Bajaj Allianz General Insurance Company Limited
Corporate Identity Number: U66010PN2000PLC015329. IRDAI Registration No.113
Regd. Office & Head Office: Bajaj Allianz House, Airport Road, Yerawada, Pune - 411 006

Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (AB-PM JAY), Mukhyamantri Amrutam (MA) and Mukhyamantri Amrutam Vatsalaya (MAV) Yojana In the State of Gujarat

Policy Wordings

UIN- BAJHGSP22048V012122

Whereas, the **State Health Agency (SHA), Gujarat,** hereinafter referred to as the **Insured** has by a proposal and declaration dated as stated in the **Policy** 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" (the AB-PMJAY), a Government of India scheme, Mukhyamantri Amrutam (MA) or Mukhyamantri Amrutam Vatsalya (MAV) Yojana Beneficiary Family Units named in the Policy Schedule and has agreed to pay premium in installments in accordance with Section 10.1 of Tender Document for Implementation of Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PMJAY), Mukhyamantri Amrutam (MA) and Mukhyamantri Amrutam Vatsalaya (MAV) Yojana In the State of Gujarat released by State Government of Gujarat in November 2020 as consideration for such insurance, we the Company hereby agrees to indemnify the Beneficiary Family Unit" under "PMJAY, MA and MAV in the State of Gujarat as named in the **Policy** Schedule read with these Terms and Conditions.

All General Terms, Conditions, clauses and exclusion whether mentioned in Policy Documents and not,.shall to be read as per Tender Document for Implementation of Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PMJAY), Mukhyamantri Amrutam (MA) and Mukhyamantri Amrutam Vatsalaya (MAV) Yojana In the State of Gujarat released by State Government of Gujarat.

SECTION A: DEFINITIONS:

1. **AB-PMJAY** shall refer to Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) , a scheme managed and administered by the Ministry of Health and Family Welfare, Government of India through National Health Authority with the objectives of providing and improving access of validated Beneficiary Family Units to quality inpatient care and day care surgeries for treatment of diseases and medical conditions through a network of Empanelled Health Care Providers for the risk covers defined in in this document and also for reducing out of pocket health care expenses
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 which are resident in the Service Area.
3. **AB-PMJAY Guidelines** mean the guidelines issued by MoHFW and/or NHA from time to time for the implementation of the AB-PMJAY, to the extent modified by the Tender Documents pursuant to which the Insurance Contract has been entered into; provided that MoHFW and/or NHA or the State Health Agency may, from time to time, amend or modify the AB-PMJAY Guidelines or issue new AB-PMJAY Guidelines, which shall then be applicable to the Insurer. This includes all the guidelines issued by MoHFW and/or NHA for the implementation of PMJAY.
4. **Annexure** means an annexure to the Scheme which is made part of this Insurance Contract.
5. **Accident** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.
6. **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 Insurer.
7. **Law/Applicable Law** means any statute, law, ordinance, notification, rule, regulation, judgment, order, decree, bye-law, approval, directive, guideline, policy, requirement or other governmental restriction or

any similar form of decision applicable to the relevant party and as may be in effect on the date of the execution of this Agreement and during the subsistence thereof.

8. **Beneficiary** means a member of the PMJAY or MA or MA Vatsalya Beneficiary Family Units who is eligible to avail benefits under the Pradhan Mantri Jan Arogya Yojana or under Mukhyamantri Amrutam or Mukhyamantri Amrutam Vatsalya Yojana. Referred to as PMJAY or MA or MA Vatsalya Beneficiary henceforth in the document.
9. **Beneficiary Family Unit or "Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana" (the AB-PMJAY), a Government of India scheme, Mukhyamantri Amrutam (MA) or Mukhyamantri Amrutam Vatsalya (MAV) Yojana or PMJAY, MA and MAV 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 & 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 broadly defined occupational un-organised workers (in Urban Sector) of the Socio-Economic Caste Census (SECC) 2011 database of the State/ UT Government along with the existing MA and MA Vatsalya Beneficiary Families not figuring in the SECC Database of the State / UTs Referred to as PMJAY Beneficiary Family Unit henceforth in the document.
10. **Benefit Risk Cover or Benefit Cover** refers to the
annual basic cashless hospitalisation coverage of Rs.5,00,000/- under Model ''C'' (any one model as decided by the State Health Agency Gujarat) that the insured families would receive under the Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana, or Mukhyamantri Amrutam or Mukhyamantri Amrutam Vatsalya Yojana.
11. **Benefit Package or Health Benefit Package** refers to the bundled package of services required to treat a condition/ailment/ disease that insured families would receive under AB-PMJAY, MA or MAV and detailed in schedule 3 to the Scheme subject to exclusions.
12. **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.
13. **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.
14. **CHC** means a community health centre located at the block level in the State.
15. **Claim** means a claim that is received by the Insurer from an Empanelled Health Care Provider, on behalf of covered Beneficiaries, either online or through alternate mechanism in absence of internet connectivity.
16. **Clause** means a clause of this Insurance Contract.
17. **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.
18. **Condition precedent** means a Policy term or a condition upon which the Company's liability under the Policy is conditional upon.
19. **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
20. **Days** mean and shall be interpreted as calendar days unless otherwise specified.
21. **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.

22. **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.
23. **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.
24. **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-NHPM Beneficiary Family Unit, and all premium paid hereon .as to those Beneficiaries and AB-NHPM Beneficiary Family Unit, shall be forfeited to the Company,
25. **EHCP or Empanelled Health Care Providers** 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 under AB-PMJAY.
26. **Fraud** shall mean and include any intentional deception, manipulation of facts and / or documents or misrepresentation made by a person or organization with the knowledge that the deception could result in unauthorized financial or other benefit to herself/himself or some other person or organization. It includes any act that may constitute fraud under any applicable law in India.
27. **Health Service provider** means the empanelled Third Party Administrator [TPA] of the Company.
28. **Health Benefit Package** refers to the bundled package of services required to treat a condition/ailment/ disease that insured families would receive under AB-PMJAY, MA and MAV and detailed in schedule 3 to the Scheme subject to exclusions.
29. **Health Insurance:** The term health insurance is a type of insurance that covers medical expenses.
30. **Health Insurance Policy** is a contract between an insurer and an individual /group/household/family in which the insurer agrees to provide specified health insurance cover at a particular “premium”
31. **Hospital** All the hospitals empanelled under AB-NHPM for providing general care have to meet the minimum criteria established under the Mission detailed in Annex 1 as mentioned in the wording.
32. **Hospitalisation** means any Medical Treatment or Surgical Procedure which requires 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.
33. **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.
34. **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:—
    (i) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests—
    (ii) it needs ongoing or long-term control or relief of symptoms—
    (iii) it requires your rehabilitation or for you to be specially trained to cope with it—
    (iv) it continues indefinitely—
    (v) it recurs or is likely to recur.
35. **Inpatient care** means treatment for which the Beneficiary has to stay in a hospital for more than 24 hours for a covered event.
36. **Insurance Contract/Agreement** shall mean this contract between the State Health Agency and the Insurer for the provision of the benefits under the Risk Cover, to the Beneficiaries and setting out the terms and conditions for the implementation of the ABPMJAY.
37. **ICU or Intensive Care Unit** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
38. **Material Breach** means breach of any term and condition as enlisted in this Insurance Contract caused due to any act and/or omission by the Insurer’s willful misconduct and/or negligence.

39. **MA Yojana** shall refer to Mukhyamantri Amrutam Yojana managed and administered by the Health and Family Welfare Department, Government of Gujarat 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.
40. **MA Vatsalya Yojana** shall refer to Mukhyamantri Amrutam Vatsalya Yojana managed and administered by the Health and Family Welfare Department, Government of Gujarat 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.
41. **Material Misrepresentation** shall mean an act of intentional hiding or fabrication of a material fact which, if known to the other party, could have terminated, or significantly altered the basis of a contract, deal, or transaction.
42. **Medical Practitioner** means a person who holds a valid registration from the medical council of any state of India and is thereby entitled to practice medicine within its jurisdiction, acting within the scope and jurisdiction of his/her license.
43. **Medical Advise** means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.
44. **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.
45. **Medical Treatment** means any medical treatment of an illness, disease or injury, including diagnosis and treatment of symptoms thereof, relief of suffering and prolongation of life, provided by a Medical Practitioner, but that is not a Surgical Procedure. Medical Treatments include but not limited to: bacterial meningitis, bronchitis-bacterial/viral, chicken pox, dengue fever, diphtheria, dysentery, epilepsy, filariasis, food poisoning, hepatitis, malaria, measles, meningitis, plague, pneumonia, septicaemia, tuberculosis (extra pulmonary, pulmonary etc.), tetanus, typhoid, viral fever, urinary tract infection, lower respiratory tract infection and other such diseases requiring Hospitalization, as per HBPs detailed in schedule 3 (a) of the Scheme as per this Insurance Contract.
46. **Medically Necessary Treatment:** Medically necessary treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
    a. is required for the medical management of the illness or injury suffered by the insured;
    b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    c. must have been prescribed by a medical practitioner;
    d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
47. **Model ''C''** refers to the Risk Cover / Health Cover (RC/HC) of Rs.5,00,000/- (Rupees Five Lakh only) per family per annum that the insured families would receive under the Ayushman Bharat -Pradhan Mantri Jan Arogya Yojana, or Mukhyamantri Amrutam or Mukhyamantri Amrutam Vatsalya Yojana.
48. **MoHFW** shall mean the Ministry of Health and Family Welfare, Government of India.
49. **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.
50. **Non-Network Provider means a**ny hospital, day care centre or other provider that is not part of the network of Company.
51. **NHA** shall mean the National Health Authority 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 coordination and convergence with other similar schemes being implemented by the Government of India and State Governments.
52. **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.
53. **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.
54. **Package Rate** means the fixed maximum charges for a Medical Treatment or Surgical Procedure or for any Follow-up Care that will be paid by the Insurer under Cover, which shall be determined in accordance with the rates provided in this Contract.
55. **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 per contract entered between SHA and the Insurer.

56. **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.
57. **Pre-Existing Disease**
    means any condition, ailment or injury or disease
a. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or
   For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.
58. **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.
59. **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.
60. **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
61. **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.
62. **REQUEST FOR PROPOSAL or RFP:** Request for Proposal dt. November 2020 floated by Government of Gujarat for Selection of Insurance Company for the implementation of Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PMJAY), Mukhyamantri Amrutam (MA) and Mukhyamantri Amrutam Vatsalaya (MAV) Yojana In the State of Gujarat

1. **Risk Cover** shall mean an annual risk cover of Rs.5,00,000 under model 'C' under Scheme, covering in-patient care and day care surgeries for treatment of diseases and medical conditions pertaining to secondary and / or tertiary treatment as defined in schedule 3 (a) of the Scheme as per the Insurance Contract, through a network of Empanelled Health Care Providers (EHCP) for the AB-PM-JAY, MA and MAV, Beneficiary Family Units validated by the State Government or the designated State Health Agency (SHA).
2. **Service Area** refers to all the districts in the State of Gujarat covered and included under thisTender Document for the implementation of AB-PM JAY, MA and MAV.
3. **State Government** refers to the duly elected Government in the State in which the tender is issued.
4. **State Health Agency (SHA)** (SHA) refers to the agency/ body set up by the Gujarat Health Protection Society, Health and Family Welfare Department, Government of Gujarat for the purpose of coordinating, managing and implementing the Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana, Mukhyamantri Amrutam and Mukhyamantri Amrutam Vatsalya Yojana in the State of Gujarat.
5. **Policy Schedule** means a schedule of this Insurance Contract.
6. **Scheme** shall mean the AYUSHMAN BHARAT Pradhan Mantri Jan Arogya Yojana managed and administered by the Ministry of Health and Family Welfare, Government of India through National Health Agency and, Mukhyamantri Amrutam and Mukhyamantri Amrutam Vatsalya Yojana managed and administered by the Health and Family Welfare Department, Gujarat as per RFP.
7. **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.
8. **Sum Insured shall** mean the sum of Rs.5,00,000/- under Model ''C'' as per work order dt.31-05-2021 issued by Gujarat State as per AB-PMJAY, MA and MAV Beneficiary Family Unit per annum against which the AB-PMJAY, MA and MAV Beneficiary Family Unit may seek benefits as per the benefit package under the AB-PMJAY, MA and MAV as per Beneficiaries detailed in 1 to RFP dt. November 2020 under the Scheme under the Scheme.
9. **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.
10. **Turn-around Time** means the time taken by the Insurer in completing the ta sk.These tasks include but not limited to beneficiary verification, processing preauthorization, processing a Claim received from an Empanelled Health Care Provider and in making a Claim Payment including investigating such Claim or rejection of the such Claim etc. defined in this Contract.

11. **Unproven/ experimental treatment** means treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

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

AB-PMJAY	Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana
AL	Authorisation Letter (from the Insurer)
BFU	Beneficiary Family Unit
BIS	Beneficiary Identification System
BPL	Below Poverty Line
RC	Risk Cover
CGRMS	Central Grievance Redressal 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
GRC	Grievance Redressal Committee
IRDAI	Insurance Regulatory Development Authority of India
MA	Mukhyamantri Amrutam Yojana
MAV	Mukhyamantri Amrutam Vatsalya Yojana
MoHFW	Ministry of Health & Family Welfare, Government of India
NGRC	National Grievance Redressal Committee
NHA	National Health Authority
NOA	Notice of Award
PMAM	Pradhan Mantri Arogya Mitra
PHC	Primary Health Centre
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

SECTION B: COVERAGE AND BENEFITS

The Company indemnify the Beneficiary/ies the benefits within the Scheme, to be provided on a cashless basis up to the Sum Insured for their annual coverage, package charges on specified **Medical** and or **Surgical** procedures and subject to other terms and conditions outlined herein, are the following:

AB PMJAY Beneficiaries and Beneficiary Family Unit-

a) Unit of coverage under the Scheme shall be a family and each family for this Scheme shall be called a AB-PMJAY, MA and MAV Beneficiary Family Unit, which will comprise all members in that family. Any addition in the family will be allowed only as per the provisions approved by the Government.
b) The presence of name in the beneficiary list, (amended from time to time, due to addition of family member, as per Guidelines - schedule 4 of the Scheme *(Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PMJAY), Mukhyamantri Amrutam (MA) and Mukhyamantri Amrutam Vatsalaya (MAV) Yojana*
In the State of Gujarat) shall be the proof of eligibility of the Beneficiary Family Unit for the purpose of availing benefits under this Insurance Contract and a Policy issued pursuant to this Insurance Contract.

Benefits under AB-PM JAY, MA and MAV Risk Cover

1. Risk Cover (RC) will include hospitalization / treatment expenses coverage including treatment for medical conditions and diseases requiring secondary and tertiary level of medical and surgical care treatment and

also including defined day care procedures (as applicable) and follow up care along with cost for pre and post-hospitalisation treatment as detailed in schedule 3 (a) of the Scheme.

2. As on the date of commencement of the Policy Cover Period, the AB-PMJAY, MA and MAV **Sum Insured** in respect of the Risk Cover for each AB-PMJAY, MA and MAV Beneficiary Family Unit **shall be Rs.5,00,000/-** under Model ''C'' [under the Scheme] 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, MA and MAV Beneficiary Family Unit.
3. **Pre-existing conditions/diseases** are to be covered from the first day of the start of policy, subject to the exclusions given in Schedule 2 of the Scheme which are reproduced in Section C hereinafter.
4. Coverage of health services related to surgical nature for defined procedures shall also be provided on a day care basis. The Insurance Company shall provide coverage for the defined **day care treatments**, procedures and medical treatments as given in schedule 3 of the Scheme.
5. **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 as detailed in HBPs schedule 3 (a) of the Scheme.
6. AB-PMJAY, MA and MAV Cover-
   The benefits within this Scheme under the Risk Cover are to be provided on a cashless basis to the AB-PMJAY, MA and MAV Beneficiaries up to the limit of their annual coverage and includes:
   i. Hospitalization expense benefits
   ii. Day care treatment benefits (as applicable)
   iii. Follow-up care benefits
   iv. Pre- and post-hospitalization expense benefits
   v. New-born child/ children benefits
7. For availing select treatment in any empanelled hospitals, pre-authorisation is required to be taken for defined cases.
8. Except for exclusions listed in Section C of this Insurance Contract read with schedule 2 to the Scheme, treatment/procedures will also be allowed, in addition to the procedures listed in schedule 3 to the Scheme, of up to a limit of Rs.1,00,000 to any ABPMJAY, MA and MAV Beneficiary (called 'Unspecified Procedure') within the overall limit of Rs.5,00,000. Operations pertaining to Unspecified Procedure are to be governed as per Unspecified Packages Guidelines provided under schedule 3 to the Schemet.
9. The Insurer shall reimburse claims of Empanelled Health Care Provider under the ABPMJAY, MA and MAV based on Package Rates determined as follows:
   a. If the package rate for a medical treatment or surgical procedure requiring Hospitalization or Day Care Treatment (as applicable) is fixed in schedule 3 to the Scheme, then the Package Rate so fixed shall apply for the Policy Cover Period.
   b. If the package rate for a surgical procedure requiring Hospitalization or Day Care Treatment (as applicable) is not listed in schedule 3 to the Scheme, then the Insurer may preauthorize an appropriate amount based on rates for similar procedures defined in schedule 3 to the Scheme or based on other applicable national or state health insurance schemes such as CGHS. In case of medical care, the rate will be calculated on per day basis as specified in schedule 3 to the Scheme except for special inputs like High end radiological diagnostic and High-end histopathology (Biopsies) and advanced serology investigations packages or some other special inputs existing in the HBP (or are released by NHA in future) which can be clubbed with medical packages.
   c. PM-JAY, MA and MAV is a cashless scheme, where no beneficiary should be made to pay for availing treatment in any PMJAY empaneled hospitals. However, upon exhaustion of the beneficiary PM-JAY, MA and MAV wallet of Rs.5.00 Lakhs, or if the treatment cost exceeds the benefit coverage amount available with the beneficiary families then the liability for such remaining treatment cost as per the package rates defined in the schedule 3 to the Scheme will not be of the insurer. Beneficiary and SHA (through ISA/TPA) will need to be clearly communicated in advance about the additional payment at the start of such treatment.
   d. In case an AB-PMJAY, MA and MAV Beneficiary is required to undertake multiple surgical procedures in one OT session, then the procedure with highest rate shall be considered as the primary package and reimbursed at 100%, thereupon the 2nd surgical procedure shall be reimbursed at 50% of package rate, 3rd and subsequent surgical procedures shall be reimbursed at 25% of the package rate.
   e. Surgical and Medical packages will not be allowed to be availed at the same time (Except for certain add on procedures as defined in schedule 3 to the Scheme and configured in NTMS). In exceptional circumstances, hospital may raise a request for such preauth which will be decided by SHA with the help of concerned medical specialist.

f. Certain packages as mentioned in schedule 3 to the Scheme will only be reserved for Public EHCPs as decided by the SHA. The state may permit availing of these packages in Private EHCPs only after a referral from a Public EHCP is made. Some modifications (in not more than 10% of total number of packages) may be done by SHA in this regard.
g. Incentivization will be provided to certain hospitals {as defined in schedule 3 (c) to the Scheme} which will be over and above the rates defined in schedule 3 to the Scheme.

10. For the purpose of Hospitalization expenses as package rates shall include all the costs associated with the treatment, amongst other things:
    a. Registration charges.
    b. Bed charges
    c. Nursing and boarding charges.
    d. Surgeons, Anaesthetists, Medical Practitioner, Consultants fees etc.
    e. Anaesthesia, Blood Transfusion, Oxygen, O.T. Charges, Cost of Surgical Appliances etc.
    f. Medicines and drugs.
    g. Cost of prosthetic devices, implants etc.
    h. Pathology and radiology tests: Medical procedures include basic Radiological imaging and diagnostic tests such as X-ray, USG, Haematology, pathology etc. However, High end radiological diagnostic and High-end histopathology (Biopsies) and advanced serology investigations packages can be booked as a separate add-on procedure if required. Surgical packages are all inclusive and do not permit addition of other diagnostic packages.
    i. Food to patient.
    j. Transport cost of Rs.300 during each hospitalization.
    k. Pre and Post Hospitalization expenses: Expenses incurred for consultation, diagnostic tests and medicines prior to admission of the patient in the same hospital and cost of diagnostic tests and medicines up to 15 days after discharge from the hospital for the same ailment / surgery.
    l. Any other expenses related to the treatment of the patient in the hospital.
11. For the purpose of Day Care Treatment expenses shall include, amongst other things:
    a. Registration charges;
    b. Surgeons, anaesthetists, Medical Practitioners, consultants' fees, etc.;
    c. Anaesthesia, blood transfusion, oxygen, operation theatre charges, cost of surgical appliances, etc.;
    d. Medicines and drugs;
    e. Cost of prosthetic devices, implants, organs, etc.
    f. Pathology and radiology tests: Medical procedures include basic Radiological imaging and diagnostic tests such as X-ray, USG, Haematology, pathology etc. However, High end radiological diagnostic and High-end histopathology (Biopsies) and advanced serology investigations packages can be booked as a separate add-on procedure if required. Surgical packages are all inclusive and do not permit addition of other diagnostic packages.
    g. Pre and Post Hospitalization expenses: Expenses incurred for consultation, diagnostic tests and medicines prior to admission of the patient in the same hospital and cost of diagnostic tests and medicines up to 15 days after discharge from the hospital for the same ailment / surgery.
    h. Transport cost of Rs.300 during each hospitalization.
    i. Any other expenses related to the Day Care Treatment provided to the Beneficiary by an Empanelled Health Care Provider.
12. Revision/Stratification of Package Rates during Term of the contract: SHA may, due to change of policy directions from NHA or following due diligence and based on the incidence of diseases or reported medical conditions or on its own, if deemed necessary, suggests revision of HBP then
    a. If Packages are added/ Revised and cost of added/revised package is below Rs.1,00,000 (Rupees one Lakh only) then revision/addition is binding on the Insurer without any additional financial implication on SHA, in case the procedures were otherwise allowed in unspecified package. In this case revised/added package rates shall be deemed to have been included in schedule 1 (a) with effect from the date on which SHA informs the Insurer in writing.
    b. If Packages are added and cost of added package is above Rs.1,00,000 (Rupees one lakh only) and in cases the cost of package is less than Rs.1,00,000 but it was earlier excluded from HBP, then Insurer shall make the claims payment of such packages and SHA will make quarterly payment for such claims as per the actual additional expenditure by the Insurance Company.
    c. If there is further increase in cost of any existing package, then claims of increased cost of package shall be paid by the Insurer and this additional cost will be paid by SHA as per the actual additional expenditure by Insurance Company.

- d. No financial implications on any Party if certain Packages are dropped/or cost is reduced from the existing Package list. No change in premium or payment to the Insurance Company shall be made in case of changes in reservation policy.

13. The SHA and Insurer shall publish the Package Rates on its website in advance of each Policy Cover Period.
14. 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 schedule 3 and that require hospitalization or day care treatments (as applicable).
    - a. If NHA / SHA during the currency of contract, find that a treatment is being booked under unspecified category repeatedly, or some treatment is required to be included within the list to address a pressing health problem which is or have become widely prevalent, then NHA / SHA may add such treatments in the HBP list. This will not entail any additional financial burden on the part of SHA.
15. 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 total of Risk Cover for an AB-PMJAY, MA and MAV Beneficiary Family Unit.

Benefits Available only through Empanelled Health Care Providers

The benefits under the AB-PMJAY, MA and MAV Risk Cover shall only be available to

- A. AB-PMJAY, MA and MAV Beneficiary through an EHCP after Aadhaar based identification as far as possible as per Guidelines. In case Aadhaar is not available then other defined Government recognised ID will be used for this purpose. State Government shall share with the insurance company within 7 days of signing the agreement a list of defined Government IDs.
- B. The benefits under the AB-PMJAY, MA and MAV Cover shall, subject to the available AB-PMJAY, MA and MAV Sum Insured, be available to the AB-PMJAY, MA and MAV Beneficiary on a cashless and paperless basis at any EHCP.
- C. Specialized tertiary level services shall be available and offered only by the EHCP empanelled for that particular service. Not all EHCPs can offer all tertiary level services, unless they are specifically designated by the SHA for offering such tertiary level services.

PACKAGE RATES

- A. Packages and Package Rates: The Package list for portability will be the list of mandatory AB- PMJAY packages released by the NHA and package rates as applicable and modified by the Treatment State will be applicable. The Clause for honouring these rates by all ICs and Trusts shall have to be built into the agreement.
    - Clauses for preauthorization requirements and transaction management system shall be as per the treatment state guidelines.
    - The beneficiary balance, reservation of procedures for public hospitals as well as segmentation (into secondary/tertiary care or low cost/high cost procedures) shall be as per the home state guidelines.
    - Therefore, for a patient from Rajasthan, taking treatment in Tamil Nadu for CTVS in an EHCP – balance check and reservation of procedure check will be as per Rajasthan rules, but TMS and preauthorization requirements shall be as per TN rules. The hospital claim shall be made as per TN rates for CTVS by the TN SHA (through IC or trust) and the same rate shall be settled at the end of every month by the Rajasthan SHA (through IC or trust).

CASHLESS ACCESS OF SERVICES

- a. The AB-PMJAY, MA and MAV 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.
- b. The insurer shall reimburse EHCP as per the package cost specified in this Document agreed for specified packages or as pre-authorised amount in case of unspecified packages.
- c. The Insurer shall ensure that each EHCP shall at a minimum possess the Hospital IT Infrastructure required to access the AB-PMJAY, MA and MAV Beneficiary Database and undertake verification based on the Beneficiary Identification process laid out, using unique AB-PMJAY, MA and MAV Family ID on the AB-PMJAY, MA and MAV Card and also ascertain the balance available under the AB-PMJAY, MA and MAV Cover provided by the Insurer.
- d. The Insurer shall provide each EHCP with an operating manual describing in detail the verification, pre-authorisation and claims procedures within 7 days of signing of agreement.

e. The Insurer shall train Ayushman Mitras that are deputed in each EHCP who responsible for the administration of the AB-PMJAY, MA and MAV on the use of the Hospital IT infrastructure for making Claims electronically and providing Cashless Access Services.
f. The EHCP shall establish the identity of the member of a AB-PMJAY, MA and MAV Beneficiary Family Unit by Aadhaar Based Identification System (No person shall be denied the benefit in the absence of Aadhaar Card through use of alternate Government ID) and ensure:
    i. That the patient is admitted for a covered procedure and package for such an intervention is available.
    ii. AB-PMJAY, MA and MAV Beneficiary has balance in her/ his AB-PMJAY, MA and MAV Cover amount.
    iii. Provisional entry shall be made on the system 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 procedure.
    iv. 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, MA and MAV Beneficiary Family Unit to complete the transaction.

PRE-AUTHORISATION OF PROCEDURES

a. All procedures in schedule 3 to the Scheme 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 schedule 3 to the Scheme.
b. Insurer will not allow any EHCP, 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, MA and MAV.
c. 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.
d. The RAL should reach the authorisation department of the Insurer within 6 hours of admission in case of emergency.
e. In cases of failure to comply with the timelines stated in above Clause 12.d, the EHCP shall forward the clarification for delay with the request for authorisation.
f. The Insurer shall ensure that in all cases pre-authorisation request related decisions are communicated to the EHCP as per TAT mentioned in schedule 12.B.2 to the Scheme. If there is no response from the Insurer within prescribed TAT of EHCP filing the pre-authorisation request, the request of the EHCP shall be deemed to be automatically authorised and shall affect performance KPIs mentioned in schedule 12.B.2 to the Scheme.
g. The Insurer shall not be liable to honour any claims from the EHCP for procedures featuring in schedule 3 to the Scheme, for which the EHCP does not have a pre-authorisation, if prescribed.
h. Reimbursement of all claims for procedures listed under schedule 3 to the Scheme shall be as per the limits prescribed for each such procedure unless stated otherwise in the pre-authorisation letter/communication.
i. 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.
j. 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.
k. 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.
l. The Insurer needs to file a report to the SHA explaining reasons for denial of every such pre-authorisation request.
m. 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.
n. 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.
o. The authorisation is given only for the necessary treatment cost of the ailment covered and mentioned in the RAL for hospitalization.

p. The entry on the AB-PMJAY/ MA/ MAV 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.

q. 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, MA and MAV beneficiary. The Insurer upon receipt of the bills and documents would release the authorized amount.

r. 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.

s. In cases where the AB-PMJAY, MA and MAV 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, MA and MAV beneficiary was admitted.

t. Regarding Claims Adjudication, Insurer shall ensure adherence to guidelines issued and updated from time to time by NHA.

SECTION C: EXCLUSIONS TO THE POLICY

In Line with Schedule 2 to the Scheme, the Company shall not be liable under the Scheme to make any payment under this Insurance Contract in respect of any expenses whatsoever incurred by any Insured beneficiaries in connection with or in respect of:

i. Condition that does not require hospitalization and can be treated under Out Patient Care.

ii. Except those expenses covered under pre and post hospitalization 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, prosthetic, cosmetic procedure, filling of tooth cavity, root canal including wear and tear of teeth, periodontal diseases, dental implants etc. are excluded. Exception to the above would be treatment needs arising from trauma / injury, neoplasia /tumor / cyst requiring hospitalization for bone treatment.

iv. Any assisted reproductive techniques, or infertility related procedures, unless featuring in the National Health Benefit Package list.

v. Vaccination and immunization

vi. Surgeries related to ageing face & body, laser procedures for tattoo removals, augmentation surgeries and other purely cosmetic procedures such as fat grafting, neck lift, aesthetic rhinoplasty etc.

vii. Circumcision for children less than 2 years of age shall be excluded (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident)

viii. Persistent Vegetative State: a condition in which a medical patient is completely unresponsive to psychological and physical stimuli and displays no sign of higher brain function, being kept alive only by medical intervention.

SECTION D: 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 Policy Schedule.

2. **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 Gandhinagar shall have the exclusive jurisdiction over any disputes arising under, out of or in connection with this Insurance Contract.

3. **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 Gujarat or any other department, organization or public body that is under the ownership and/or control of the Government of Gujarat.

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 Gujarat, the Insurer shall pay all or part of the Claims Payments to the person(s) so notified.

4. **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 is required to 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 participating in the Scheme are deemed to be in arrangement with ALL other States through, NHA, 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 Schedule 9 to the Scheme.
    Note: Beneficiaries having MA and MAV cards will not have portability facility in other state.

5. **Claims Adjudication-**

1. Claim Payments and Turn-around Time

The Insurer shall comply with the following procedure regarding the processing of Claims received from the Empanelled Health Care Providers:

a. The Insurer shall require the Empanelled Health Care Providers to submit their Claims electronically as early as possible as but not later than 7 days after discharge in the defined format to be prescribed by the NHA/SHA/Insurer. If EHCP fails to submit the claims within 7 days, the EHCP shall take written permission from Insurer/TPA & ISA for submission of claims. Claims submitted beyond 21 days of discharge of patients will not be admissible. However, in case of Public EHCPs this time may be relaxed as defined by SHA.
b. The Insurer shall decide on the acceptance or rejection of any Claim received from an Empanelled Health Care Provider. Any rejection notice issued by the Insurer to the EHCP shall state clearly that such rejection is subject to the Empanelled Health Care Provider’s right to file a complaint with the relevant Grievance Redressal Committee against such decision to reject such Claim.
c. If the Insurer rejects a Claim, the Insurer shall issue an electronic (e)-notification of rejection to the Empanelled Health Care Provider stating details of the Claim summary; reasons for rejection; and details of the District Grievance Nodal Officer. E-notification of rejection shall be issued to the State Health Agency and the Empanelled Health Care Provider within 15 days (30 days for Portability Cases) of receipt of the electronic Claim. The Insurer should inform the Empanelled Health Care Provider of its right to seek redressal for any Claim related grievance before the District Grievance Redressal Committee in its e-notification of rejection.
d. If a Claim is rejected because the Empanelled Health Care Provider making the Claim is not empanelled for providing the health care services in respect of which the Claim is made, then the Insurer shall while rejecting the Claim inform the Beneficiary of an alternate Empanelled Health Care Provider where the benefit can be availed in future. The Insurer shall be responsible for settling all claims as per timelines provided in Schedule 12 B to the Scheme.
e. The Insurer shall make the full Claim Payment without deduction of tax, for all PHCs, CHCs, District Hospitals and other government sponsored hospitals, subject to compliance of Income Tax Act, 1961 and its Allied Rules. In case of private healthcare providers the Insurer shall make the full Claim Payment without deduction of tax, if the Empanelled Health Care Provider submits a tax exemption certificate to the Insurer within 7 days after signing the agreement with the Insurer making a Claim. If the Empanelled Health Care Provider fails to submit a tax exemption certificate to the Insurer, then the Insurer shall make the Claim Payment after deducting tax at the applicable rate.

f. If the Beneficiary is admitted by an Empanelled Health Care Provider during a Policy Cover Period, but is discharged after the end of such Policy Cover Period and the Policy is not renewed, then the arising Claim shall be paid in full by the Insurer subject to the available Sum Insured.
g. If a Claim is made during a Policy Cover Period and the Policy is not subsequently renewed, then the Insurer shall make the Claim Payment in full subject to the available Sum Insured.
h. The process specified in paragraphs (b) to (e) above in relation to Claim Payment or investigation of the Claim shall be completed such that the Turn-around Time shall be no longer than 15 days.
i. If delay by SHA in release of Premium results in delay of Claim Payment by the Insurer beyond laid down TATs, then the same may not be considered towards penalty under Schedule 12 B to the Scheme
j. The counting of days for the purpose of this Clause shall start from the date of receipt of the Claim.
k. The Insurer shall make Claim Payments to each Empanelled Health Care Provider against Claims received through electronic transfer to such Empanelled Health Care Provider's designated bank account.
l. All Claims audits/investigations shall be undertaken by qualified and experienced Medical Practitioners appointed by the Insurer to ascertain the nature of the disease, illness or accident and to verify the eligibility thereof for availing the benefits under this Insurance Contract and relevant Policy. The Insurer's medical staff shall not impart or advise on any Medical Treatment, Surgical Procedure or Follow-up Care or provide any OPD Benefits or provide any guidance related to cure or other care aspects.
m. The Insurer shall submit monthly details of:
    i. all Claims that are under investigation to the district nodal officer of the State Health Agency for its review;
    ii. every Claim that is pending Beyond Turn Around Time to the State Health Agency, along with its reasons for delay in processing such Claim; and
    iii. details of applicable penalty as per KPIs mentioned under Schedule 12 to the Scheme.
n. The Insurer may collect at its own cost, complete Claim papers from the Empanelled Health Care Provider, if required for audit purposes. This shall not have any bearing on the Claim Payments to the Empanelled Health Care Provider.
o. In case the insurer hires Third Party Administrator (TPA), it shall ensure that the TPA does not approve or reject any Claims on its behalf and that the TPA is only engaged in the processing of Claims. The TPA may however recommend to the Insurer on the action to be taken in relation to a Claim. However, the final decision on approval and rejection of Claims shall be made by the Insurer.
p. The Insurer shall, at all times, comply with and ensure that its TPA is in compliance with TPA Regulations, Health Insurance Regulations and any other Law issued or notified by the IRDAI in relation to the provision of Cashless Access Services and Claims processing.
q. The overall responsibility of the execution of the Contract will rest solely and completely with the Insurer, irrespective of whether it engages a TPA or not.
r. With regard to submission of claims, claims processing, handling of claim queries, and all other related details, Insurer shall adhere to prevalent NHA's Claims Adjudication guideline.

2. Penalty on Delay in Settlement of Claims

Performance KPIs				
SN	**KPIs**	**Timeline**	**Baseline KPI Measure**	**Penalty**

1	Pre-authorisation	Action within 6 * hours: of raising preauthorization request (all auto approvals beyond 6 hours will be considered non-compliance)	95% Compliance	· Compliance from compliance below 95% up to 90% then penalty of 5% of the monthly total delayed preauthorization amount · Compliance below 90% up to 85% then penalty of 10% of the monthly total delayed preauthorization amount · Compliance below 85% then penalty of 20% of the monthly total delayed preauthorization amount with one instance of triggering of SPD** (for calculation, monthly delayed preauthorization amount shall be the amount for delayed pre- authorizations for the admissions in that month. Penalty shall be calculated on this amount and Insurer shall pay the penalty as per Penalty Notice per quarter, please see Clause 23.5 of the Scheme) Example: if the IC handled 100 preauthorization in the month and failed to meet TAT for 16 cases, 20% preauthorization amount of only these 16 cases will be charged as penalty. Even if the preauthorization is rejected, not meeting the TAT will invite the penalty
			100% Compliance	In case of wrongful pre-authorization approval, penalty of three times over & above the preauthorization amount
2	Scrutiny, Claim processing and payment of the claims	Action within 15 days of claim submission for claims within state and 30 days & for claims from outside state (Portability cases). (This is applicable if the Insurer fails to make the Claims Payment within a Turn-around Time of 15 days/30 days for a reason other than delay on the part of SHA, if any)	100% Compliance	If the Insurer fails to make the Claim Payment within Turn Around Time (TAT)***, then the Insurer shall be liable to pay a penal interest to the EHCP at the rate of 0.1% for each claim amount for every day of delay or the part thereof on every delayed claim. · If the compliance in the month falls below 85% of number claims, it will be treated as one instance of SPD trigger Example: if the IC processed 100 claims in the month and failed to meet TAT for 16 claims, it will be liable to pay penalty of 0.1% for each claim per day of these 16 claims to EHCPs. It will also be treated as one instance of triggering of SPD
			100% Compliance	In case any claim is adjudicated wrongly then penalty of three times over and above the claim amount
	Delays in compliance to orders of the Grievance Redressal Committee (GRC)	Beyond 30 days of the date of the order of the GRC	100% Compliance	Rs. 25,000 per week or part thereof

· *6 hours: As per threshold set in TMS

· ** Service Provider Default (SPD) is special termination clause in the agreement and triggering of which is a failure to meet baseline KPIs and will be considered as Default by IC. Default herein shall occur if SPD trigger

o Occurs 8 (eight) times during any one year of the agreement

In this event, agreement with IC is liable for termination and IRDAI shall be informed to take stringent actions against IC under relevant rules. However, SPD triggers shall only be applicable from 3rd month of signing of the contract

· Penalty amount for Performance KPIs shall be calculated each month and Insurers shall pay all penalties imposed by the SHA within 7 working days of receipt Penalty Notice from SHA (Clause 23.5).

· At any point during term of contract, if penalty amount is 10% of the total contract value, contract shall be liable to be terminated

· *** in case of claims processing, TAT will be determined as days during which claim is with IC (Excluding the days claim is pending at EHCPs end)

Example: 1

The day EHCP raises claim will be treated as Day 1 If IC raises query on Day 4,

and EHCP complies with query on Day 10,

IC takes action (accepting or rejection of claim) on Day 12 Payment on Day 15

3. 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, if the Empanelled Health Care Provider feels that the Claim is payable. Such decision of the Insurer may be appealed by filing a grievance with the DGNO within 15 days of rejection of claim, in accordance with Clause 26 of this Insurance Contract. SHA may relax these timelines for public hospitals.

b. The Insurer and/or the DGNO or the DGRC, as the case may be, may re-open the Claim, if the Empanelled Health Care Provider submits the proper and relevant Claim documents that substantiates their right to re-open such claims.

4. No Duty of Disclosure

a. Notwithstanding the issue of the Tender Documents and any other information provided by the State Health Agency prior to the date of this Insurance Contract, the Insurer hereby acknowledges that it does not rely on and has not been induced to enter into this Insurance Contract or to provide the Covers or to assess the Premium for providing the Covers on the basis of any statements, warranties, representations, covenants, undertakings, indemnities or other statements whatsoever and acknowledges that none of the State Health Agency or any of its agents, officers, employees or advisors or any of the enrolled Beneficiary Family Units have given or will give any such warranties, representations, covenants, undertakings, indemnities or other statements.

b. Prior to commencement of each Policy Cover Period for any State, the State Health Agency or NHA undertake to prepare or cause a third party to prepare the Beneficiary Database as correctly as possible. The Insurer acknowledges that, notwithstanding such efforts being made by the State Health Agency, the information in the Beneficiary Database may not be accurate or correct and that the Beneficiary Database may contain errors or mistakes.
Accordingly, the Insurer acknowledges that the State Health Agency makes no warranties, representations, covenants, undertakings, indemnities or other statements regarding the accuracy or correctness of the Beneficiary Database that will be provided by it to the Insurer.

c. The Insurer represents, warrants and undertakes that it has completed its own due diligence and is relying on its own judgment in assessing the risks and responsibilities that it will be undertaking by entering into this Insurance Contract and in providing the Covers to the enrolled Beneficiary Family Units and in assessing the adequacy of the Premium for providing the Covers for the Beneficiary Family Units.

d. Based on the acknowledgements of the Insurer in this Clause, the Insurer:
   i. acknowledges and confirms that the State Health Agency has made no and will make no material disclosures to the Insurer;
   ii. acknowledges and confirms that the State Health Agency shall not be liable to the Insurer for any misrepresentation or untrue, misleading, incomplete or inaccurate statements made by the State Health Agency or any of its agents, officers, employees or advisors at any time, whether made wilfully, negligently, fraudulently or in good faith; and
   iii. hereby releases and waives all rights or entitlements that it has or may have to:
   – make any claim for damages and/or declare this Insurance Contract or any Policy issued under this Insurance Contract declared null and void; or as a result of any untrue or incorrect statements, misrepresentation, miss- description or non-disclosure of any material particulars that affect the Insurer's ability to provide the Covers.

5. No Contributions

a. The Insurer agrees that any Beneficiary Family Unit or any of the Beneficiaries or any other third party shall be entitled to obtain additional health insurance or any other insurance cover of any nature whatsoever, including in relation to the benefits provided under this Insurance Contract and a Policy, either individually or on a family floater cover basis.

b. Notwithstanding that such Beneficiary Family Unit or any of the Beneficiaries or any third party acting on their behalf effect additional health insurance or any other insurance cover of any nature whatsoever, the Insurer agrees that:

   i. its liability to make a Claim Payment shall not be waived or discharged in part or in full based on a rateable or any other proportion of the expenses incurred and that are covered by the benefits under the Covers;

   ii. it shall be required to make the full Claim Payment in respect of the benefits provided under this Insurance Contract and the relevant Policy; and

   iii. if the total expenses incurred by the Beneficiary exceeds the available Sum Insured under the Covers, then the Insurer shall make payment to the extent of the available Sum Insured in respect of the benefits provided under this Insurance Contract and the relevant Policy and the other insurers shall pay for any excess expenses not covered.

6. Fraud Control and Management

a. The insurer is expected to have the capability of develop a comprehensive fraud control system for the scheme which shall at the minimum include regular monitoring, data analytics, ecards audit, medical audit, field investigation, hospital audit, corrective action etc. It shall comply with provisions of PMJAY, MA and MAV Anti-Fraud Guidelines and Advisories as issued time to time.

b. For an indicative (not exhaustive) list of fraud triggers that may be automatically and on a real-time basis be tracked as provided in Schedule 13 to the Scheme. The Insurer can add more triggers to the list and track them.

c. For all trigger alerts related to possible fraud at the level of EHCPs, the Insurer shall take the lead in immediate investigation of the case in close coordination and under constant supervision of the SHA.

d. Investigations pursuant to any such alert shall be concluded within 07 (seven) days and all final decision related to outcome of the Investigation and consequent penal action, if the fraud is proven, shall vest solely with the SHA.

e. The SHA shall take all such decision within the provisions of the Insurance Contract, PMJAY, MA and MAV Anti Fraud Guidelines, Recovery Guidelines and Advisories etc. and be founded on the Principles of Natural Justice and as per applicable laws.

f. The SHA shall on an ongoing basis measure the effectiveness of anti-fraud measures in the Scheme through a set of indicators. For a list of such indicative (not exhaustive) anti-fraud measures indicators, are referred to in Schedule 14 to the Scheme.

g. The Insurer shall be responsible for monitoring and controlling the implementation of the AB-PMJAY, MA and MAV in the State in accordance with Clause 23 of the Scheme.

h. In the event of a fraudulent Claim being made or a false statement or declaration being made or used in support of a fraudulent Claim or any fraudulent means or device being used by any Empanelled Health Care Provider or the TPA or other intermediary hired by the Insurer or any of the Beneficiaries to obtain any benefits under this Insurance Contract or any Policy issued by the Insurer (each a Fraudulent Activity), then the Insurer's sole remedies as per the approval of SHA shall be to:

   i. refuse to honour a fraudulent Claim or Claim arising out of Fraudulent Activity or reclaim all benefits paid in respect of a fraudulent Claim or any Fraudulent Activity relating to a Claim from the Empanelled Health Care Provider and/or any entity that has undertaken or participated in a Fraudulent Activity; and/or

   ii. take disciplinary action against the Empanelled Healthcare provider that has made a fraudulent Claim or undertaken or participated in any unethical practices, including but not limited to issuing showcase notice, levying penalties as per provisions or refer for suspension or de-empanelment to the State Empanelment Committee, with the procedure specified in Schedule 5 to the Scheme;

   iii. terminate the services agreement with the intermediary appointed by the Insurer; and/or provided that the Insurer keeps the SHA informed of actions taken by it along with details thereof.

   iv. The State Health Agency shall have the right to conduct a random audit of any or all cases in which the Insurer has exercised such remedies against an Empanelled Health Care Provider and/or any Beneficiary. If the State Health Agency finds that the Insurer has wrongfully de-

empanelled an Empanelled Health Care Provider, then the Insurer shall be required to reinstate such benefits to such Empanelled Health Care Provider.

i. The Insurer hereby releases and waives all rights or entitlements to:
    i. make any claim for damages and/or have this Insurance Contract or any Policy issued under this Insurance Contract declared null and void; or
    as a result of any fraudulent Claim by or any Fraudulent Activity of any Empanelled Health Care Provider.

6. **Portability Guidelines**
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 AB-PMJAY 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.
In this regard the guidelines in Schedule 9 to the Scheme will be followed.

7. **Payment Of Premium**

The SHA shall ensure payment of the premium as per the following ratio.
Centre Govt : State Govt Premium Ratio = 60:40

8. **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 days 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 Clause 28.6 shall not apply from the date of such withdrawal and this Insurance Contract shall terminate forthwith upon the withdrawal of the Migration Request. The reasons for withdrawal of Migration Request shall be placed on record by SHA.
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)
    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).

9. **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 the entire Term of Policy Cover Period for the State. If the contract is terminated earlier by the SHA, date of termination of Policy shall be considered as Term for Policy Cover Period and stated for Insurer’s average claim Ratio. 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 Clause 10.2.b of the Scheme.

b. After adjusting flat 15% percent of premium towards administrative cost (including all costs excluding only service tax and any cess, if applicable) and after settling of all claims, if there remains surplus: 100 percent of leftover surplus should be refunded by the Insurer to the SHA as per timeline mentioned in Schedule 12 D of the Scheme.
c. If the Insurer fails to refund the Premium within 90-day period and/ or the default interest thereon, the SHA shall be entitled to recover such amount along with applicable Penalty as a debt due from the Insurer. Please refer to Clause 41 of the Scheme for details regarding Dispute Resolution.
d. 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 bear 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, MA and MAV for Central and State Governments' share. After the ceiling is reached claims cost will need to be borne entirely by the Insurer.
e. However, Payment of Premium by SHA and Refund of premium by Insurer are two separate activities. Payment of Premium shall be as per Clause 10.1 of the Scheme and Refund of Premium by Insurer shall be as per Clause 10.2 of the Scheme. Under no circumstances, any party shall claim to correlate these two activities.

10. **Grievance Redressal**

A robust and strong grievance redressal mechanism has been designed for AB-PMJAY, MA and MAV. The District authorities under the Scheme shall act as a frontline for the redressal of Beneficiaries' / Providers / other Stakeholder's grievances. The District authorities under the Scheme 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 under the Scheme 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, MA and MAV set of three tier Grievance Redressal Committees have been set up to attend to the grievances of various stakeholders at different levels. Details of Grievance Redressal mechanisms and guidelines are published and revised by NHA from time to time, Insurer shall ensure adherence to these guidelines while conducting grievance redressal.

Complaints and grievance redressal management system for EHCP will be handled by the home state of beneficiaries, if EHCP is not satisfied with the SHA resolution, the complaint or grievance shall be escalated to NHA, and NHA will be the final decision-making authority. NHA would establish a specific pathway for grievance redressal for EHCP which the authority to would have not only immediately redress the grievance but also recommend action to be undertaken within a stipulated time period. A major change will be affected with the introduction of a National Call Center. Complaints from various stakeholders including hospital authorities and beneficiaries will be logged at the call center and the call center shall direct these complaints to the intended authorities. Each complaint/grievance shall be closely monitored by a dedicated team at NHA to check resolution timelines and intervene when unresolved. Guidelines on the same will be communicated by NHA including the channels through which complaints/ grievances can be registered, acknowledged, monitored and resolved at various levels.