Bajaj Allianz General Insurance Company Limited
Bajaj Allianz House, Airport Road, Yerewada, Pune- 411006.
IRDA REGISTRATION NO. 113.
CIN: U66010PN2000PLC015329
UIN: BAJHGSP20133V011920

Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) In UT of Jammu and Kashmir and UT of Ladakh

Policy Wordings

Whereas, the **State Health Agency (SHA)** hereinafter referred to as the I**nsured** has by a proposal and declaration dated as stated in the Schedule which shall be the basis of this contract and is deemed to be incorporated herein, has applied to Bajaj Allianz General Insurance Company Limited (herein after called the "Company" or "Insurer") for the insurance hereinafter set forth in respect of Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) Beneficiary Family Units named in the Policy Schedule and has agreed to pay premium in installments in accordance with Section 12.1 of volume II of Tender Document for Implementation of "Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana" PMJAY In UT of Jammu and Kashmir and Ladakh" volume II released by State Government of Jammu and Kashmir and Ladakh in January 2020 as consideration for such insurance, we the Company hereby agrees to AB-PMJAYPMJAY Beneficiary Family Units named in the Schedule as per these Terms and Conditions.

A. DEFINITIONS:

1. **AB-PMJAY** shall refer to Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana managed and administered by the Ministry of Health and Family Welfare, Government of India with the objective of reducing out of pocket healthcare expenses and improving access of validated Beneficiary Family Units to quality inpatient care and day care surgeries (as applicable) for treatment of diseases and medical conditions through a network of Empanelled Health Care Providers.
2. **AB-PMJAY Beneficiary Database** refers to all AB-PMJAY Beneficiary Family Units, as defined in Category under the deprivation criteria of D1, D2, D3, D4, D5 and D7, Automatically Included category (viz as Households without shelter, Destitute-living on alms, Manual Scavenger Families, Primitive Tribal Groups and Legally released Bonded Labour) and 11 defined occupational un-organised workers (in Urban Sector) of the Socio-Economic Caste Census (SECC) 2011 database of the State along with the existing RSBY Beneficiary Families not figuring in the SECC Database of the Socio-Economic Caste Census (SECC) database who are residents in Service Area as on 28.02.2018.
3. **Accident** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.
4. **Appellate Authority** shall mean the authority designated by the State Health Agency which has the powers to accept and adjudicate on appeals by the aggrieved party against the decisions of any Grievance Redressal Committee set up pursuant to the Insurance Contract between the State Health Agency and the Company.
5. **Basic Sum Insured** shall mean the sum of rs. 5,00,000 per AB-PMJAY Beneficiary Family Unit per annum against which the AB-PMJAY Beneficiary Family Unit may seek benefits as per the benefit package proposed under the AB-PMJAY
6. **Beneficiary** means a member of the AB-PMJAY Beneficiary Family Units who is eligible to avail benefits under the Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana. .
7. **Beneficiary Family Unit** refers to those families including all its members figuring in the Socio-Economic Caste Census (SECC) database under the deprivation criteria of D1, D2, D3, D4, D5 and D7, Automatically Included category (viz as Households without shelter, Destitute-living on alms, Manual Scavenger Families, Primitive Tribal Groups and Legally released Bonded Labour) and broadly 11 defined occupational un-organised workers (in Urban Sector) of the Socio-Economic Caste Census (SECC) 2011 database of the State / UT along with the existing RSBY Beneficiary Families not figuring in the SECC Database under the Ayushman Bharat -Pradhan Mantri Jan Arogya Yojana.
8. **Benefit Package** refers to the package of benefits that the insured families would receive under the AB-PMJAY.
9. **Cashless Access Service** means a facility extended by the Insurer to the Beneficiaries where the payments of the expenses that are covered under the Risk Cover are directly made by the Insurer to the Empanelled Health Care Providers in accordance with the terms and conditions of this Insurance Contract, such that none of the Beneficiaries are required to pay any amounts to the Empanelled Health Care Providers in respect of such expenses, either as deposits at the commencement or at the end of the care provided by the Empanelled Health Care Providers.
10. **Cashless facility** means a facility extended by the Company to the insured where the payments, of the costs of treatment undergone by the Beneficiaries in accordance with the Policy terms and conditions, are directly made to the Network provider by the Company to the extent pre-authorization approved.

11. **CHC** means a community health centre located at the block level in the State/UT.
12. **Claim** means a claim that is received by the Insurer from an Empanelled Health Care Provider, either online or through alternate mechanism in absence of internet connectivity.
13. **Claim Payment** means the payment of eligible Claim received by an Empanelled Health Care Provider from the Insurer in respect of benefits under the Risk Cover made available to a Beneficiary.
14. **Condition precedent** means a Policy term or a condition upon which the Company's liability under the Policy is conditional upon
15. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
    a. Internal Congenital Anomaly- Congenital anomaly which is not in the visible and accessible parts of the body
    b. External Congenital Anomaly- Congenital anomaly which is in the visible and accessible parts of the body
16. **Days** mean and shall be interpreted as calendar days unless otherwise specified.
17. **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital and which has been registered with local authorities, wherever applicable and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:
    a. Has qualified nursing staff under its employment:
    b. Has qualified medical practitioner/s in charge:
    c. Has a fully equipped operation theatre of its own where surgical procedures are carried out:
    d. Maintains daily record of patients and will make these accessible to the Company's authorized personnel.
18. **Day Care Treatment** means any Medical Treatment and/or Surgical Procedure which is undertaken under general anaesthesia or local anaesthesia at an Empanelled Health Care Provider or Day Care Centre in less than 24 hours due to technological advancements, which would otherwise have required Hospitalization.
19. **Dental treatment** is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.
20. **Disclosure to information norm**
    In the event of misrepresentation, mis-description or non-disclosure of any material fact by any Beneficiaries and or Head of Family, the Policy shall be void for such Beneficiaries and AB-PMJAY Beneficiary Family Unit, and all premium paid hereon .as to those Beneficiaries and AB-PMJAY Beneficiary Family Unit, shall be forfeited to the Company,
21. **Empanelled Health Care Provider** means a hospital, a nursing home, a district hospital, a CHC, or any other health care provider, whether public or private, satisfying the minimum criteria for empanelment and that is empanelled by the Insurer in accordance with terms of this Contract for the provision of health services to the Beneficiaries.
22. **Expenses of Hospitalisation** for minimum period of 24 hours are admissible. However this time limit is not applied to specific treatments mentioned in the definition of Day Care Treatment which will be considered under Hospitalisation Benefit. This condition will also not apply in case of stay in Hospital of less than 24 hours provided
    i. The treatment is such that it necessitates hospitalization and the procedure involves specialized infrastructural facilities available in hospitals.
    ii. Due to technological advances hospitalization is required for less than 24 hours only.
23. **Health Service provider** means the empanelled Third Party Administrator [TPA] of the Company.
24. **Hospital** All the hospitals empanelled under AB-PMJAY for providing general care have to meet the minimum criteria established under the Mission detailed in Annex 1 as mentioned in the wording.
25. **Hospital IT Infrastructure** means the hardware and software to be installed at the premises of each Empanelled Health Care Provider for the provision of Cashless Access Services, the minimum specifications of which have been set out in the Tender Documents.
26. **Hospitalisation** means any Medical treatment or Surgical Procedure which required the Beneficiary to stay at the premises of an Empanelled Health Care Provider for 24 hours or more including day care treatment as defined above.
27. **ICU or Intensive Care Unit** means an identified section, ward
28. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.
29. **Illness means** a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.
    a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.
    b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:—it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests—it needs ongoing or long-term control or relief of symptoms— it

requires your rehabilitation or for you to be specially trained to cope with it—it continues indefinitely—it recurs or is likely to recur.

30. **Inpatient care** means treatment for which the Beneficiary has to stay in a hospital for more than 24 hours for a covered event.
31. **Maternity expense** shall include –a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean section incurred during hospitalization). b) Expenses towards lawful medical termination of pregnancy during the Policy period.
32. **Medical Practitioner** is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or Homeopathy set up by Government of India or State Government and is thereby entitled to practice medicine within its jurisdiction: and is acting within the scope and jurisdiction of license. Provided that the Medical Practitioner should not be close family members of Beneficiary or AB-PMJAY Beneficiary Family Unit.
33. **Medical Advise** means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.
34. **Medical expenses** means those expenses that the Beneficiary has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Beneficiary had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.
35. **Medically Necessary** Treatment or Treatment any Medical Treatment, Surgical Procedure, Day Care Treatment or Follow-up Care, which-
    i. is required for the medical management of the illness, disease or injury suffered by the Beneficiary;
    ii. does not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;
    iii. has been prescribed by a Medical Practitioner; and
    iv. conforms to the professional standards widely accepted in international medical practice or by the medical community in India.
36. **MoHFW** shall mean the Ministry of Health and Family Welfare, Government of India.
37. **Network Provider** means hospitals or health care providers enlisted by the Company or by a TPA and Company together to provide medical services to an insured on payment by a cashless facility.
38. **Non-Network Provider means a**ny hospital, day care centre or other provider that is not part of the network of Company.
39. **NHA** shall mean the National Health Authority/National Health Authority[as mentioned in tender] set up the Ministry of Health and Family Welfare, Government of India with the primary objective of coordinating the implementation, operation and management of AB-PMJAY. It will also foster co-ordination and convergence with other similar schemes being implemented by the Government of India and State Governments.
40. **Notification of Claim** means the process of notifying a claim to the Company or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.
41. **OPD treatment** is one in which the Beneficiary visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Beneficiary is not admitted as a day care or in-patient.
42. **Policy Cover Period** shall mean the standard period of 12 calendar months from the date of start of the Policy Cover or lesser period as stipulated by SHA from time to time unless cancelled earlier in accordance with this Insurance Contract.
43. **Premium** means the aggregate sum agreed by the Parties as the annual premium to be paid by the State Health Agency to the Insurer for each Beneficiary Family Unit that is eligible for the scheme, as consideration for providing the Cover to such Beneficiary Family Unit under this Insurance Contract.
44. **Pre-Existing Disease**
    Any condition, ailment or injury or related condition(s) for which Beneficiaries had signs or symptoms, and / or were diagnosed, and / or for which medical advice / treatment was received within 48 months prior to the first Policy issued by the Company and renewed continuously thereafter.
45. **Pre-hospitalization Medical Expenses means expenses** incurred immediately before the Beneficiary is Hospitalised, provided that:
    i. Such Medical Expenses are incurred for the same condition for which the Beneficiary's Hospitalisation was required, and
    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Company.
46. **Post-hospitalization Medical Expenses means** Expenses incurred immediately after the Beneficiary is discharged from hospital , provided that:
    i. Such Medical Expenses are incurred for the same condition for which theBeneficiary'sHospitalisation was required, and
    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Company.
47. **Qualified Nurse** is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India

48. **Renewal** defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all waiting periods.
49. **Risk Cover** shall mean an annual risk cover of Rs.5,00,000 covering inpatient care and day care surgeries (as applicable) for treatment of diseases and medical conditions through a network of Empanelled Health Care Providers (EHCP) for the eligible AB-PMJAY Beneficiary Family Units.
50. **Service Area** refers to the entire Union Territory of JAMMU AND KASHMIR and Union Territory of Ladakh covered and included under this Policy Wordings for the implementation of AB-PMJAY.
51. **State Health Agency (SHA)** refers to the agency/ body set up by the Department of Health and Medical Education, Government of JAMMU AND KASHMIR for the purpose of coordinating and implementing the Ayushman Bharat - Pradhan Manti Jan Arogya Yojana in the UT of JAMMU AND KASHMIR.
52. **Scheme** shall mean the Ayushman Bharat - Pradhan Manti Jan Arogya Yojana managed and administered by the Ministry of Health and Family Welfare, Government of India.
53. **Sum Insured** shall mean the sum of Rs 5,00,000 per AB-PMJAY Beneficiary Family Unit per annum against which the AB-PMJAY Beneficiary Family Unit may seek benefits as per the benefit package proposed under the AB-PMJAY.
54. **State/UT** refers to the duly elected Government in the UT of J & K and UT of Ladakh for which the tender is issued.
55. **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a hospital or day care centre by a medical practitioner.
56. **Third Party Administrators or TPA** means any person who is licensed by Insurance Regulatory and Development Authority of India [IRDAI] under prevailing Regulations, and is engaged, for a fee or remuneration by the Company, for the purposes of providing Policy and Claim Facilitation services to the Beneficiaries as well as to the Company upon a claim being made.
57. Turn-around Time means the time taken by the Insurer in processing a Claim of Beneficiaries received from an Empanelled Health Care Provider and in making a Claim Payment including investigating such Claim or rejection of the such Claim.
58. **Unproven/ experimental treatment** means treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.
59. **UT** refers to the Service Area in UT of J&K and UT of Ladakh and included under this Policy Wordings and tender document for the implementation of AB-PMJAY.

The words which are not defined herein, if any, shall have the same meaning as defined by IRDAI under applicable Regulations/guidelines. Provided further if any words that are defined herein are modified/redefined by IRDAI, then such modified/redefined definitions shall apply.

ABBREVIATIONS USED

AL	Authorisation Letter (from the Insurer)
BFU	Beneficiary Family Unit
BPL	Below Poverty Line
BRC	Basic Risk Cover
CCGMS	Central Complaints Grievance Management System
CHC	Community Health Centre
CRC	Claims Review Committee
DAL	Denial of Authorisation Letter
DGRC	District Grievance Redressal Committee
DGNO	District Grievance Nodal Officer
EHCP	Empanelled Health Care Provider
HPGRC	High Powered Grievance Redressal Committee
GRC	Grievance Redressal Committee
IRDAI	Insurance Regulatory Development Authority of India
MoHFW	Ministry of Health & Family Welfare, Government of India
NGRC	National Grievance Redressal Committee
NHA	National Health Agency
NOA	Notice of Award
PHC	Primary Health Centre
AB-PMJAY	Ayushman Bharat - Pradhan Manti Jan Arogya Yojana
RAL	Request for Authorisation Letter (from the EHCP)
SECC	Socio Economic Caste Census
SGRC	State Grievance Redressal Committee

SGNO	State Grievance Nodal Officer
SHA	State Health Agency
UCN	Unique Complaint Number

B. AB-PMJAY Beneficiaries and Beneficiary Family Unit

a. All AB-PMJAY Beneficiary Family Units, as defined under the deprivation criteria of D1, D2, D3, D4, D5 and D7, Automatically Included category (in rural areas) and broadly defined occupational un-organised workers (in Urban Sector) of the Socio-Economic Caste Census (SECC) database of the UT (as updated from time to time) shall be considered as eligible for benefits under the Scheme and be automatically covered under the Scheme.

b. Unit of coverage under the Scheme shall be a family and each family for this Scheme shall be called a AB-PMJAY Beneficiary Family Unit, which will comprise all members in that family. Any addition in the family will be allowed only in case of marriage and/or birth/ adoption.

C. COVERAGE AND BENEFITS

The benefits under this scheme, to be provided on a cashless basis to the Beneficiary/ies up to the limit of their annual coverage, package charges on specified **Medical** and or **Surgical** procedures and subject to other terms and conditions outlined herein, are the following:

Benefits under AB-PMJAY Risk Cover

1. The benefits within this Scheme under the Risk Cover are to be provided on a cashless basis to the AB-PMJAY Beneficiaries up to the limit of their annual coverage and includes:
    a) Hospitalization expense benefits
    b) Day care treatment benefits (as applicable)
    c) Follow-up care benefits
    d) Pre and post hospitalization expense benefits
    e) New born child/ children benefits
2. The details of benefit package including list of exclusions are furnished in Annex 2.2: 'Exclusions to the Policy' and Annex 2. 3: 'Packages and Rates' as mentioned in tender document and same are also annexed to these Policy Wordings/Schedule as Annexure 2.2 and Annexure 2.3.
3. For availing select treatment in any empanelled hospitals, preauthorisation is required to be taken for defined cases.
4. Except for listed exclusions listed in Annex 2.2 as mentioned in the tender document, services for any other surgical treatment services will also be allowed, in addition to the procedures listed in Annex 2.3 (as mentioned in the tender document and same are also annexed to these Policy Wordings/Schedule as Annexure 2.2 and Annexure 2.3), of upto a limit of Sum Insured to any AB-PMJAY Beneficiary, provided the services are within the sum insured available and preauthorisation has been provided by the company.

Sum Insured

a. As on the date of commencement of the Policy Cover Period, the AB-PMJAY Sum Insured in respect of the Risk Cover for each AB-PMJAY Beneficiary Family Unit shall be Rs. 5,00,000 (Rupees Five Lakh Only) per family per annum on family floater basis. This shall be called the Sum Insured, which shall be fixed irrespective of the size of the AB-PMJAY Beneficiary Family Unit.

b. The Insurer shall ensure that the Risk Cover shall be provided to each AB-PMJAY Beneficiary family Unit on a family floater basis covering all the members of the AB-PMJAY Beneficiary family unit including Senior Citizens i.e., the Sum Insured shall be available to any or all members of such Beneficiary Family Unit for one or more claims during each Policy Cover period. New family members may be added after due approval process as defined by the Government.

c. The maximum liability of the Insurer on a family floater basis for one or more Claims under the RC during any Policy Cover Period shall not exceed Rs. 5,00,000 (Rupees Five Lakh Only) in respect of a AB-PMJAY Beneficiary Family Unit .

d. Pre- existing conditions/ diseases shall be covered, subject to exclusions provided in Annexure 2.2 to these Policy Wordings/Schedule.

PACKAGE RATES

a. The Insurer shall reimburse claims of public and private health care providers under the AB-PMJAY based on Package Rates determined as follows:
   i) If the package rate for a medical treatment or surgical procedure requiring Hospitalization or Day Care Treatment (as applicable) is fixed in Annex 2.3 as mentioned in the tender document which is also annexed as Annexure 2.3 to these Policy Wordings/Schedule, then the Package Rate so fixed shall apply for the Policy Cover Period.
   ii) If the package rate for a surgical procedure requiring Hospitalization or Day Care Treatment (as applicable) is not listed in Annex 2.3 (as mentioned in the tender document and same is also annexed to these Policy Wordings/Schedule as Annexure 2.3), then the Insurer may preauthorise an appropriate amount
   iii) The flat daily package rates for medical packages specified in Annex 2.3 (as mentioned in the tender document and same is also annexed to these Policy Wordings/Schedule as Annexure 2.3) shall apply.
   iv) If the treatment cost is more than the benefit coverage amount available with the beneficiary families then the remaining treatment cost will be borne by the AB-PMJAY Beneficiary family.
   v) The follow up care prescription for identified packages are set out in Annex 2.3 (as mentioned in the tender document and same is also annexed to these Policy Wordings/Schedule as Annexure 2.3).
   vi) In case of AB-PMJAY Beneficiary is required to undertake multiple surgical treatment, then the highest package rate shall be taken at 100%, thereupon the 2nd treatment package shall taken as 50% of package rate and 3rd treatment package shall be at 25% of the package rate.
   vii) Surgical and Medical packages will not be allowed to be availed at the same time.
   viii) Certain packages as mentioned in Annex 2.3 (as mentioned in the tender document and same is also annexed to these Policy Wordings/Schedule as Annexure 2.3) will only be reserved for Public EHCPs as decided by the SHA. They can be availed in Private EHCPs only after a referral from a Public EHCP is made.
   ix) Certain packages as indicated in Annex 2.3 (as mentioned in the tender document and same is also annexed to these Policy Wordings/Schedule as Annexure 2.3) have differential pricing NABH and Non-NABH, for Hospitals running PG/ DNB Course, for rural and urban EHCPs and for EHCPs in aspirational districts as identified by NITI Aayog

b. These package rates (in case of surgical procedures or interventions or day care procedures, as applicable) or flat per day rate (in case of medical treatments) will include:
   a) Registration Charges,
   b) Bed charges (General Ward),
   c) Nursing & Boarding Charges,
   d) Surgeons, Anesthetists, Medical Practitioner, Consultants Fees,
   e) Anesthesia, Blood Transfusion, Oxygen, OT Charges, Cost of Surgical Appliances etc
   f) Medicines and Drugs,
   g) Cost of Prosthetic Devices, Implants etc.
   h) Pathology and radiology tests: radiology to include but not be limited to X-ray, MRI, CT Scan, etc.
   i) Diagnosis and Tests, etc
   j) Food to the Patient,
   k) Pre and Post Hospitalisation expenses: Expenses incurred for consultation, diagnostic tests and medicines before the admission of the patient in the same hospital and cost of diagnostic tests and medicines and up to 15 days of the discharge from the hospital for the same ailment/ surgery.
   l) Any other expenses related to the treatment of the patient in the hospital.

c. During the Policy Cover Period, the Insurer or SHA shall not seek or permit any change to the Package Rates.
d. Either Party may suggest the inclusion of additional Package for determination of rates following due diligence and procedures and based on the incidence of diseases or reported medical conditions and other relevant data. The Parties shall then agree on the package rates for such medical treatments or surgical procedures, as the case may be; but the decision of the SHA in this regard shall be final and binding on the Insurer. The agreed package rates shall be deemed to have been included in Annex 2.3 (as mentioned in the tender document and same is also annexed to these Policy Wordings/Schedule as Annexure 2.3) with effect from the date on which the Parties have mutually agreed to the new package rates in writing.
e. The SHA and Insurer shall publish the Package Rates on its website in advance of each Policy Cover Period.
f. As part of the regular review process, the Parties (the Insurer and EHCP) shall review information on incidence of common medical treatments or surgical procedures that are not listed in Annex 2.3 as mentioned in the tender document and that require hospitalization or day care treatments (as applicable).
g. No claim processing of package rate for a medical treatment or surgical procedure or day care treatment (as applicable) that is determined or revised shall exceed the sum total of Risk Cover for a AB-PMJAY Beneficiary Family Unit.

However, package rates for some medical treatment or surgical procedures may exceed the Sum Insured limit, which in turn would enable AB-PMJAY beneficiaries to avail treatment of such medical conditions or surgical procedures on their own cost / expenses at the negotiated rate rather than on an open-ended or fee for service basis.

CASHLESS ACCESS OF SERVICES

1. The AB-PMJAY beneficiaries shall be provided treatment free of cost for all such ailments covered under the Scheme within the limits/ sub-limits and sum insured, i.e., not specifically excluded under the Scheme.
2. The EHCP shall be reimbursed as per the package cost specified in the Tender Document agreed for specified packages or as pre-authorised amount in case of unspecified packages.
3. The Insurer shall ensure that each EHCP shall at a minimum possess the Hospital IT Infrastructure required to access the AB-PMJAY Beneficiary Database and undertake verification based on the Beneficiary Identification process laid out, using unique AB-PMJAY Family ID on the AB-PMJAY Card and also ascertain the balance available under the AB-PMJAY Cover provided by the Insurer.
4. The Insurer shall provide each EHCP with an operating manual describing in detail the verification, pre-authorisation and claims procedures.
5. The Insurer shall train Ayushman Mitras that will be deputed in each EHCP that will be responsible for the administration of the AB-PMJAY on the use of the Hospital IT infrastructure for making Claims electronically and providing Cashless Access Services.
6. The EHCP shall establish the identity of the member of a AB-PMJAY Beneficiary Family Unit by Aadhaar Based Identification System (No person shall be denied the benefit in the absence of Aadhaar Card) and ensure:
    a. That the patient is admitted for a covered procedure and package for such an intervention is available.
    b. AB-PMJAY Beneficiary has balance in her/ his AB-PMJAY Cover amount.
    c. Provisional entry shall be made on the server using the AB-PMJAY ID of the patient. It has to be ensured that no procedure is carried out unless provisional entry is completed through blocking of claim amount.
    d. At the time of discharge, the final entry shall be made on the patient account after completion of Aadhaar Card Identification Systems verification or any other recognised system of identification adopted by the SHA of AB-PMJAY Beneficiary Family Unit to complete the transaction.

PRE-AUTHORISATION OF PROCEDURES

1. All procedures in Annex 2.3 (as mentioned in the tender document and same is also annexed to these Policy Wordings/Schedule as Annexure 2.3) that are earmarked for pre-authorisation shall be subject to mandatory pre-authorisation. In addition, in case of Inter-State portability, all procedures shall be subject to mandatory pre-authorisation irrespective of the pre-authorisation status in Annex 2.3 (as mentioned in the tender document and same is also annexed to these Policy Wordings/Schedule as Annexure 2.3).
2. No EHCP shall, under any circumstances whatsoever, to undertake any such earmarked procedure without pre-authorisation unless under emergency. Process for emergency approval will be followed as per guidelines laid down under AB-PMJAY
3. Request for hospitalization shall be forwarded by the EHCP after obtaining due details from the treating doctor, i.e. “request for authorisation letter” (RAL). The RAL needs to be submitted online through the Scheme portal and in the event of any IT related problem on the portal, then through email or fax. The medical team of Insurer would get in touch with the treating doctor, if necessary.
4. The RAL should reach the authorisation department of the Insurer within 6 hours of admission in case of emergency.
5. In cases of failure to comply with the timelines stated in above in 4, the EHCP shall forward the clarification for delay with the request for authorisation.
6. The Insurer shall ensure that in all cases pre-authorisation request related decisions are communicated to the EHCP within 12 hours for all normal cases and within 1 hour for emergencies. If there is no response from the Insurer within 12 hours of an EHCP filing the pre-authorisation request, the request of the EHCP shall be deemed to be automatically authorised.
7. The Insurer shall not be liable to honour any claims from the EHCP for procedures featuring in Annex 2.3 (as mentioned in the tender document and same is also annexed to these Policy Wordings/Schedule as Annexure 2.3), for which the EHCP does not have a pre-authorisation, if prescribed.
8. Reimbursement of all claims for procedures listed under Annex 2.3 (as mentioned in the tender document and same is also annexed to these Policy Wordings/Schedule as Annexure 2.3) shall be as per the limits prescribed for each such procedure unless stated otherwise in the pre-authorisation letter/communication.
9. The RAL form should be dully filled with clearly mentioned Yes or No. There should be no nil, or blanks, which will help in providing the outcome at the earliest.
10. The Insurer guarantees payment only after receipt of RAL and the necessary medical details. And only after the Insurer has ascertained and negotiated the package with the EHCP, shall issue the Authorisation Letter (AL). This shall be completed within 24 hours of receiving the RAL.

11. In case the ailment is not covered or the medical data provided is not sufficient for the medical team of the authorisation department to confirm the eligibility, the Insurer can deny the authorisation or seek further clarification/ information.
12. The Insurer needs to file a report to the SHA explaining reasons for denial of every such pre-authorisation request.
13. Denial of authorisation (DAL)/ guarantee of payment is by no means denial of treatment by the EHCP. The EHCP shall deal with such case as per their normal rules and regulations.
14. Authorisation letter (AL) will mention the authorisation number and the amount authorized as a package rate for such procedure for which package has not been fixed earlier. The EHCP must see that these rules are strictly followed.
15. The authorisation is given only for the necessary treatment cost of the ailment covered and mentioned in the RAL for hospitalization.
16. The entry on the AB-PMJAY portal for claim amount blocking as well at discharge would record the authorisation number as well as package amount agreed upon by the EHCP and the Insurer.
17. In case the balance sum available is less than the specified amount for the Package, the EHCP should follow its norms of deposit/running bills etc. However, the EHCP shall only charge the balance amount against the package from the AB-PMJAY beneficiary. The Insurer upon receipt of the bills and documents would release the authorized amount.
18. The Insurer will not be liable for payments in case the information provided in the RAL and subsequent documents during the course of authorisation is found to be incorrect or not fully disclosed.
19. In cases where the AB-PMJAY beneficiary is admitted in the EHCP during the current Policy Cover Period but is discharged after the end of the Policy Cover Period, the claim has to be paid by the Insurer from the Policy which was operating during the period in which the AB-PMJAY beneficiary was admitted.

D. EXCLUSIONS:

Exclusions to the Policy

The Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

i. Conditions that do not require hospitalization: Condition that do not require hospitalization and can be treated under Out Patient Care. Out patient Diagnostic, Medical and Surgical procedures or treatments unless necessary for treatment of a disease covered under day care procedures (as applicable) will not be covered.Further expenses incurred at Hospital or Nursing Home primarily for evaluation / diagnostic purposes only during the hospitalized period and expenses on vitamins and tonics etc. unless forming part of treatment for injury or disease as certified by the attending physician.

ii. Except those expenses covered under pre and post hospitalisation expenses, further expenses incurred at Hospital or Nursing Home primarily for evaluation / diagnostic purposes only during the hospitalized period and expenses on vitamins and tonics etc unless forming part of treatment for injury or disease as certified by the attending physician.

iii. Any dental treatment or surgery which is corrective, cosmetic or of aesthetic procedure, filling of cavity, root canal including wear and tear etc. unless arising from disease or injury and which requires hospitalisation for treatment.

iv. Congenital external diseases: Convalescence, general debility, “run down” condition or rest cure, Congenital external diseases or defects or anomalies,unless requiring to maintain the functionality will not be excluded and they are as given:
Cleft lip, cleft palate, ectopic anus/anorectal malformation, undescended testis, hydrocele, thyroglossal cyts excision, correction of thyroglossal duct fistula, meningocele, Benign cystic hygroma, polydactylyl involving more than two fingers, pre-auricular sinus, Branchial cyst/fistula, hemagioma and lymphagioma.

v. Fertility related procedures: Hormone replacement therapy for Sex change or treatment which results from or is in any way related to sex change.

vi. Vaccination: Vaccination, inoculation or change of life or cosmetic or of aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness. Circumcision (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident),

vii. Suicide: Intentional self-injury/suicide

viii. Persistent Vegetative State

E. GENERAL CONDITIONS:

1. Every notice of communication to be given or made under this Policy shall be delivered in writing at the address of the Company and/or TPA office as shown in the Schedule.

2. **Multiple Policies**

i. In case of multiple policies which provide fixed benefits, on the occurrence of the covered event/s in accordance with the terms and conditions of the Policy, each Insurer shall make the claim payments independent of payments received under other similar polices.

ii. If two or more Policies are taken by an Insured during a period from one or more insurers to indemnify treatment costs, the Insured shall have the right to require a settlement of his/her claim in terms of any of his/her Policies.
   a. In all such cases the insurer who has issued the chosen Policy shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen Policy.
   b. Balance claim or claims disallowed under the earlier chosen policy/policies may be made from the other policy/policies even if the sum insured is not exhausted in the earlier chosen policy/policies. The insurer(s) in such cases shall independently settle the claim subject to the terms and conditions of other policy / policies so chosen.
   c. If the amount to be claimed exceeds the Sum Insured under a single Policy after considering the deductibles or co-pay, the Policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
   d. Where an Insured has policies from more than one insurer to cover the same risk on indemnity basis, the Insured shall only be indemnified the medical expenses incurred in accordance with the terms, conditions and coverage's of the chosen Policy.
   e. If Insured has multiple Policies, he/ she has the right to prefer claims from other Policy/Policies for the amounts disallowed under the earlier chosen Policy/ Policies, even if the Sum Insured is not exhausted. The Company shall settle the claim subject to the terms and conditions of the Policy.

3. **Portability of Benefits**
   a. The benefits of AB-PMJAY will be portable across the country and a beneficiary covered under the scheme will be able to get benefits under the scheme across the country at any EHCP.
   b. Package rates of the hospital where benefits are being provided will be applicable while payment will be done by the insurance company that is covering the beneficiary under its policy.
   c. The Insurer undertakes that it will honour claims from any empanelled hospital under the scheme within India and will settle claims within 30 days of receiving them.
   d. To ensure true portability of AB-PMJAY, State Governments shall enter into arrangement with ALL other States that are implementing AB-PMJAY for allowing sharing of network hospitals, transfer of claim & transaction data arising in areas beyond the service area.
   e. Detailed guidelines of portability are provided at Annex 2.7 "Claims Management Guidelines including Portability" of Volume II- Tender documents

4. **Governing Law and Jurisdiction**
   1. This Insurance Contract and the rights and obligations of the Parties under this Insurance Contract shall be governed by and construed in accordance with the Laws of the Republic of India.
   2. The courts in Srinagar or Jammu shall have the exclusive jurisdiction over any disputes arising under, out of or in connection with this Insurance Contract.

5. **Assignment by Beneficiaries or Empanelled Health Care Providers**

   1. The Parties agree that each Policy shall specifically state that no Beneficiary shall have the right to assign or transfer any of the benefits or the Covers made available to it under this Insurance Contract or any Policy.

   2. The Parties agree that the Empanelled Health Care Providers may assign, transfer, pledge, charge or mortgage any of their rights to receive any sums due or that will become due from the Insurer in favour of any third party.

   Without limiting the foregoing, the Parties acknowledge that the public Empanelled Health Care Providers in the Service Area that are under the management of Rogi Kalyan Samitis may assign all or part of their right to receive Claims Payments from the Insurer in favour of the Government of J&K or any other department, organization or public body that is under the ownership and/or control of the Government of J&K.

   On and from the date of receipt of a written notice from the public Empanelled Health Care Providers in the Service Area or from the Government of J&K, the Insurer shall pay all or part of the Claims Payments to the person(s) so notified.

6. **Claims Management Guidelines including Portability**
   All Empanelled Health Care Providers (EHCP) will make use of IT system of AB-PMJAY to manage the claims related transactions. IT system of AB-PMJAY has been developed for online transactions and all stakeholders are advised to maintain online transactions preferably to ensure the claim reporting in real time. However,

keeping in mind the connectivity constraints faced by some districts an offline arrangement has also been included in the IT system that has to be used only when absolute. The AB-PMJAY strives to make the entire claim management paperless that is at any stage of claim registration, intimation, payment, investigation by EHCP or by the Insurer the need of submission of a physical paper shall not be required. This mean that this claim data will be sent electronically through IT system to the Central/ State server. The NHA, SHA, Insurer (if applicable), and EHCP shall be able to access this data with respect to their respective transaction data only.
Once a claim has been raised (has hit the Central/State server), the following will need to be adhered to by the Insurance Companies regarding claim settlement:

1. Claim Payments and Turn-around Time

The Insurer or TPA appointed by Insurer shall follow the following process regarding the processing of claims received from the EHCP:

A. The Insurer or TPA appointed by Insurer shall decide on the acceptance or rejection of any claim received from an EHCP. Any rejection notice issued by the Insurer or TPA appointed by Insurer shall clearly state that rejection is subject to the EHCP's right to appeal against rejection of the claim.
B. If a claim is not rejected, the Insurer or TPA appointed by Insurer shall either make the payment (based on the applicable package rate) or shall conduct further investigation into the claim received from EHCP.
C. The process specified in clause A and B above (rejection or payment/investigation) in relation to claim shall be carried out in such a manner that it is completed (Turn- around Time, TAT) shall be no longer than 15 calendar days (irrespective of the number of working days).
D. The EHCP is expected to upload all claim related documents within 24 hours of discharge of the beneficiary.
E. The counting of days for TAT shall start from the date on which all the claim documents are accessible by the Insurer or its TPA agency.
F. The Insurer or TPA appointed by Insurer shall make claim payments to each EHCP against payable claims on a weekly basis through electronic transfer to such EHCP's designated bank account. Insurer is then also required to provide the details of such payments against each paid claim on the online portal (IT System of AB-PMJAY).
G. All claims investigations shall be undertaken by a qualified and experienced medical staff/team, with at least one MBBS degree holder, appointed by the Insurer or TPA appointed by Insurer or its representative, to ascertain the nature of the disease, illness or accident and to verify the eligibility thereof for availing the benefits under this Agreement and relevant Cover Policy. The Insurer's or TPA's medical staff shall not impart any advice on any treatment or medical procedures or provide any guidance related to cure or other care aspects. However, the Insurance Company or TPA appointed by Insurer can ensure that the treatment was in conformity to the Standard Treatment Guidelines, if implemented.
H. The Insurer or TPA appointed by Insurer will need to update the details on online portal (IT system of AB-PMJAY) of:
   i. All claims that are under investigation on a fortnightly basis for review; and
   ii. Every claim that is pending beyond 15 days, along with its reasons for delay in processing such Claim.
   iii. The Insurer or TPA appointed by Insurer may collect at its own cost, complete Claim papers (including diagnostic reports) from the EHCP, if required for audit purposes for claims under investigation. This shall not have any bearing on the Claim Payments to the Empanelled Health Care Provider.
   iv. The Company shall not be liable to make any payment under this Policy in respect of any claim, if the Policy has been obtained by Beneficiaries misrepresentation of material facts or if the claim be in any respect fraudulent, or if any false declaration be made or used by Beneficiaries in support thereof or if any fraudulent means or devices are used by the Beneficiaries or any one acting on behalf of Beneficiaries to obtain any benefits under this Policy or if the loss or damage be occasioned by the willful act, or with the connivance of the Beneficiaries, all benefits under this Policy to the respective Beneficiaries shall be forfeited.

2. Penalty on Delay in Settlement of Claims

There will be a penalty for delay in settlement of claims by the Insurance Companies or TPA appointed by Insurer's beyond the turnaround time of 15 days. A penalty of 1% of claimed amount per week for delay beyond 15 days to be paid directly to the hospitals by the Insurance Companies or TPA appointed by Insurer. This penalty will become due after 30 days in case of Inter-State claims or portability of Benefits

3. Update of Claim Settlement

The Insurance Company or TPA appointed by Insurer will need to update the claim settlement data on the portal on a daily basis and this data will need to be updated within 24 hours of claims payment. Any claim payment which has not been updated shall be deemed to have been unpaid and the interest, as applicable, shall be charged thereon.

4. If any dispute or difference shall arise Insurer and the respective Beneficiaries as to the quantum of claim to be paid under the Policy, (liability under claim being otherwise admitted by Insurer) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the Insurer and the respective Beneficiaries or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of Insurer and the respective Beneficiaries to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Indian Arbitration and Conciliation Act, 1996. The seat of arbitration and venue for all hearings will be Srinagar or Jammu, India.
   It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has repudiated or not accepted liability under or in respect of the claim of the Beneficiaries under this Policy.
   It is hereby expressly stipulated and declared that in case of admission of claim with dispute as to quantum of amount admitted under the claim, it shall be a condition precedent to any right of action or suit upon this Policy that award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained.
   It is also hereby further expressly agreed and declared that if the Company shall disclaim/repudiate liability to the Beneficiaries for any claim hereunder and if the Beneficiaries shall not within 12 calendar months from the date of such disclaimer/repudiation, have made the subject matter of a Suit or proceeding before a Court of Law or any other competent statutory forum/tribunal, then all benefits under the Policy shall be forfeited and the rights of Beneficiaries shall stand extinguished and the liability of the Company shall also stand discharged.

   All medical surgical procedures under this Policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency

5. Right of Appeal and Reopening of Claims
   A. The Empanelled Health Care Provider shall have a right of appeal against a rejection of a Claim by the Insurer or TPA appointed by Insurer, if the Empaneled Health Care Provider feels that the Claim is payable. An appeal may be made within thirty (30) days of the said rejection being intimated to the hospital to the District-level Grievance Committee (DGC).
   B. The Insurer or TPA appointed by Insurer and/or the DGC can re-open the Claim, if the Empaneled Health Care Provider submits the proper and relevant Claim documents that are required by the Insurer or TPA appointed by Insurer.
   C. The DGC may suo moto review any claim and direct either or both the Insurer or TPA appointed by Insurer and the health care provider to produce any records or make any deposition as it deems fit.
   D. The Insurer or TPA appointed by Insurer or the health care provider may refer an appeal with the State- level Grievance Committee (SGC) on the decision of the DGC within thirty days (30) failing which the decision shall be final and binding. The decision of the SGC on such appeal is final and binding.
   E. The decisions of the DGC and SGC shall be a speaking order stating the reasons for the decision
   F. If the DGC (if there is no appeal) or SGC directs the Insurer or TPA appointed by Insurer to pay a claim amount, the Insurer or TPA appointed by Insurer shall pay the amount within 15 days. Any failure to pay the amount shall attract an interest on the delayed payment @ 1% for every week or part thereof. If the Insurer or TPA appointed by Insurer does not pay the amount within 2 months they shall pay a fine of Rs. 25,000/- for each decision of DGC not carried out and Rs. 50,000 for each non-compliance of decision of SGC. This amount shall be remitted to the State Health Agency.

6. Guidelines for Portability
   An Empanelled Health Care Provider (EHCP) under AB-PMJAY in any state should provide services as per AB-PMJAY guidelines to beneficiaries from any other state also participating in AB-PMJAY. This means that a beneficiary will be able to get treatment outside the EHCP network of his/her Home State. Any empanelled hospital under AB-PMJAY will not be allowed to deny services to any ABPMJAY beneficiary. All interoperability cases shall be mandatorily under pre-authorisation mode and pre-authorisation guidelines of the treatment delivery state in case of AB-PMJAY implementing States / UTs or indicative pre-authorisation guidelines as issued by NHA, shall be applicable.

7. **Payment Of Premium**

The SHA shall ensure payment of the premium as per the following schedule or as per any revised schedule notified by the Government of India:

Sr. No.	Central & State Premium Split Ratio	Instalment 1 (On or before the commencement of	Instalment 2 (After completion of 2nd	Instalment 3 (After completion of 10

		the Policy Cover Period)	Quarter of the Policy Cover Period)	months of the Policy Cover Period)
i.	For 8 North-East and 2 Himalayan States and UT of J&K: Centre: State: 90:10	45% of (State Govt. Share) & 45% of (Central Government Share)	45% of (State Govt. Share) & 45% of (Central Government Share)	10% of (State Govt. Share) & 10% of (Central Government Share)
ii.	For other States Centre: State: 60:40	45% of (State Govt. Share) & 45% of (Central Government Share)	45% of (State Govt. Share) & 45% of (Central Government Share)	10% of (State Govt. Share) & 10% of (Central Government Share)
iii	For Union Territories with Legislation Centre: State: 60:40	45% of (State Govt. Share) & 45% of (Central Government Share)	45% of (State Govt. Share) & 45% of (Central Government Share)	10% of (State Govt. Share) & 10% of (Central Government Share)
iv	For Union Territories without Legislation: Centre: 100%	45% of (Central Government Share)	45% of (Central Government Share)	10% of (Central Government Share)

8. **Penalties**

Sr. No.	Additional Defaults	Penalty
1	If premium refund is not made by the Insurer to the SHA within 30 days of the communication for refund sent by the SHA to the Insurer	1% penal interest for every week of delay or part thereof and if not received within 30 days, penal interest to be recovered through legal means
2	If the premium is not paid to the Insurer, by the SHA within 6 months of the commencement of the AB-PMJAY Cover	Interest @ 1% of the premium amount for every 7 days' delay shall be paid by the SHA to the Insurer
3	If claim payment to the hospital is delayed beyond defined period of 15 days.	An interest of 1% for every seven day of delay after 15 days
4	For claims outside State, if claim payment to the hospital is delayed beyond defined period of 30 days.	An interest of 1% for every seven day of delay after 30 days

9. Renewal of the Insurance Contract
   a. The 3-year Term of this Insurance Contract is subject to renewal after two years for one more year.
   b. All decisions related to renewal shall vest with the SHA.
   c. The SHA shall take the decision regarding the Insurance Contract renewal based on the parameters specified in Section 11.5 of Volume II of Tender Document.
   d. The Insurer hereby acknowledges and accepts that the decision related to renewal is at the discretion of the SHA and this shall not be deemed as a right of the Insurer under this Insurance Contract.

10. Refund of Premium and Payment of Additional Premium at the end of contract period

   a. The SHA shall issue a letter to the Insurer stating the Insurer's average Claim Ratio for all 12/24/36 months of Policy Cover Period (depending on renewal for subsequent years) for the State/UT. In the letter, the SHA shall indicate the amount of premium that the Insurer shall be obliged to return. The amount of premium to be refunded shall be calculated based on the provisions of D 13 b.

   b. After adjusting a defined percent for expenses of management (including all costs excluding only service tax and any cess, if applicable) and after settling all claims, if there is surplus: 100 percent of leftover surplus

should be refunded by the Insurer to the SHA within 30 days. The percentage that will be need to be refunded will be as per the following:

i. In category A States
   a. Administrative cost allowed 10% if claim ratio less than 60%.
   b. Administrative cost allowed 15% if claim ratio between 60-70%.
   c. Administrative cost allowed 20% if claim ratio between 70-80%.

ii. In Category B States
   a. Administrative cost allowed 10% if claim ratio less than 60%.
   b. Administrative cost allowed 12% if claim ratio between 60-70%.
   c. Administrative cost allowed 15% if claim ratio between 70-85%.

c. All the surplus as determined through formula mentioned above should be refunded by the insurer to the SHA within 30 days.

d. If the Insurer delays payment of or fails to pay the refund amount within 60 days of the date of expiration of the Policy Cover Period, then the Insurer shall be liable to pay interest at the rate of one percent of the refund amount due and payable to the SHA for every 7 days of delay beyond such 60 day period.

e. If the Insurer fails to refund the Premium within such 90-day period and/ or the default interest thereon, the SHA shall be entitled to recover such amount as a debt due from the Insurer through means available within law.

f. The SHA is under no obligation to pay any further premium to the Insurer if claim ratio of the Insurer is upto 120 percent for Category A States and 115 percent for Category B States.

g. If the Insurer's average Claim Ratio for the full 12 months is in excess of 120 percent for Category A States and 115 percent for Category B States, then the SHA will be liable to pay 50% of additional claim cost in excess of the total Premium already paid by it and remaining 50% shall be borne by the insurance company. The total premium, including this additional claim cost, shall be borne by SHA only till the ceiling limit of premium set under AB-PMJAY for Central and UT Governments' share. After the ceiling is reached claims cost will need to be borne entirely by the Insurer.

11. Termination of the Insurance Contract and Consequences

Grounds for Termination

a. If the SHA does not renew the Insurance Contract of the Insurer as per D 12 mentioned above, it shall be terminated prematurely.
b. The Insurance Contract may be terminated also on the occurrence of one or more of the following events:
   i) the Insurer fails to duly obtain a renewal of its registration with the IRDAI or the IRDAI revokes or suspends the Insurer's registration for the Insurer's failure to comply with applicable Insurance Laws or the Insurer's failure to conduct the general or health insurance business in accordance with applicable Insurance Laws or the code of conduct issued by the IRDAI; or
   ii) the Insurer's average Turn-around Time over a period of 90 days is in excess of 45 days per Claim provided all premium due is paid by the SHA in time to the Insurer; or
   iii) the Insurer has failed to pay any of the Liquidated Damages/ penalties within 60 days of receipt of a written notice from the SHA requesting payment thereof; or
   iv) the Insurer's liability for Liquidated Damages for any Policy Cover Period would exceed the Aggregate Liquidated Damages Liability Cap of five percent; or
   v) the Insurer amends or modifies or seeks to amend or modify the Premium or the terms and conditions of the AB-PMJAY Cover for any renewal Policy Cover Period; or
   vi) the Insurer is otherwise in material breach of this Insurance Contract that remains uncured despite receipt of a 60-day cure notice from the SHA; or
   vii) any representation, warranty or undertaking given by the Insurer proves to be incorrect in a material respect or is breached; or
   viii) Non-performance on KPIs.
   ix) Fraudulent practices
c. Termination shall take place following the legal protocols specified in the Insurance Contract
d. Premature termination of Insurance Contract shall give the following rights to the SHA:
   i) Quantify pending dues of the Insurer to the SHA and pending claims of the EHCP and ensure recovery from the SHA.

ii) Quantify premium to be refunded on account of premature termination in lieu of the remaining Policy Cover Period.
iii) Demand that the Insurer unconditionally migrates the Policies of all the AB-PMJAY beneficiaries to another Insurance Company at a time and as per the guidelines issued.

12. **Migration of Policies Post Termination**

a. At least 120 days prior to the expiration of this Insurance Contract or the Termination Date, the SHA may issue a written request to the Insurer seeking a migration of the Policies for all the districts in the Service Area (Migration Request) to another insurance company (New Insurer).
b. Once the SHA has issued such a Migration Request:
   i) The SHA shall have the right to identify the New Insurer to whom the Policies will be migrated up to 30 days prior to the expiration date or the Termination Date.
   ii) The SHA shall also have the right to withdraw the Migration Request at any time prior to the 30 day period immediately preceding the expiration date or the Termination Date. If the SHA chooses to withdraw the Migration Request, then the remaining provisions of this Section shall not apply from the date of such withdrawal and this Insurance Contract shall terminate forthwith upon the withdrawal of the Migration Request.
c. Upon receiving the Migration Request, the Insurer shall commence preparing Claims data, and current status of implementation of training provided to Empanelled Health Care Providers and any other information sought by the SHA in the format prescribed by the SHA at that point in time.
d. Within 7 days of receiving notice of the New Insurer, the Insurer shall promptly make available all of the data prepared by it to the New Insurer.
e. The Insurer shall not be entitled to:
   i) refuse to honour any Claims made by the EHCPs on or before the date of expiration or the Termination Date until the migration process has been completed and the New Insurer assumes all of the risks under the Policies for the Service Area; or
   ii) cancel the Policies for the Service Area until the migration process has been completed and the New Insurer assumes all of the risks under the Policies for the Service Area; or
   iii) charge the SHA, the New Insurer or any third person with any commission, additional charges, loading charges or otherwise for the purpose of migrating the Policies to the New Insurer.
f. The Insurer shall be entitled to retain the proportionate Premium for the period between the date on which a termination notice has been issued and the earlier to occur of: (x) the date on which the New Insurer assumes all the risks under the Policies; and (y) the date of withdrawal of the Migration Request (the Migration Termination Date).

13. **Grievance Redressal**

The District authorities shall act as a frontline for the redressal of Beneficiaries' / Providers / other Staekholder's grievances. The District authorities shall also attempt to solve the grievance at their end. The grievances so recorded shall be numbered consecutively and the Beneficiaries / Providers or any other aggrieved party shall be provided with the number assigned to the grievance. The District authorities shall provide the Beneficiaries / Provider or any other aggrieved party with details of the follow-up action taken as regards the grievance as per the process laid down. The District authorities shall also record the information in pre-agreed format of any complaint / grievance received by oral, written or any other form of communication. Under the Grievance Redressal Mechanism of AB-PMJAY, set of three tier Grievance Redressal Committees have been set up to attend to the grievances of various stakeholders at different levels.

Grievance Department has to be manned by dedicated resources to address the grievances from time to time as per the instructions of the NHA. The District authorities shall act as a frontline for the redressal of Beneficiaries'/ Providers/ other Stakeholder's grievances. The District authorities shall also attempt to solve the grievance at their end. The grievances so recorded shall be numbered consecutively and the Beneficiaries / Providers shall be provided with the number assigned to the grievance. The District authorities shall provide the Beneficiaries / Provider with details of the follow-up action taken as regards the grievance as and when the Beneficiaries require it to do so. The District authorities shall also record the information in pre-agreed format of any complaint / grievance received by oral, written or any other form of communication. Under the Grievance Redressal Mechanism of AB-PMJAY, following set of three tier Grievance Redressal Committees have been set up to attend to the grievances of various stakeholders at different levels:

District Grievance Redressal Committee (DGRC)

The District Grievance Redressal Committee (DGRC) will be constituted by the State Health Agency (SHA) in each district within 15 days of signing of MoU with the Insurance Company.

i. Deputy Commisioner shall be the Chairperson of the DGRC.
ii. Chief Medical Officer shall be the Convenor of the DGRC.
iii. Representatives from the district level offices of the Departments of Rural

iv. Development.
v. The District Coordinator of the Insurer.
vi. The District Grievance Nodal Officer (DGNO)
vii. The DGRC may invite other experts for their inputs for specific cases.

Note: DGNO shall try to resolve the complaint by forwarding the same to Action Taking Authority (ATA). If the complaint is not resolved or comments are not received over the same within 15 days of the complaint, then the matter may be referred to DGRC.

State Grievance Redressal Committee (SGRC)

The State Grievance Redressal Committee (SGRC) will be constituted by the State Health Agency within 15 days of signing of MoU with the Central Government.

i. CEO of State Health Authority / State Nodal Agency shall be the Chairperson of the SGRC.
ii. Representatives of the Departments of Rural Development, Women & Child Development, Labour, Tribal Welfare.
iii. Director Health Services (Jammu/Kashmir).
iv. Principal Medical College (Jammu/Srinagar)
v. The State Grievance Nodal Officer (SGNO) of the SHA shall be the Convenor of SGRC.
vi. The SGRC may invite other experts for their inputs on specific cases

Note: In case of any grievance between SHA and Insurance Company, SGRC will be chaired by the Secretary of Department of Health & Family Welfare of the State. If any party is not agreed with the decision of DGRC, then they may approach the SGRC against the decision of DGRC.

National Grievance Redressal Committee (NGRC)

The NGRC shall be formed by the MoHFW, GoI at the National level. The constitution of the NGRC shall be determined by the MoHFW in accordance with the Scheme Guidelines from time to time. Proposed members for NGRC are:

a. CEO of National Health Agency (NHA) – Chairperson
b. JS , Ministry of Health & Family Welfare- Member
c. Additional CEO of National Health Agency (NHA)- Member Convenor
d. Executive Director, IEC, Capacity Building and Grievance Redressal
e. NGRC can also invite other experts/ officers for their inputs in specific cases.

CEO (NHA) may designate Addl. CEO (NHA) to chair the NGRC. Investigation authority for investigation of the grievance may be assigned to Regional Director- CGHS/Director Health Services/ Mission director NHM of the State/UT concerned. NGRC will consider:

a. Appeal by the stakeholders against the decisions of the State Grievance Redressal Committees (SGRCs)
b. Also, the petition of any stakeholder aggrieved with the action or the decision of the State Health Agency / State Government
c. Review of State-wise performance based monthly report for monitoring, evaluation and make suggestions for improvement in the Scheme as well as evaluation methodology
d. Any other reference on which report of NGRC is specifically sought by the Competent Authority.
The Meetings of the NGRC will be convened as per the cases received with it for consideration or as per the convenience of the Chairman, NGRC.

Grievance Settlement of Stakeholders

If any stakeholder has a grievance against another one during the subsistence of the policy period or thereafter, in connection with the validity, interpretation, implementation or alleged breach of any provision of the scheme, it will be settled in the following way by the Grievance Committee:

A. Grievance of a Beneficiary

i) Grievance against insurance company, hospital, their representatives or any functionary
If a beneficiary has a grievance on issues relating to entitlement, or any other AB-PMJAY related issue against Insurance Company, hospital, their representatives or any functionary, the beneficiary can call the toll free call centre number 14555 (or any other defined number by the State) and register the complaint. Beneficiary can also approach DGRC. The complaint of the beneficiary will be forwarded to the relevant person by the call centre as per defined matrix. The DGRC shall take a decision within 30 days of receiving the complaint. If either of the parties is not satisfied with the decision, they can appeal to the SGRC within 30 days of the decision of the DGRC. The SGRC shall take a decision on the appeal within 30 days of receiving the appeal. The decision of the SGRC on such issues will be final.

Note: In case of any grievance from beneficiary related to hospitalisation of beneficiary (service related issue of the beneficiary) the timelines for DGRC to take decision is within 24 hours from the receiving of the grievance.

ii) Grievance against district authorities
If the beneficiary has a grievance against the District Authorities or an agency of the State Government, it can approach the SGRC for resolution. The SGRC shall take a decision on the matter within 30 days of the receipt of the grievance. The decision of SGRC shall be final.

B. Grievance of a Health Care Provider

i Grievance against beneficiary, insurance company, their representatives or any other functionary
If a Health Care Provider has any grievance with respect to beneficiary, Insurance Company, their representatives or any other functionary, the Health Care Provider will approach the DGRC. The DGRC should be able to reach a decision within 30 days of receiving the complaint.
Step I- If either of the parties is not satisfied with the decision, they can go to the SGRC within 30 days of the decision of the DGRC, which shall take a decision within 30 days of receipt of appeal.
Step II- If either of the parties is not satisfied with the decision, they can go to the NGRC within 30 days of the decision of the SGRC, which shall take a decision within 30 days of receipt of appeal. The decision of NGRC shall be final.

C. Grievance of insurance company

i) Grievance against district authorities/ health care provider
If Insurance Company has a grievance against District Authority / Health Care Provider or an agency of the State Government, it can approach the SGRC for resolution. The SGRC shall decide the matter within 30 days of the receipt of the grievance.
In case of dissatisfaction with the decision of the SGRC, the affected party can file an appeal before NGRC within 30 days of the decision of the SGRC and NGRC shall take a decision within 30 days of the receipt of appeal after seeking a report from the other party. The decision of NGRC shall be final.

14. **Compliance with the Orders of the Grievance Redressal Committees**

i The Insurer shall ensure that all orders of the Grievance Redressal Committees by which it is bound are complied with within 30 days of the issuance of the order, unless such order has been stayed on appeal.

ii If the Insurer fails to comply with the order of any Grievance Redressal Committee within such 30-day period, the Insurer shall be liable to pay a penalty of Rs. 25,000 per month for the first month of such non-compliance and Rs. 50,000 per month thereafter until the order of such Grievance Redressal Committee is complied with. The Insurer shall be liable to pay such penalty to the SHA within 15 days of receiving a written notice.

iii On failure to pay such penalty, the Insurer shall incur an additional interest at the rate of one percent of the total outstanding penalty amount for every 15 days for which such penalty amount remains unpaid.

Annex 1: Detailed Empanelment Criteria

A Hospital would be empanelled as a network private hospital with the approval of the respective State Health Authority1 if it adheres with the following minimum criteria:

1. Should have at least 10 inpatient beds with adequate spacing and supporting staff as per norms.
   i) Exemption may be given for single-specialty hospitals like Eye and ENT.
   ii) General ward - @80sq ft per bed, or more in a Room with Basic amenities- bed, mattress, linen, water, electricity, cleanliness, patient friendly common washroom etc. Non-AC but with fan/Cooler and heater in winter.
2. It should have adequate and qualified medical and nursing staff (doctors2 & nurses3), physically in charge round the clock; (necessary certificates to be produced during empanelment).
3. Fully equipped and engaged in providing Medical /Surgical services, commensurate to the scope of service/ available specialities and number of beds.
   i) Round-the-clock availability (or on-call) of a Surgeon and Anaesthetist where surgical services/ day care treatments are offered.
   ii) Round-the-clock availability (or on-call) of an Obstetrician, Paediatrician and Anaesthetist where maternity services are offered.
   iii) Round-the-clock availability of specialists (or on-call) in the concerned specialties having sufficient experience where such services are offered (e.g. Orthopaedics, ENT, Ophthalmology, Dental, general surgery (including endoscopy) etc.)
4. Round-the-clock support systems required for the above services like Pharmacy, Blood Bank, Laboratory, Dialysis unit, Endoscopy investigation support, Post op ICU care with ventilator support, X-ray facility (mandatory) etc., either 'In-House' or with 'Outsourcing arrangements', preferably with NABL accredited laboratories, with appropriate agreements and in nearby vicinity.
5. Round-the-clock Ambulance facilities (own or tie-up).
6. 24 hours emergency services managed by technically qualified staff wherever emergency services are offered
   i) Casualty should be equipped with Monitors, Defibrillator, Nebulizer with accessories, Crash Cart, Resuscitation equipment, Oxygen cylinders with flow meter/ tubing/catheter/face mask/nasal prongs, suction apparatus etc. and with attached toilet facility.
7. Mandatory for hospitals wherever surgical procedures are offered:
   i) Fully equipped Operation Theatre of its own with qualified nursing staff under its employment round the clock.
   ii) Post-op ward with ventilator and other required facilities.
8. Wherever intensive care services are offered it is mandatory to be equipped with an Intensive Care Unit (For medical/surgical ICU/HDU/Neonatal ICU) with requisite staff
   i) The unit is to be situated in close proximity of operation theatre, acute care medical, surgical ward units, labour room and maternity room as appropriate.
   ii) Suction, piped oxygen supply and compressed air should be provided for each ICU bed.
   iii) Further ICU- where such packages are mandated should have the following equipment:
      1) Piped gases
      2) Multi-sign Monitoring equipment
      3) Infusion of ionotropic support
      4) Equipment for maintenance of body temperature
      5) Weighing scale
      6) Manpower for 24x7 monitoring
      7) Emergency cash cart
      8) Defibrillator.
      9) Equipment for ventilation.
      10) In case there is common Paediatric ICU then Paediatric equipments, e.g.: paediatric ventilator, Paediatric probes, medicines and equipment for resuscitation to be available.
   iv) HDU (high dependency unit) should also be equipped with all the equipment and manpower as per HDU norms.
9. Records Maintenance: Maintain complete records as required on day-to-day basis and is able to provide necessary records of hospital / patients to the Society/Insurer or his representative as and when required.
   i) Wherever automated systems are used it should comply with MoHFW/ NHA EHR guidelines (as and when they are enforced)
   ii) All AB-PMJAY cases must have complete records maintained
   iii) Share data with designated authorities for information as mandated.
10. Legal requirements as applicable by the local/state health authority.

11. Adherence to Standard treatment guidelines/ Clinical Pathways for procedures as mandated by NHA from time to time.
12. Registration with the Income Tax Department.
13. NEFT enabled bank account
14. Telephone/Fax
15. Safe drinking water facilities/Patient care waiting area
16. Uninterrupted (24 hour) supply of electricity and generator facility with required capacity suitable to the bed strength of the hospital.
17. Waste management support services (General and Bio Medical) – in compliance with the bio-medical waste management act.
18. Appropriate fire-safety measures.
19. Provide space for a separate kiosk for AB-PMJAY beneficiary management (AB-PMJAY non-medical4 coordinator) at the hospital reception.
20. Ensure a dedicated medical officer to work as a medical5 co-ordinator towards AB-PMJAY beneficiary management (including records for follow-up care as prescribed)
21. Ensure appropriate promotion of AB-PMJAY in and around the hospital (display banners, brochures etc.) towards effective publicity of the scheme in co-ordination with the SHA/ district level AB-PMJAY team.
22. IT Hardware requirements (desktop/laptop with internet, printer, webcam, scanner/ fax, bio-metric device etc.) as mandated by the NHA.
23. Only those Private Hospitals/Institutions which are registered under Directorate of Health Services (Jammu/Kashmir) can be empaneled under ABPMJAY

Category 2: Advanced criteria:

Over and above the essential criteria required to provide basic services under AB-PMJAY (as mentioned in Category 1) those facilities undertaking defined speciality packages (as indicated in the benefit package for specialities mandated to qualify for advanced criteria) should have the following:

1. These empanelled hospitals may provide specialized services such as Cardiology, Cardiothoracic surgery, Neurosurgery, Nephrology, Reconstructive surgery, Oncology, Paediatric Surgery, Neonatal intensive care etc.
2. A hospital could be empanelled for one or more specialities subject to it qualifying to the concerned speciality criteria for respective packages
3. Such hospitals should be fully equipped with ICCU/SICU/ NICU/ relevant Intensive Care Unit in addition to and in support of the OT facilities that they have.
4. Such facilities should be of adequate capacity and numbers so that they can handle all the patients operated in emergencies.

i) The Hospital should have sufficient experienced specialists in the specific identified fields for which the Hospital is empanelled as per the requirements of professional and regulatory bodies/ as specified in the clinical establishment act/ State regulations.

ii) The Hospital should have sufficient diagnostic equipment and support services in the specific identified fields for which the Hospital is empanelled as per the requirements specified in the clinical establishment act/ State regulations.

5. Indicative domain specific criteria are as under:

A. **Specific criteria for Cardiology/ CTVS**

1. CTVS theatre facility (Open Heart Tray, Gas pipelines Lung Machine with TCM, defibrillator, ABG Machine, ACT Machine, Hypothermia machine, IABP, cautery etc.)
2. Post-op with ventilator support
3. ICU Facility with cardiac monitoring and ventilator support
4. Hospital should facilitate round the clock cardiologist services.
5. Availability of support speciality of General Physician & Paediatrician
6. Fully equipped Catheterization Laboratory Unit with qualified and trained Paramedics.

B. **Specific criteria for Cancer Care**

1. For empanelment of Cancer treatment, the facility should have a Tumour Board which decides a comprehensive plan towards multi-modal treatment of the patient or if not then appropriate linkage mechanisms need to be established to the nearest regional cancer centre (RCC). Tumor Board should consist of a qualified team of Surgical, Radiation and Medical /Paediatric Oncologist in order to ensure the most appropriate treatment for the patient.
2. Relapse/recurrence may sometimes occur during/ after treatment. Retreatment is often possible which may be undertaken after evaluation by a Medical/ Paediatric Oncologist/ Tumor Board with prior approval and pre-authorization of treatment.

3. For extending the treatment of chemotherapy and radiotherapy the hospital should have the requisite Pathology/ Haematology services/ infrastructure for radiotherapy treatment viz. for cobalt therapy, linear accelerator radiation treatment and brachytherapy available in-house. In case such facilities are not available in the empanelled hospital for radiotherapy treatment and even for chemotherapy, the hospital shall not perform the approved surgical procedure alone but refer the patients to other centres for follow-up treatments requiring chemotherapy and radiotherapy treatments. This should be indicated where appropriate in the treatment approval plan.
4. Further hospitals should have following infrastructure for providing certain specialized radiation treatment packages such as stereotactic radiosurgery/ therapy.
    i. Treatment machines which are capable of delivering SRS/SRT
    ii. Associated Treatment planning system
    iii. Associated Dosimetry systems

C. **Specific criteria for Neurosurgery**

1. Well Equipped Theatre with qualified paramedical staff, C-Arm, Microscope, neurosurgery compatible OT table with head holding frame (horse shoe, may field / sugita or equivalent frame).
2. ICU facility
3. Post-op with ventilator support
4. Facilitation for round the clock MRI, CT and other support bio-chemical investigations.

D. **Specific criteria for Burns, Plastic & Reconstructive surgery**

1. The Hospital should have full time / on - call services of qualified plastic surgeon and support staff with requisite infrastructure for corrective surgeries for post burn contractures.
2. Isolation ward having monitor, defibrillator, central oxygen line and all OT equipment.
3. Well Equipped Theatre
4. Intensive Care Unit.
5. Post-op with ventilator support
6. Trained Paramedics
7. Post-op rehab/ Physiotherapy support/ Phycology support.

E. **Specific criteria for /Paediatric Surgery**

1. The Hospital should have full time/on call services of paediatric surgeons
2. Well-equipped theatre
3. ICU support
4. Support services of paediatrician
5. Availability of mother rooms and feeding area.
6. Availability of radiological/ fluoroscopy services (including IITV), Laboratory services and Blood bank.

F. Specific criteria for specialized new born care.

1. The hospital should have well developed and equipped neonatal nursey/Neonatal ICU (NICU) appropriate for the packages for which empanelled, as per norms
2. Availability of radiant warmer/ incubator/ pulse oximeter/ photo therapy/ weighing scale/ infusion pump/ ventilators/ CPAP/ monitoring systems/ oxygen supply / suction / infusion pumps/ resuscitation equipment/ breast pumps/ bilimeter/ KMC (Kangaroo Mother Care) chairs and transport incubator - in enough numbers and in functional state; access to hematological, biochemistry tests, imaging and blood gases, using minimal sampling, as required for the service packages
3. For Advanced Care and Critical Care Packages, in addition to 2. Above: parenteral nutrition, laminar flow bench, invasive monitoring, in-house USG. Ophthalmologist on call.
4. Trained nurses 24x7 as per norms
5. Trained Paediatrician(s) round the clock
6. Arrangement for 24x7 stay of the Mother – to enable her to provide supervised care, breastfeeding and KMC to the baby in the nursery/NICU and upon transfer therefrom; provision of bedside KMC chairs.
7. Provision for post-discharge follow up visits for counselling for feeding, growth / development assessment and early stimulation, ROP checks, hearing tests etc.

G. **Specific criteria for Polytrauma**

1. Shall have Emergency Room Setup with round the clock dedicated duty doctors.
2. Shall have the full-time service availability of Orthopaedic Surgeon, General Surgeon, and anaesthetist services.

3. The Hospital shall provide round the clock services of Neurosurgeon, Orthopaedic Surgeon, CT Surgeon, General Surgeon, Vascular Surgeon and other support specialists as and when required based on the need.
4. Shall have dedicated round the clock Emergency theatre with C-Arm facility, Surgical ICU, Post-Op Setup with qualified staff.
5. Shall be able to provide necessary diagnostic support round the clock including specialized investigations such as CT, MRI, emergency biochemical investigations.

H. **Specific criteria for Nephrology and Urology Surgery**

6. Dialysis unit
7. Well-equipped operation theatre with C-ARM
8. Endoscopy investigation support
9. Post op ICU care with ventilator support
10. Sew lithotripsy equipment