases, for which hospitalization is required (however, there is no mandatory requirement of being admitted for 24 hours), or treatments that fall under day-care procedures, are included in this scheme.

14.2 If a beneficiary (regular employee) gets married after joining the scheme, their spouse (husband/wife) will considered covered under the scheme from the date of marriage and will be eligible to avail medical facilities as required.

However, the beneficiary must update the necessary information in the MorBijlee Company mobile app within one month for the health card and inform the concerned nodal officer accordingly.

14.3 A newborn (if eligible) will be considered covered under this scheme from birth and will be eligible to avail medical facilities as required.However, the beneficiary must update this information in their mobile app within one month for health card and inform the concerned nodal officer accordingly.

14.4 Expenses as per CGHS rates for the first two deliveries (normal or cesarean) are covered under maternity benefits in the scheme .

14.5 Expenses required for the treatment of injuries or illness resulting from intentional self-harm or from injuries sustained during a suicide attempt are included in the scheme; however, the beneficiary will have to bear an additional 25% co-payment of the total approved expenses, which will not be reimbursable.

14.6 If, on the advice of a specialist doctor, termination of pregnancy becomes necessary due to any disease, the expenses shall be admissible as per the prescribed limits of the scheme. However, if the termination is not medically advised under such conditions, the beneficiary will have to bear the entire cost, which shall not be reimbursable.

14.7 In cases where treatment, such as a liver transplant or other illnesses, is required as a result of alcohol addiction, and the treatment is available under the cashless facility, the beneficiary will be required to bear an additional 25% co-payment of the total approved expenses, which will not be reimbursable.

If the treatment is not available under the cashless facility, reimbursement of expenses incurred will be admissible up to a maximum of 75% of the amount calculated as per the applicable CGHS rates.

14.8 The maximum admissible amount for the expenses of knee and hip replacements will be limited to the applicable CGHS rates.

14.9 Expenses incurred for Enhanced External Counterpulsation (EECP) – Day Care shall be admissible with a 25% co-pay.

14.10 If a beneficiary is admitted to a Category-1 or Category-2 network hospital in an emergency situation—such as anxiety, rapid breathing, low oxygen levels, chest pain, or similar complaints—and after investigations no specific disease is found and the patient is discharged within one or two days, then in such cases, the expenses for medical treatment/investigations shall be admissible under cashless/reimbursement facility with a 25% co-pay.

14.11 Expenses incurred for treatment at home (Domiciliary Hospitalisation), based on the recommendation of the treating doctor of network hospital or the doctor of State Power Company , shall be admissible under the scheme up to a limit of ₹50,000 per beneficiary per policy year.

14.12 If a stapler is used for the treatment of piles (haemorrhoids), then the expense toward stapler shall be admissible at the amount billed by the hospital or ₹20,000, whichever is less.

14.13 Expenses for the treatment of congenital internal/external diseases, defects, and deformities are covered under the scheme.

14.14 In case of an accident, the reasonable one-time expenses for the external prosthetic devices , fitting, and assistive devices (such as glasses, hearing aids, artificial limbs, etc.) are also included under the scheme.

14.14 Expenses incurred for plastic surgery due to an accident are covered under the scheme.

14.15 Expenses for the treatment of mental illnesses are also covered under the scheme.

14.16 In cases of organ transplantation, the medical expenses of the organ donor are covered under the scheme.

14.17 Expenses for treatment/ investigation of chemotherapy, dialysis, radiotherapy, kidney /liver failure, HIV, etc. are covered under the scheme. However, Chemotherapy infusion charges will be payable separately.

14.18 (a) In cases of dialysis, the lab charges are included in the CGHS package rates.

(b) If cashless facility for dialysis, including medicines, is not available, the required medicines related to dialysis can be obtained from the Power Company's hospital/dispensary. Otherwise, the beneficiary may purchase such medicines from the market, but an effort should be made to obtain the maximum discount from the medical store.

(c) Reimbursement of medicine expenses will be made after at least 10%/20% discount on the MRP as per the provisions of the scheme.

14.19 Expenses such as hospital registration fees, service charges, surcharges, and consumables/disposables used during treatment (excluding non-medical items) shall be covered under the scheme, subject to approval by the ISA after necessary verification (as per the guidelines of the Insurance Regulatory and Development Authority of India), if applicable.

If the hospital bills consumables/disposables based on MRP, then in such cases, the ISA will approve the amount after applying a reasonable/at least 10% discount on the MRP.

14.20 Expenses for treatment/investigation incurred during hospitalization for COVID or Swine Flu are covered under the scheme.

15. The following expenses are not included/covered under this scheme (Exclusions):

15.1 Unproven Treatments – Expenses related to any unproven treatments and services/supplies. *(Unproven treatments are those treatment procedures or supplies for which significant medical documentation supporting their necessity is not attached.)*

15.2 Gender Reassignment Treatments – Expenses related to changing the characteristics of the body to the opposite gender through any treatment, including surgical management

15.3 Infertility – This includes the following:

i) All expenses related to artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT,ICSI, including assisted reproductive services.

ii) All expenses related to gestational surrogacy.

However, expenses for delivery (normal and cesarean delivery) arising from the above will be admissible only within the limits specified.

15.4 Refractive Errors – Expenses incurred for treatment to correct vision when the refractive error is less than 7.5 diopters.

15.5 Consumption of Prohibited Drugs (drugs such as hash, cannabis, cocaine, etc.) – Expenses incurred for treatment arising from the use of prohibited or any condition and consequences resulting from drug addiction.

15.6 Non-Prescription Drugs/Diagnostics – Expenses for investigation or medicines which/that are not prescribed by a doctor.

15.7 Violation of Law – Expenses for treatment of any illness resulting from, or directly caused by, a beneficiary's intentional violation or attempted violation of the law.

15.8 Cosmetic or Aesthetic Treatments – Expenses incurred for cosmetic or aesthetic/beauty treatments for any reason.

15.9 Plastic Surgery for Non-Medical Reasons – Expenses for plastic surgery performed for reasons other than an accident or as part of treatment for a disease.

15.10 Expenses for spectacles, contact lenses, or hearing aids under normal circumstances.

15.11 Expenses for any dental surgery that is cosmetic in nature.

15.12 Expenses for surgical treatment of obesity and related complications.

15.13 Expenses for vitamins and tonics that are not part of a treatment prescribed by a doctor.

15.14 Non-Medical Expenses – Expenses for personal comfort or convenience, unless they are part of treatment, and all other non-medical expenses.

15.15 Expenses for treatments, investigations, or medical services obtained by beneficiaries outside the country are not covered under this scheme.

16. Power Company Health Scheme (PCHS) Rates means:-

a) Special ceiling rate are prescribed for certain treatments/investigations, (i.e. the *special rates* or the *rates of the Health Care Organization* (diagnostic centre/hospital), whichever is lower, shall be applicable). In addition sub-limits of expenses also prescribed for certain procedures.

b) For all other remaining treatments/investigations
The Central Government Health Scheme (CGHS) rates prescribed for Tier-I/II/III (X/Y/Z category) cities {i.e., the applicable *CGHS rates for the concerned city* or the *rates of the Health Care Organization* (diagnostic centre/hospital) whichever is lower, shall apply}.

17. The cashless and reimbursement rates for treatments and investigations, as well as ward charges in the five categories of network hospitals, are as follows –

Categories of Network Hospitals	Description	Rates for Treatment/Investigations (Cashless & Reimbursement)	Ward Charges (for Private Ward)
Category–1	Hospitals have agreement /tied up for cashless treatment at PCHS rates	PCHS Rate	a) For hospitals with 50 beds or more – Maximum ₹4,500 per day, or the hospital's rate, whichever is lower. b) For hospitals with less than 50 beds – Maximum ₹3,000 per day, or the hospital's rate, whichever is lower.
Category–2	Government, charitable, and public sector undertaking (PSU) hospitals	Hospital rate	Hospital rate
Category–3	Hospitals have agreement /tied up with the Power Company for cashless treatment at Non-CGHS rates	Hospital rate	Hospital rate
Category–4	Hospitals have agreement /tied up with the ISA group company for cashless treatment at Non-CGHS rates	Hospital rate	Hospital rate
Category–5	Hospitals for Ayurveda, Yoga, and Naturopathy treatments (Reimbursement only)	Hospital rate	Hospital rate
-	Non-network hospitals (Reimbursement only)	PCHS Rate	As per Category–1

Note – Category–2 hospitals (Government, Charitable, and Public Sector Undertaking hospitals) generally do not provide medical facilities on a cashless basis. Therefore, beneficiaries shall be eligible for reimbursement at the hospital's rate, subject to co-pay and any additional co-pay payable, if applicable.

18. Rates of Co-pay (Part payment) and additional co-pay by the beneficiary:

SN	Description	Hospital Category	Rates of Co-pay and Additional Co-pay (for Private Ward)	
			Amount claimed in the previous period	
			Rs. 9 lakh or less	More than Rs. 9 lakh
1	Delivery, cataract, dental treatment, and knee/hip replacement	any category	any amount billed in excess from applicable CGHS rates	
2	Modern treatments such as robotic surgery, immunotherapy for cancer treatment, natural bypass (E.E.C.P. day-care), high-end diagnostics.	Category -1, 2 and 3	25%	45% (25%+20%)
		Category-4	30%	50% (30%+20%)
3	If any beneficiary is admitted to a hospital in an emergency—for example, due to panic, rapid breathing, low oxygen level, or chest pain—and no specific serious disease is found.	Category -1, 2 and 3	25%	45% (25%+20%)
		Category-4	30%	50% (30+20%)
4	If due to alcohol addiction, liver transplant or treatment of other liver-related diseases or other illnesses is required.	Category-1and 2	25%	45% (25%+20%)
		Category-3	50% (25%+25%)	70% (50%+20%)
		Category-4	55% (30%+25%)	75% (55%+20%)
5	Any other treatment (apart from the above) carried out at non-CGHS rates.	Category-3	25%	45% (25%+20%)
		Category-4	30%	50% (30%+20%)
6	Hospitals for Ayurveda, Yoga, and Naturopathy treatments (reimbursement only).	Category-5	50% or { Billed amount – Rs. 15,000 (for Option-1) / Rs. 10,000 (for Option-2), whichever is higher } (per beneficiary)	

19. Additional Co-pay – In addition to the co-pay amounts described above, the following additional co-pay shall also be payable:

a) If, due to alcohol addiction, a liver transplant or treatment of other liver-related diseases or any other illnesses is provided under the cashless facility, then 25% of the total approved expenditure shall be borne by the beneficiary as additional co-pay.

b) If, during any scheme year, the beneficiary receives cashless/reimbursement medical benefits exceeding Rs. 9 lakh, then in the next scheme year, the beneficiary shall pay 20% of the expenditure as additional co-pay for any treatment/investigation taken at non-CGHS rates.

Example (1): A beneficiary received treatment in a private ward of Apollo Hospital, Hyderabad, which is listed under Category-4**.**

The details of expenses incurred are as follows:

- Amount billed by the hospital for private ward: Rs. 4,35,000
- Non-medical expenses: Rs. 5,000
- Amount approved by ISA: Rs. 4,30,000
- Applicable CGHS rate for the above treatment in private ward: Rs. 3,50,000
- Applicable co-pay rate as per Table-1: 30%

Calculation of the amount payable by the beneficiary:

(a) Amount calculated at the applicable co-pay rate on the ISA-approved bill for private ward: Rs. 4,30,000 × 30% = Rs. 1,29,000

(b) Difference between the ISA-approved bill for private ward and the applicable CGHS rate for private ward: Rs. 4,30,000 – Rs. 3,50,000 = Rs. 80,000

(c) The lesser of (a) and (b) will be the final amount payable as co-pay.
Thus, the beneficiary will pay Rs. 80,000 as co-pay, and Rs. 5,000 towards non-medical expenses**.**

Example (2) - If the beneficiary who underwent the above treatment has already claimed Rs. 9.5 lakh during the previous annual period, then the total payable amount including co-pay and additional co-pay will be calculated as follows:

- Amount billed by the hospital for private ward: Rs. 4,35,000
- Non-medical expenses: Rs. 5,000
- Amount approved by ISA: Rs. 4,30,000
- Applicable Additional Co-pay Rate: 20%
- Additional Co-pay Payable: Rs. 86,000
- Co-pay Payable: Rs. 80,000
- Total amount payable as Co-pay and Additional Co-pay: Rs. 1,66,000

Example (3) - If the beneficiary who underwent the above treatment is suffering from alcohol addiction, then the total payable amount including co-pay and additional co-pay will be as follows:

- Amount billed by the hospital for private ward: Rs. 4,35,000
- Non-medical expenses: Rs. 5,000
- Amount approved by ISA: Rs. 4,30,000
- Applicable Additional Co-pay Rate: 25%
- Additional Co-pay Payable: Rs. 1,07,500
- Co-pay Payable: Rs. 80,000
- Total amount payable as Co-pay and Additional Co-pay: Rs. 1,87,500

Example (4) - If the beneficiary is suffering from alcohol addiction and has also claimed more than Rs. 9 lakh in the previous annual period, then the total payable amount, including co-pay and additional co-pay, will be as follows:

- Amount billed by the hospital for private ward: Rs. 4,35,000
- Non-medical expenses: Rs. 5,000
- Amount approved by ISA: Rs. 4,30,000
- Applicable Additional Co-pay Rate: 45%
- Additional Co-pay Payable: Rs. 1,93,500
- Co-pay Payable: Rs. 80,000
- Total amount payable as Co-pay and Additional Co-pay: Rs. 2,73,500

20. For implants (other than lenses), if the MRP wrapper with barcode is submitted along with the purchase invoice, the expenses for implants will be approved subject to the CGHS rate. However, if a particular implant does not have a prescribed CGHS rate, then upon submission of the purchase bill from the hospital, approval will be given based on the purchase price. In all other cases, approval will be granted after applying 25% discount on the MRP.

21. For any treatment/investigation whose rates are not specified in the CGHS rate list or in the rate list prescribed by the Power Company (if any), the amount payable to the hospital by the ISA shall be the lower of the following:

    1. The prevailing rate for the same treatment/investigation in other similar hospitals**,** or
    2. The rate billed by the hospital where the treatment/investigation is taken, after applying a minimum 10% discount.

    The difference between the payable amount and the billed amount shall NOT be recovered from the beneficiary

22. The Implementing Support Agency shall ensure that the total payable amount to the hospital for medicines/lenses/implants is approved after applying the applicable discounted rates. The approval letter must clearly specify, separately, how much of this payable amount is to be paid by the Power Company as per the scheme provisions and how much is to be paid by the beneficiary. This information shall be communicated to the beneficiary as well as the concerned hospital/diagnostic centre

23. If a beneficiary visits a hospital for OPD/investigations and, after the investigations, the hospital advises admission and the beneficiary gets admitted, then all expenses incurred during the OPD visit shall be claimable by the hospital under the cashless scheme, and the hospital shall refund those expenses to the beneficiary.

24. For regular employees, in cases of accidents occurring during departmental duty, treatment/investigation facilities in network hospitals shall be available in cashless without any upper limit, subject to the recommendation of the controlling officer (which must be provided within 24 hours of admission). This includes any follow-up treatment related to the same accident, whenever required after the initial treatment.

    The expenses incurred under this head will not be adjusted against the beneficiary's selected option under the cashless/reimbursement medical facility. That is, the

entire expenditure—including all non-medical expenses—shall be borne directly by the concerned State Power Company without any deductions.

25. Before making payment for online consultation bills, the expenses must be entered in the respective beneficiaries' claim accounts. The ISA will make payment of such bills company-wise.

26. As per the current CGHS rules, the maximum number of admissible hospitalisation days under package rates is as follows:

- Specialised / Super-specialised treatment – Maximum 12 days
- Major surgery – Maximum 7 days
- Laparoscopic surgery – Maximum 3 days
- Angioplasty – Maximum 3 days
- Normal delivery – Maximum 3 days
- Day-care or minor OPD surgery – Maximum 1 day

If, during hospitalization within the above time limits, the patient's condition does not adequately improve, or if complications arise, or for any other justified reason additional hospitalization beyond the prescribed time is required, then in such exceptional cases, based on certified documents and medical records from the hospital, the following expenses for the days exceeding the package duration shall be admissible:

- Room rent
- Investigation charges
- Doctors' visit charges
  (Not more than 2 visits per day by any two specialists/consultants)
- Cost of medicines, etc.

However, billing for these additional days shall be payable only if prior approval has been obtained from the Implementing Support Agency (ISA).

27. Reimbursement of Claims:

27.1 Under the following circumstances, the medical expenses paid by the beneficiary for treatment/investigation, as per the provisions of the scheme, shall be reimbursable at the prescribed rates for both regular employees and pensioners, upon submission of the claim in the prescribed format:

i) Expenses incurred for treatment/investigation under IPD / Day-care / Preventive Health Check-up in hospitals where cashless medical facility was not available**.**

ii) Expenses incurred under IPD / Day-care for treatment/investigation by regular employees of State Power Companies, in any hospital (where cashless medical facility was not available)**,** with prior approval from the company's medical officer, as per the provisions of the scheme.

iii) Expenses incurred on medicines / investigation / treatment related to the *same illness* for which the patient was admitted, up to 15 days before the date of admission and up to 30 days after discharge, are included under the scheme.

In case of physiotherapy, expenses incurred for physiotherapy treatment from a physiotherapy practitioner registered with the State Government, up to 60 days after discharge, are included.

If physiotherapy has been postponed due to plaster, then the expenses incurred under this head for up to 60 days from the next day after removal of the plaster are also included.

iv) Expenses incurred for purchasing necessary medical devices listed in Annexure-4, for use by the beneficiary during or after treatment, as advised by the treating specialist, shall be reimbursable (up to the prescribed limit, if any), as per the provisions of the scheme.

v) After cashless treatment in a network hospital, at the time of discharge, the ISA shall clearly mention in the *Final Approval* the amount payable by the beneficiary as per the provisions of the scheme.
If, apart from this amount, the hospital has unnecessarily collected any additional amount from the beneficiary (at the time of admission/discharge), such expenses, if admissible under the scheme, shall be reimbursable.

vi) If the beneficiary has taken another health insurance policy at personal expense (outside the cashless scheme), then such beneficiaries must first submit the claim to their health insurance company.
If, during this process, certain expenses on treatment/investigation have to be borne by the beneficiary, then a claim for reimbursement of such expenses, along with the required documents, may be submitted through the ISA under the Cashless Medical Facility Scheme.

vii) Expenses arising due to other reasons, such as errors in calculating the amount payable by the beneficiary under co-pay, etc.

27.2 Pre-intimation before availing Treatment/Investigation on cash basis:-

If any treatment / investigation is not available on cashless basis at any hospital / diagnostic center, the beneficiary must necessarily provide prior intimation before admission as an inpatient (IPD), or before the start of treatment in day-care/preventive health check-up.

This intimation must be given through the Mor Bijli Company mobile app or to the Raipur helpdesk of the Implementation Support Agency via WhatsApp or SMS, along with the patient's health card and the complete address of the hospital, and details of the disease for which treatment is sought, as per the following:

1. Name of the beneficiary
2. Name of the regular employee/pensioner
3. Name of the power company
4. Vidal ID number
5. Name and address of the hospital, including contact number

6. Name of the illness
7. Date on which treatment will begin
8. Estimated duration of treatment
9. Estimated cost of treatment

If, for any reason, prior intimation cannot be given, then the beneficiary must necessarily inform within 24 hours of admission as an indoor (IPD) patient**.** In cases where prior intimation is not given, the percentage (0–100%) of the claim amount that will be reimbursable shall be decided by the Executive Director/Chief Engineer (Human Resources), Transmission Company, based on the recommendation of the Chief Medical Officer, Transmission Company. This decision shall be binding on all

27.3 Time Limit for Reimbursement Claims

The maximum time limit for submitting a reimbursement claim for treatment/investigation expenses shall be three calendar months from the date of discharge/investigation.

If a claim is submitted after three months but within six months from the date of discharge, then 90% of the admissible amount under the scheme provisions will be reimbursable in such cases.

Similarly, claims submitted after six months from the date of discharge will be considered time-barred.

In cases where claims are not submitted within the six-month time limit, then under special circumstances, the decision regarding what proportion (0–75%) of the admissible amount will be reimbursable shall be taken by the Executive Director/Chief Engineer (Human Resources), Transmission Company**,** based on the recommendation of the Central Medical Expert Committee**.** This decision shall be binding on all.

27.4 Limit on Reimbursement of Medical Expenses

(i) During the annual period of the scheme, medical facilities (cashless/reimbursement) will be provided within the limit of the selected option (₹5 lakh / ₹10 lakh, as applicable).

(ii) If expenses exceed the above limit, the regular employee (beneficiary) may submit a claim for reimbursement to the office of the controlling officer under the provisions of the Chhattisgarh State Power Company Medical Reimbursement Scheme. However, pensioners (beneficiaries) must bear such excess expenses themselves.

(iii) Reimbursement of such claims will be allowed at CGHS rates, and no separate approval from the company's medical officer will be required for this.

(iv) If the treatment/investigation expenses incurred for the family beneficiaries of a regular employee exceed the medical facility limit available under the selected cashless health plan option (₹5 or ₹10 lakh), then the required additional amount must be paid directly to the concerned hospital by the beneficiary. A reimbursement claim for such expenses may be submitted to the controlling office. These expenses will be reimbursed as per CGHS rates.

Under this arrangement:

- Verification of expenses up to the selected option limit will be done by the Implementation Support Agency (ISA).
- Verification of expenses beyond the selected option limit will be the responsibility of the power company's medical officers.

(v) If the entire treatment is taken at a non-network hospital, the beneficiary shall submit the claim up to the limit of the selected option through the ISA. The claim for the remaining amount may be submitted to the controlling office using attested copies of the required documents.

The controlling officer's office will process reimbursement claims of regular employees (beneficiaries) covered under the cashless health scheme only for those claims where the medical expenses exceed the limit of the selected option (₹5 lakh / ₹10 lakh).

In all other cases, reimbursement claims for inpatient, day-care, and preventive health check-up expenses of beneficiaries who have opted for the cashless health scheme shall be processed only through the ISA.

If, under any circumstance, such beneficiaries obtain treatment /investigation/preventive health check-ups in any hospital with prior permission from the power company's medical officer, even then the reimbursement claim for such expenses must be processed only through the ISA.

If the beneficiary mistakenly submits the claim to the controlling office, it shall be the responsibility of the controlling office not to process the claim, but instead return it to the beneficiary or forward it to the ISA's cashless helpdesk center at Raipur (Dangania) for necessary action.

(vi) If such cases are forwarded by the controlling office to the office of the power company's medical officers for necessary verification, then the power company's medical officers shall conduct the required verification and forward the case to the ISA's Cashless Helpdesk Center at Raipur (Dangania) for payment.

(vii) If the beneficiary fails to submit any of the required prescribed documents for reimbursement claims, or if the ISA raises any other objection and informs the beneficiary accordingly, and the beneficiary does not submit the required information/documents to the ISA within the stipulated time limit, then the ISA shall be free to settle the claims based on the available documents. Such cases shall not be re-examined or reconsidered thereafter.

(viii) Reimbursement of Treatment Expenses when the beneficiary has an Additional Health Insurance Policy (Other than the Cashless Medical Facility)- If a beneficiary has purchased any other health insurance policy (health insurance) apart from the cashless medical scheme, then such beneficiaries are expected to first file a claim with their health insurance company. (However, if the beneficiary has taken a Deductible Policy, then the deductible amount may be claimed first from the Power Company under this scheme, and only the remaining amount should be claimed from the insurance company.) If, during the course of treatment/investigation, some expenses have to be borne by the beneficiary personally, then a reimbursement claim for such expenses may be submitted under the cashless medical facility scheme through the ISA, along with all required documents.
(If original documents are not available, then certified duplicate copies of bills, discharge summary, etc., issued by the hospital, along with full details of the claim submitted to the insurance company and the amount received from it, must be submitted.) The ISA will first assess the payable amount for the entire treatment as per the scheme provisions/CGHS rates. If the claimed amount is less than the payable amount, the claimed amount will be reimbursed. Otherwise, only the payable amount will be reimbursed.

In such cases, the sum total of the amount received from the insurance company and the claim amount payable under the cashless medical facility scheme must not exceed the total expenditure incurred on treatment/investigation (including any amount paid under the cashless facility, if applicable).

Before approving such cases, the ISA must forward them to the Chief Nodal Officer and obtain their remarks.

Example

A beneficiary has selected Option-1 of the cashless medical scheme and has also purchased a ₹5 lakh health insurance policy. During hospital admission, the beneficiary avails the cashless facility provided under the private health insurance. If the total treatment cost amounts to ₹8 lakh, and the insurance company provides cashless coverage/reimbursement of only ₹4.5 lakh, and the remaining ₹3.5 lakh has to be paid by the beneficiary, then: The beneficiary may submit a reimbursement claim for ₹3.5 lakh under the cashless medical scheme. If, as per the scheme provisions, the payable amount for the entire treatment is more than ₹3.5 lakh, then the beneficiary will be reimbursed ₹3.5 lakh. If, as per the scheme provisions, the payable amount for the entire treatment is ₹2.5 lakh, then the beneficiary will be reimbursed ₹2.5 lakh.

28. Entry/Exit from scheme and change of option and renewal:

28.1 For beneficiaries who do not wish to make any changes in their selected option, the cashless medical/reimbursement facility (₹10 lakh/₹5 lakh) will be automatically renewed (auto-renewal) for the next scheme year as per the previously selected option.

The contribution amount, as prescribed for the selected option, will continue to be deducted from their salary/pension for the next scheme year.

28.2 If changes are made in the scheme provisions from time to time, opportunities to change the scheme options may generally be provided at the beginning of a new scheme year, as required.

28.3 If any regular employee/pensioner wishes to join the scheme during any scheme year, they must provide the required information in the Mor Bijli Company App**.** After six months (excluding the month in which the application is submitted), once consent is given for the deduction of the required contribution amount, the individual may be included in the scheme from the month in which the contribution deduction is made**.**

28.4 For changing the option (from Option-1 to Option-2 or from Option-2 to Option-1), the beneficiary must update the selected option information in the mobile app one month before the start of the new scheme year. Such permission to change the option will be given to regular employees/pensioners only once in their lifetime, and only if the beneficiary has not availed more than 50% of the monetary limit of the medical facility available under the selected option (₹10 lakh / ₹5 lakh) in any previous scheme year (whether through cashless treatment or reimbursement).

Example

If a beneficiary wants to change from Option-2 to Option-1, and the beneficiary has availed ₹2.25 lakh under cashless medical facility/reimbursement in any previous scheme year, then they will be allowed to change from Option-2 to Option-1 in the next scheme year.

However, if the beneficiary has availed ₹2.51 lakh under cashless medical facility/reimbursement in any previous scheme year, then they will not be allowed to change from Option-2 to Option-1, because they have already used more than 50% of the monetary limit available under Option-2.

28.5 If a beneficiary (regular employee/pensioner) dies unexpectedly, the cashless facility for the remaining eligible dependent family members shall continue as per the selected option as long as the prescribed contribution continues to be received**.** If the eligible dependent is not receiving family pension or is covered under the New Pension Scheme (NPS)**,** then they must deposit the prescribed contribution for the remaining period of the current scheme year and for the next scheme year in advance, in a single lump sum**.**

However, if no eligible dependent family member remains alive under the scheme, then the facility shall be terminated immediately, and no contribution shall be payable for the remaining period.

28.6 If a beneficiary is dissatisfied with the contribution requirements, other provisions of the scheme, or its implementation, they may opt out of the scheme at any time. However, for pensioners only, it must be ensured that the total benefits availed (cashless/reimbursement) since the start of the scheme do not exceed the total amount of contribution paid by them. If the benefits taken exceed the contributions paid, then the pensioner may exit the scheme only after paying the difference amount in a single lump sum.

28.7 Once a regular employee or pensioner exits the scheme, they generally will not be allowed to rejoin the scheme in the future.

29. No-Claim Bonus

29.1 If, during any one scheme year, no claim is submitted under this scheme for medical treatment/investigation (including preventive health check-up expenses) for any member of the beneficiary's family (regular employee/pensioner), then the medical facility limit available to such a family in the next scheme year (cashless/reimbursement), as per the selected option (₹5 lakh / ₹10 lakh per family per year), may be increased by 5% per no-claim year, up to a maximum of 50%.

That is:

- For Option-1, the No-Claim Bonus will be ₹50,000 for each No-Claim scheme Year.
- For Option-2, the No-Claim Bonus will be ₹25,000 for each No-Claim scheme Year.

29.2 As long as the medical expenditure limit (₹5 lakh / ₹10 lakh) under the selected option is not exhausted, beneficiaries covered under the cashless health scheme must submit all reimbursement claims for treatments/investigation included in this scheme only through the ISA. However, if a beneficiary mistakenly submits a reimbursement claim to their controlling officer's office and receives reimbursement from there, then they will not be eligible for the No-Claim Bonus for that year.

29.3 The No-Claim Bonus will become admissible six months after the start of the next annual period.
For example:
The No-Claim Bonus for the second scheme year of the scheme (which starts in October 2025) will become admissible after six months, i.e., from 01 April 2026.

29.4 Once a beneficiary receives the No-Claim Bonus even once, this benefit will continue to remain available in the following years as a carry-forward, regardless of whether a claim is made later.

For example:
If a beneficiary has selected Option-1 and receives a No-Claim Bonus in the first year, then in subsequent years the medical facility limit (cashless/reimbursement) will increase from ₹10 lakh to ₹10.50 lakh.

If the same beneficiary makes a claim during the second annual period, then they will not receive a No-Claim Bonus for that year, but the medical facility limit for the third annual period will remain ₹10.50 lakh**.**

30. In cases where there is any doubt, dispute, or ambiguity regarding hospital bills or claims submitted by beneficiaries—whether raised by the I.S.A., the power company's doctors/officers, or the hospital itself—and such cases are referred to the Chief Nodal Officer for resolution, these matters may be further referred to the C.M.E.C. for final settlement.

In such cases, the decision taken by the Executive Director/Chief Engineer (Human Resources), Transmission Company, based on the recommendations received from the C.M.E.C., shall be final and binding on all parties.

31. Timely payment to hospitals/diagnostic centers is the key to the success of this scheme. At present, the required payments to hospitals and beneficiaries are being made by the respective State Power Company through the I.S.A.

Payments to the concerned hospitals/beneficiaries shall generally be made within 10 working days from the date of receipt of the bills/reimbursement claims at the designated office of the I.S.A. However, if any objection is raised by the I.S.A., the count of 10 working days shall begin from the date on which all objections are fully resolved by the hospital/beneficiary.

If the concerned hospital/beneficiary fails to resolve the objections within the specified time limit, or submits an incomplete response, then the I.S.A. shall take appropriate action on such claims, as per the merits of the case, within 45 days from the date of receipt of the bill/reimbursement claim.

32. If the payable amount is not paid to the hospitals within 30 days from the date of submitting the bills or from the date of disposal of the objection, whichever is later, then the ISA or the concerned State Power Company, which is responsible for the delay, shall pay the balanced amount to the concerned hospitals along with the applicable simple interest. The rate of simple interest shall be 0.23% per week (12% annually) for the delayed period or any part thereof.

33. If, after verification by the designated doctors/officers/audit teams of the companies (CSPC) — including internal audit, A.G. audit, or agencies assigned for medical desk audit — it is found that the I.S.A. has paid any excess amount to a hospital in relation to any bill/claim, then upon receiving information from the power company:

- The I.S.A. shall recover the excess amount from the relevant hospital bills, or
- Adjust the amount against the hospital's dues/bills within the next 30 days.

If this is not done, it shall be the responsibility of the I.S.A. to ensure that the amount is deposited from its own resources into the relevant company's float account**.**

34. Resolution of Complaints/Disputes/Dis-satisfaction:

34.1 In response to continuous requests from various employee/official/retired employee organizations, a cashless health scheme has been designed on a contributory basis with better provisions, in accordance with the CGHS scheme. The core structure of this cashless health scheme will remain contributory.

(i) If a beneficiary is dissatisfied with the implementation of the scheme, they may first submit their complaint in writing to the Cashless Helpdesk Center or through the Mor Bijli Company mobile app.

If the beneficiary is not satisfied with the resolution provided by the I.S.A., they may submit the detailed case along with supporting evidence/documents in writing to the office of the Executive Director/Chief Engineer (Human Resources), Transmission Company, through an appropriate channel.

The matter should generally be resolved within three months, and the decision taken by the Executive Director/Chief Engineer (Human Resources), Transmission Company shall be final and binding on all parties**.**

34.2 In case of any uncertainty/doubt/ambiguity/dispute on the need or reimbursement of any kind of treatment/investigation or approval of bills of hospitals/investigation centers or interpretation of any provision of this circular etc., the matter will be referred to the Central Medical Expert Committee (CMEC). In such cases, the decisions taken by the Executive Director/Chief Engineer (Human Resources) of the Transmission Company on the recommendation of the Central Medical Expert Committee (CMEC) will be binding on everyone.

34.3 If the claims submitted by any hospital or the beneficiaries appear to be doubtful, then after proper investigation such cases will be referred to the Central Medical Expert Committee (CMEC). Central Medical Expert Committee (CMEC) can reject such cases as well as recommend recovery of additional amount as financial penalty or other action, on which the decisions taken by the Executive Director/Chief Engineer (Human Resources) Transmission Company will be binding on all.

34.4 If any hospital violates the terms of the contract or violates the terms of empanelment or any complaint is received from the beneficiaries or there are repeated errors in billing or unnecessary amount is recovered from the beneficiaries or any lapse is found in the treatment/investigation of the beneficiary or ISA. If any adverse observation is received in respect of such hospitals by audit or ISA Cashless or the rating of such hospitals is below average, then the decision to keep such hospitals in grey-list (temporary exclusion from the list of network hospitals) will be taken by the Chief Nodal Officer/Coordinator, Cashless Scheme. If any assurance is received that the mistakes being made by the concerned hospital will not be repeated in the future or necessary improvements will be made, then the decision to remove them from the gray list can also be taken by the Chief Nodal Officer/Coordinator, Cashless Scheme. If the required improvements are not made by the concerned hospital, then such case will be referred to CMEC. It will be presented for appropriate action.

35. Verification and Updating of Beneficiary Information:

The information of beneficiaries and their dependent family members is provided based on the details submitted either through the Mor Bijli Company mobile app or in the prescribed written form for the cashless health scheme, to the relevant office/nodal officer. Beneficiaries are responsible for verifying the submitted information periodically, and if any updates are required, they must:

1. Update the required information in the mobile app between the 1st and 7th of each month, and
2. Submit a declaration in the prescribed format (downloaded from the mobile app, printed, and signed) to their controlling officer's office.

The controlling officer will check the submitted documents, and if satisfied, will make recommendations for the required changes and ensure that the updated information is forwarded to the relevant power company nodal officer. The nodal officer will then forward the necessary changes to the Central Nodal Officer. Beneficiaries will be solely responsible for any errors or intentionally false information provided. However, the relevant nodal officer, through the controlling officer, will periodically verify the data to ensure that only eligible beneficiaries receive the benefits of the scheme in accordance with the rules.

36. Miscllaneneous:

36.1 Hospitals located in Chhattisgarh are generally being contracted to provide medical/treatment and diagnostic services on a cashless basis at P.C.H.S. rates. However, if some major multi-specialty hospitals do not agree to provide certain specialty treatments on a cashless basis at P.C.H.S. rates, then considering the needs of beneficiaries, such hospitals may be listed for treatment at other rates, such as the hospital's own rates (including discounts). Similarly, for pensioners/other beneficiaries residing outside Chhattisgarh**,** if major hospitals are not willing to provide cashless medical/treatment services at rates contracted by central/state government undertakings (such as NTPC, SBI, etc.) or at CGHS rates, and if the contracts/agreements of such hospitals are with the ISA's group company and they also agree to provide cashless medical services to power company beneficiaries at the same contracted rates, then such hospitals may also be included in the list of network hospitals**.**

36.2 For beneficiaries who are admitted or receive treatment under day-care up to the last date of the scheme's scheme year, the expenses incurred for such treatment (including pre- and post-treatment costs) will be considered within the same scheme year, even if the treatment/discharge from the hospital occurs in the next scheme year. If any regular employee, pensioner, hospital, diagnostic center, medical store, or I.S.A. misuses any provision(s) of the scheme and thereby causes or attempts to cause financial loss to the Chhattisgarh State Power Company, it shall be considered a serious offense.

Accordingly:

- Strict disciplinary action may be taken against the concerned employee/ pensioner, including removal from the scheme.
- The name of the listed/contracted hospital or diagnostic center may be removed from the network, and the contract may be terminated.
- The culprits may be levied fines and/or subjected to appropriate legal action**.**