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-PMJAY) & Jammu Kashmir Health Scheme 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 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 (AB-PMJAY) & Jammu Kashmir Health Scheme Beneficiary Family Units named in the Policy Schedule and has agreed to pay premium in installments in accordance with Clause 10 of Tender Document for Implementation of "Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana" & Jammu Kashmir Health Scheme In UT of Jammu and Kashmir and Ladakh" released by State Government of Jammu and Kashmir and Ladakh in July 2020 as consideration for such insurance, we the Company hereby agrees to AB-PMJAY/JKHS Beneficiary Family Units named in the Policy Schedule as per these Terms and Conditions.

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 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/UT 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 part of Jammu & Kashmir Health Scheme, all the households figuring in SECC – 2011 data, irrespective of socio-economic conditions of the households, including presently serving and retired employees of Govt of Jammu and Kashmir and other family units not figuring in the SECC Database of the UT of Jammu & Kashmir but have domicile in the UT of J & K notified through the administrative orders issued by Govt of Jammu & Kashmir shall be part of the AB-PMJAY beneficiary database.
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 Company. This includes all the guidelines issued by MoHFW and/or NHA, SHA for the implementation of AB-PMJAY and Jammu & Kashmir Health Scheme.
4. **Annexure** means an annexure to 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 Company.
7. **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

8. **Beneficiary** means a member of the family unit with permanent domicile in the UT of Jammu & Kashmir are eligible to avail benefits under the scheme, irrespective of their socio-economic conditions, including family members of Jammu & Kashmir Govt Employees currently serving or retired from the Govt Service. SECC-2011 data shall be used has base database for beneficiary identification and family units that are currently not figuring in the SECC -2011 Database of the UT of Jammu & Kashmir but have domicile in the UT of J & K shall also be eligible under the scheme. SHA shall notify the newly added households, whose names are currently not figuring in the SECC-2011 data through the administrative orders. For the purpose of premium sharing, the beneficiaries shall be categorised as under viz., centrally sponsored SECC2011 family units; and JKHS beneficiary units.
9. **Beneficiary Family Unit** refers to those families including all its members figuring in the Socio-Economic Caste Census (SECC)-2011 database of UT Government and other family units not figuring in the SECC Database of the UT of Jammu & Kashmir but have domicile in the UT of J & K notified through the administrative orders issued by Govt of Jammu & Kashmir. Referred to as AB-PM JAY Beneficiary Family Unit henceforth in the document.
   For the purpose of implementation of Jammu & Kashmir Health Scheme, all the families enumerated in the SECC- 2011 data, irrespective of their socio economic conditions, who are having domicile in the UT of Jammu & Kashmir, including currently serving and retired Govt employees of UT of Jammu & Kashmir shall be considered as eligible beneficiary family unit and the other family units not figuring in SECC – 2011 data but have domicile in the UT of J & K notified through the administrative orders issued by Govt of Jammu & Kashmir in this regard shall be considered as eligible families. For the purpose of scheme administration, all the eligible families under the Jammu & Kashmir Health Scheme shall also be referred to as eligible AB-PMJAY beneficiaries/ beneficiary families. New family members shall be added as per the provisions of schedule-4 Insurance Policy Schedules.
   In case of UT of Ladakh, Beneficiary Family Unit refers to those families including all its members figuring in the Socio-Economic Caste Census (SECC)-2011 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 enrolled RSBY Beneficiary Families not figuring in the SECC Database of the State / UTs Referred to as AB-PM JAY Beneficiary Family Unit henceforth in the document.
10. **Benefit Package or Health Benefit Package** refers to the bundled package of services required to treat a condition/ailment/disease that the insured families would receive under the AB-PMJAY.
11. **Cashless Access Service** means a facility extended by the Company to the Beneficiaries where the payments of the expenses that are covered under the Risk Cover are directly made by the Company 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.
12. **CHC** means a community health centre located at the block level in the State/UT.
13. **Claim** means a claim that is received by the Company from an Empanelled Health Care Provider, either online or through alternate mechanism in absence of internet connectivity.
14. **Claim Payment** means the payment of eligible Claim received by an Empanelled Health Care Provider from the Company in respect of benefits under the Risk Cover made available to a Beneficiary.
15. **Condition precedent** means a Policy term or a condition upon which the Company's liability under the Policy is conditional upon
16. **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
17. **Days** mean and shall be interpreted as calendar days unless otherwise specified.
18. **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.

19. **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.
20. **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.
21. **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,
22. **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 As per Annex.1: **Detailed Empanelment Criteria** mentioned in this Policy and that is empanelled by the Company in accordance with terms of this Contract for the provision of health services to the Beneficiaries under AB-PMJAY/JKHS.
23. **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.
24. **Health Service provider** means the empanelled Third Party Administrator [TPA] of the Company.
25. **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.
26. **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.
27. **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.
28. **ICU or Intensive Care Unit** means an identified section, ward
29. **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.
30. **Illness means** a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Cover 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.
31. **Inpatient care** means treatment for which the Beneficiary has to stay in a hospital for more than 24 hours for a covered event.
32. **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 Cover Period.
33. **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.

34. **Medical Advise** means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.
35. **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.
36. **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.
37. **MoHFW** shall mean the Ministry of Health and Family Welfare, Government of India.
38. **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.
39. **Non-Network Provider means a**ny hospital, day care centre or other provider that is not part of the network of Company.
40. **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.
41. **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.
42. **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.
43. 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.
44. **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 Company, unless cancelled earlier in accordance with this Insurance Contract.
45. **Policy Schedule/ Schedule/Group Policy Schedule** means the Group Policy Schedule and any annexure to it read with endorsements, if any, and read with respective Certificate of Insurance in favour of the Beneficiary Family Units/family which are forming part of the Group Policy to be issued to **State Health Agency (SHA) as per** Tender Document for Implementation of "Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana" & Jammu Kashmir Health Scheme In UT of Jammu and Kashmir and Ladakh" released by State Government of Jammu and Kashmir and Ladakh in July 2020.

46. **Premium** means the aggregate sum agreed by the Parties as the annual premium to be paid by the State Health Agency to the Company 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.
47. **Pre-Existing Disease** shall mean any condition, ailment, 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 its reinstatement or
    b) 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 issued by the insurer or its reinstatement.
48. **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.
49. **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.

50. **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
51. **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.
52. **Risk Cover** shall mean an annual risk cover of Rs. 5,00,000/- (Rupees five lakhs only) on family floater basis, 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 Insurance Contract, through a network of Empanelled Health Care Providers (EHCP) for the AB-PM-JAY Beneficiary Family Units, including the beneficiary families covered under Jammu & Kashmir Health Scheme, validated by the UT Government or the State Health Agency (SHA), Jammu & Kashmir. All the beneficiary families, whether covered under Centrally Sponsored Scheme of AB PM JAY or covered under Jammu & Kashmir Health Scheme shall have same benefits and maximum cover per beneficiary family shall not exceed Rs. 5,00,000 per annum.
53. **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.
54. **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.
55. **schedule means schedules to** Tender Document for Implementation of "Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana" & Jammu Kashmir Health Scheme In UT of Jammu and Kashmir and Ladakh" released by State Government of Jammu and Kashmir and Ladakh in July 2020.
56. **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.
57. **Sum Insured** shall mean the sum of Rs 5,00,000 per AB-PMJAY/JKHS Beneficiary Family Unit per annum against which the AB-PMJAY/JKHS Beneficiary Family Unit may seek benefits as per the benefit package under the AB-PMJAY. Same benefit will be extended to Beneficiary families under the Jammu & Kashmir Health Scheme. Maximum benefit per family is Rs. 5,00,000 per annum, irrespective of the category under which the Beneficiary Family Unit is covered i.e centrally sponsored scheme or Jammu & Kashmir Health Scheme.
58. **State/UT** refers to the duly elected Government in the UT of J & K and UT of Ladakh for which the tender is issued.
59. **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.
60. **Tender Document means** Tender Document for Implementation of "Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana" & Jammu Kashmir Health Scheme In UT of Jammu and Kashmir and Ladakh" released by State Government of Jammu and Kashmir and Ladakh in July 2020.
61. **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.
62. **Turn-around Time** means the time taken by the Company in completing the task. 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
63. **Unproven/ experimental treatment** means treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.
64. **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

The Parties agree that for the purpose of this Insurance Contract and any Policy issued pursuant to this Insurance Contract, all the persons that are eligible for the scheme as per SECC 2011 data and RSBY enrolled families (if applicable) in the Service Area shall be eligible to become Beneficiaries and all the households figuring in SECC- 2011 data and the other family units not figuring in SECC – 2011 data but have domicile in the UT of J & K notified through the administrative orders issued by Govt of Jammu & Kashmir in this regard and as updated from time to time shall be covered under the scheme. For administrative reasons, particularly to meet the cost of premium, the beneficiaries may be categorised into two viz., (i) centrally sponsored SECC 2011 family units; and (ii) JKHS beneficiaries. In all other cases, the Beneficiary Family Units shall be referred to as AB- PM JAY beneficiary families.

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 State/ UT (as updated from time to time) along with Beneficiary Families not figuring in the SECC 2011 Database which are resident in the Service Area (State for which this Tender Document is issued) and fall under one or more of the categories and the households covered under the Jammu & Kashmir Health Scheme, further detailed in schedule 1 of this Document shall be considered as eligible for benefits under the Scheme and be automatically covered under the Scheme.

The Company agrees that: (i) no entry or exit age restrictions will apply to the members of a Beneficiary Family Unit; and (ii) no member of a Beneficiary Family Unit will be required to undergo a pre-insurance health check-up or medical examination before their eligibility as a Beneficiary and all pre-existing illnesses of the beneficiaries will be covered.

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 as per the provisions approved by the Government.

The presence of name in the beneficiary list, data available in the Ration Cards issued by Food, Civil Supplies and Consumer Affairs Department, Govt of J & K or any other database/ any other identity notified by SHA (amended from time to time, due to addition of family member, as per Guidelines – schedule 4) 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.

C. COVERAGE AND BENEFITS

The Benefits within the scheme, to be provided on a cashless and paperless basis to the beneficiaries up to the limit of their annual coverage, package charges on specific procedures and subject to other terms and conditions outlined herein, are the following:

Benefits under AB-PMJAY Risk Cover

The benefits within this Scheme under the Risk Cover are to be provided on a cashless basis to the AB-PMJAY/JKHS 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

b. The details of benefit packages are furnished in schedule 3: 'Packages and Rates' and exclusions are furnished in schedule 2: 'Exclusions to the Policy'.
c. For availing select treatment in any empanelled hospitals, preauthorisation is required to be taken for defined cases.
d. Except for exclusions listed in schedule 2, treatment/procedures will also be allowed, in addition to the procedures listed in schedule 3, of up to a limit of Rs. 1,00,000 to any AB-PMJAY/JKHS 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 (b).
e. The Company shall reimburse claims of Empanelled Health Care Provider under the ABPMJAY based on Package Rates

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 Lakhs 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/JKHS Beneficiary Family Unit. All the Beneficiary Family Units under the scheme shall have the same benefits and risk cover. However, category wise tagging will be done for the purpose of reporting to NHA.
b. The Company shall ensure that the Scheme's Risk Cover shall be provided to each AB-PMJAY/JKHS Beneficiary Family Unit on a family floater basis covering all the members of the AB-PMJAY Beneficiary Family Unit and JKHS 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. Pre- existing conditions/ diseases are to be covered from the first day of the start of the **Policy Cover Period**, subject to exclusions provided in schedule 2 of the Tender Document.
d. Coverage of health services related to surgical nature for defined procedures shall also be provided on a day care basis. The Company shall provide coverage for the defined day care treatments, procedures and medical treatments as given in schedule 3 of the Tender Document.
e. 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).

PACKAGE RATES

a. The Company shall reimburse claims of Empanelled 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 schedule 3 of the Tender Document, 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 schedule 3 of the Tender Document, then the Company may pre-

authorise an appropriate amount based on rates for similar procedures defined in schedule 3 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 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

iii) AB PM-JAY is a cashless scheme, where no beneficiary should be made to pay for availing treatment in any AB-PMJAY empanelled hospitals. However, upon exhaustion of the beneficiary AB PM-JAY wallet of Rs.5,00,000/-, 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 will not be of the Company. Beneficiary and SHA (through ISA/TPA) will need to be clearly communicated in advance about the additional payment at the start of such treatment.

iv) In case an AB-PMJAY 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.

v) 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 and configured in NTMS). In exceptional circumstances, hospital may raise a request for such preauthorization which will be decided by SHA with the help of concerned medical specialist

vi) Certain packages as mentioned in schedule 3 of the Tender Document 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.

b. For the purpose of Hospitalisation expenses as package rates shall include all the costs associated with the treatment, amongst other things:
   a) Registration Charges,
   b) Bed charges,
   c) Nursing & Boarding Charges,
   d) Surgeons, Anesthetists, Medical Practitioner, Consultants Fees, etc
   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:
   i) 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.
   j) Food to the Patient,
   k) Pre and Post Hospitalisation expenses: Expenses incurred for consultation, diagnostic tests and medicines prior to the admission of the patient in the same hospital and cost of diagnostic tests and medicines 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. For the purpose of Day Care Treatment expenses shall include, amongst other things:
   i. Registration charges;
   ii. Surgeons, anaesthetists, Medical Practitioners, consultants' fees, etc.;
   iii. Anaesthesia, blood transfusion, oxygen, operation theatre charges, cost of surgical appliances, etc.;
   iv. Medicines and drugs;
   v. Cost of prosthetic devices, implants, organs, etc.
   vi. 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.

vii. 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.

viii. Any other expenses related to the Day Care Treatment provided to the Beneficiary by an Empanelled Health Care Provider.

d. 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.

i. 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 Company 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 3 (a) with effect from the date on which SHA informs the Company in writing.

ii. 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 Company 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 Company

iii. If there is further increase in cost of any existing package, then claims of increased cost of package shall be paid by the Company and this additional cost will be paid by SHA as per the actual additional expenditure by the Company

iv. 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 Company shall be made in case of changes in reservation policy.

e. The SHA and Company 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 Company 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).

i. 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.

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 total of Risk Cover for an AB-PMJAY Beneficiary Family Unit.

CASHLESS ACCESS OF SERVICES

1. The AB-PMJAY/JKHS 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 Company shall reimburse EHCP 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 Company shall ensure that each EHCP shall at a minimum possess the Hospital IT Infrastructure required to access the AB-PMJAY/JKHS Beneficiary Database and undertake verification based on the Beneficiary Identification process laid out, using unique AB-PMJAY/JKHS Family ID on the AB-PMJAY Card and also ascertain the balance available under the AB-PMJAY Cover provided by the Company.
4. The Company 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.
5. The Company shall train Ayushman Mitras that will be deputed in each EHCP who are responsible for the administration of the AB-PMJAY/JKHS 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/JKHS 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:

a. That the patient is admitted for a covered procedure and package for such an intervention is available.
b. AB-PMJAY/JKHS 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/JKHS Beneficiary Family Unit to complete the transaction.

PRE-AUTHORISATION OF PROCEDURES

1. All procedures in schedule 3 of the Tender Document, 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 of the Tender Document.
2. The Company shall 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
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 Company would get in touch with the treating doctor, if necessary.
4. The RAL should reach the authorisation department of the Company 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 Company 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 of the Tender Document. If there is no response from the Company within prescribed TAT of an EHCP filing the pre-authorisation request, the request of the EHCP shall be deemed to be automatically authorised and shall affect performance KPI mentioned in schedule 12.B.2.
7. The Company shall not be liable to honour any claims from the EHCP for procedures featuring in schedule 3 of the Tender Document, for which the EHCP does not have a pre-authorisation, if prescribed.
8. Reimbursement of all claims for procedures listed under schedule 3 of the Tender Document, 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 Company guarantees payment only after receipt of RAL and the necessary medical details. And only after the Company 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 Company can deny the authorisation or seek further clarification/ information.
12. The Company 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 Company.
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/JKHS beneficiary. The Company upon receipt of the bills and documents would release the authorized amount.

18. The Company 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/JKHS 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 Company from the Policy Cover Period which was operating during the period in which the AB-PMJAY/JKHS 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 and can be treated under Out Patient Care.
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, prosthetic 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 / tumour / cyst requiring hospitalisation 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.

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. If two or more policies are taken by Beneficiary/ies during a period from one or more insurers to indemnify treatment costs, the Beneficiary/ies 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 Beneficiary/ies 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. Claims under other Policy/ies may be made after exhaustion of Sum Insured in the earlier chosen Policy / Policies
   c. If the amount to be claimed exceeds the sum insured under a single Policy after considering the deductibles or co-pay, the Beneficiary/ies shall have the right to choose insurers from whom he/she wants to claim the balance amount.
   d. Where an Beneficiary/ies has policies from more than one insurer to cover the same risk on indemnity basis, the Beneficiary/ies shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen 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. AB-PMJAY portability guidelines shall be applicable for JKHS beneficiaries as well and all the JKHS beneficiaries shall avail the benefit of portability.

b. Package rates of the hospital where benefits are being provided will be applicable while payment will be done by the Company that is covering the beneficiary under its Policy.
c. The Company 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/UT Governments participating in the Scheme are deemed to be in arrangement with ALL other States/UTs 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. Portability option shall be applicable to JKHS beneficiaries as well.
e. Detailed guidelines of portability are provided at schedule 9 of the Tender Document.

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 Company 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 Company 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 Company 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 Company 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 Company shall comply with the following procedure regarding the processing of claims received from the Empanelled Health Care Providers:
   A. The Company shall require the Empanelled Health Care Providers to submit their Claims electronically as early as possible but not later than 7 days after discharge in the defined format to be prescribed by the NHA/SHA/Company. If EHCP fails to submit the claims within 7 days, the EHCP shall take written permission from SHA 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 Company shall decide on the acceptance or rejection of any Claim received from an Empanelled Health Care Provider. Any rejection notice issued by the Company 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 Company rejects a Claim, the Company 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 Company 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 Company shall while rejecting the Claim inform the Beneficiary of an alternate Empanelled Health Care Provider where the benefit can be availed in future. The Company shall be responsible for settling all claims as per timelines provided in schedule 12 B.

E. The Company 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 Company shall make the full Claim Payment without deduction of tax, if the Empanelled Health Care Provider submits a tax exemption certificate to the Company within 7 days after signing the agreement with the Company making a Claim. If the Empanelled Health Care Provider fails to submit a tax exemption certificate to the Company, then the Company 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 Company 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 Company 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 Company beyond laid down TATs, then the same may not be considered towards penalty under schedule 12 B

J. The counting of days for the purpose of this Clause shall start from the date of receipt of the Claim.

K. The Company 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 Company 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 Company'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 Company 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 of the Tender Document.

N. The Company 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 Company 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 Company 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 Company.

P. The Company 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 Company, 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, Company shall adhere to prevalent NHA's Claims Adjudication guideline.

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 Company'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 Company. 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 Company 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. Amicable Resolution:
   a) In the event of any Dispute between the Parties, either Party may require such Dispute to be referred to [CEO of SHA] and the [Chairman of the Board of Directors]/[governing body] of the Company for amicable settlement. Upon such reference, the said persons shall meet no later than 7 (seven) days from the date of reference to discuss and attempt to amicably resolve the Dispute.
   b) If the Dispute is not amicably settled within 15 (fifteen) days of the meeting for amicable resolution between the parties; either Party may refer the Dispute to arbitration

5. Any Dispute which is not resolved amicably by amicable resolution procedure shall be finally decided by reference to arbitration by a Board of Arbitrators. The provisions of the Arbitration and Conciliation Act, 1996 and Rules thereunder will be applicable and the award made there under shall be final and binding upon the parties hereto, subject to legal remedies available under the law. Such differences shall be deemed to be a submission to arbitration under the Indian Arbitration and Conciliation Act, 1996, or of any modifications, Rules or re-enactments thereof. The seat and venue of such Arbitration proceedings will be held at Jammu/Srinagar , India. Any legal dispute will come under the sole and exclusive jurisdiction of Jammu & Kashmir, India.. The language of arbitration proceedings shall be English.
   The Board of arbitrators shall consist of 3 arbitrators, with each Party appointing one arbitrator and the third arbitrator being appointed by the two arbitrators so appointed. If the parties cannot agree on the appointment of the Arbitrator within a period of one month from the notification by one party to the other of existence of such dispute, then the Arbitrator shall be appointed by the High Court of Jammu & Kashmir, India
   The Arbitrator shall make a reasoned award (the "Award"). Such award shall be implemented by the parties concerned within such time as directed by the Arbitrator in such Award.
   The Company and the SHA agree that an Award may be enforced against the Company and/or the SHA, as the case may be, and their respective assets wherever situated as stated in Arbitration Award. Both the Parties to bear their own cost pertaining to the Arbitration Proceedings.

6. 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 Company, if the Empanelled Health Care Provider feels that the Claim is payable. Such decision of the Company may be appealed by filing a grievance with the DGNO within 15 days of rejection of claim, in accordance with Grievance Redressal clause of this Insurance Contract. SHA may relax these timelines for public hospitals.
   B. The Company and/or the DGNO or the DGRC, as the case maybe, 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.

7. 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 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.

7. **Payment Of Premium**

The payment of the premium to the Company by the SHA wil be done as per the following schedule annually:

Sr. No.	**Central Central & State Premium Split Ratio**	**Instalment 1 (On or before the commencement of Policy Cover Period)**	**Instalment 2 (After completion of 2nd Quarter of the Policy Cover Period dated)**	**Instalment 3 (After completion of 10 Instalment 3 (After completion of 10 months of the Policy Cover Period) months of the Policy Cover Period)**
i.	AB-PM JAYcentrally sponsored SECC 2011 family units: Union Territory of Jammu and Kashmir: Centre: 90 State: 10	45% of premium / cost of implementation	45% of premium / cost of implementation	10% of the Premium / Cost of implementation
ii.	JKHS State : 100	45% of premium / cost of implementation	45% of premium / cost of implementation	10% of the Premium / Cost of implementation

8. **Penalties**

S. No.	Availability KPI	Timeline	Penalty
1	Premium Payment by SHA	Premium payment as per schedule	Interest @ 1% on due premium amount for every 30 days' delay or part thereof shall be paid by the SHA to the Insurer
2	Premium refund by IC	30 days from the date of notice	1.5% penal interest for every month of delay or part thereof if not received within 30 days
3	Payment of Penalties by IC	• 15 days from date or receiving the quarterly payment notice in case non contested payment • 30 days in case IC contests the levied penalty	Interest @ 1.5% on due penalty amount for every 30 days delay or part thereof shall be paid as penal interest by the Insurer to SHA

9. Renewal of the Insurance Contract
   a. The 3-year Term of this Insurance Contract is subject to review for renewal after every 12 months from start date of the Policy with reference to the performance criteria laid out in schedule 12 of the Tender Document.
   b. All decisions related to renewal shall vest with the SHA.

c. The SHA shall take the decision regarding the Insurance Contract renewal
d. The Company 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 Company 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 Company stating the Company's average Claim Ratio for the entire Term of Policy Cover Period for the UT. 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 Company's average claim Ratio. In the letter, the SHA shall indicate the amount of premium that the Company 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 Tender Document.

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 Company to the SHA as per timeline mentioned in schedule 12 D of the Tender Document.

c. If the Company 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 Company. Please refer to Clause 41 for details regarding Dispute Resolution.

d. If the Company'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/JKHS for Central and State Governments' share. After the ceiling is reached claims cost will need to be borne entirely by the Company.

e. However, Payment of Premium by SHA and Refund of premium by Company are two separate activities. Payment of Premium shall be as per Clause 10.1 and Refund of Premium by Company shall be as per Clause 10.2. Under no circumstances, any party shall claim to corelate these two activities.

11. Termination of the Insurance Contract and Consequences

Grounds for Termination
The State Health Agency shall have the right to terminate this Insurance Contract upon the occurrence of any of the following events (each an Company Event of Default), provided that such event is not attributable to a Force Majeure Event:

a) the Company fails to duly obtain a renewal of its registration with the IRDAI or the IRDAI revokes or suspends the Company's registration for the Company's failure to comply with applicable Insurance Laws or the Company'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
b) If at any time any payment, assessment, charge, lien, refund of premium, penalty or damage herein specified to be paid by the Company to the SHA, or any part thereof, shall be in arrears and unpaid within 60 days of receipt of a written notice from the SHA requesting payment thereof; or
c) the Company is otherwise in material breach of this Insurance Contract that remains unrectified despite receipt of a 60-day cure notice from the SHA; or
d) any representation, warranty or undertaking given by the Company proves to be incorrect in a material respect or is breached; or
e) The Company has successively infringed the terms and conditions of the Insurance Contract and/or has failed to rectify the same even after the expiry of the notice period for rectification of such infringement then it would amount to material breach of the terms of the Insurance Contract by the Company; or
f) The Company has failed to perform or discharge any of its obligations in accordance with the provisions of the Insurance Contract with SHA unless such event has occurred because of a Force Majeure Event, or due to reasons solely attributable to the SHA without any contributory factor of the Company; or

g) The Company engaging or knowingly has allowed any of its employees, agents, tenants, contractor or representative to engage in any activity prohibited by law or which constitutes a breach of or an offence under any law, in the course of any activity undertaken pursuant to the Insurance Contract; or
h) The Company has been adjudged as bankrupt or become insolvent; or
i) Any petition for winding up of the Company has been admitted and liquidator or provisional liquidator has been appointed or the Company has been ordered to be wound up by Court of competent jurisdiction, except for the purpose of amalgamation or reconstruction with the prior consent of the SHA, provided that, as part of such or reconstruction and the amalgamated or reconstructed entity has unconditionally assumed all surviving obligations of the Company under the Insurance Contract; or
j) The Company has abandoned the Project Office(s) of the AB-PMJAY and is noncontactable for two weeks over phone and email; or
k) Performance against KPI is below the threshold specified in schedule 12 of the Tender Document, including pertaining to SPD trigger; or
l) Intentional or unintentional act of undisputedly proven fraud committed by the Company.

Upon the occurrence of an Company Event of Default, the State Health Agency may, without prejudice to any other right it may have under this Insurance Contract, in law or at equity, issue a notice of its intention to terminate this Insurance Contract to the Company (Preliminary Termination Notice).

If the Company fails to remedy or rectify the Company Event of Default stated in the Preliminary Termination Notice within 30 days of receipt of the Preliminary Termination Notice, the State Health Agency will be entitled to terminate this Insurance Contract by issuing a final termination notice (Final Termination Notice).

SHA will provide prorata premium for the period for which Company has provided the Policy within 30 days of effective date of termination and fulfilment of obligations of Company. In case excess premium with respect to prorata Policy has been already received by the Company then Company will need to refund the excess premium excluding the premium due for the prorata period within 30 days of end of Policy.

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 Company 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. 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 Company 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 Company 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**

A robust and strong grievance redressal mechanism has been designed for AB-PMJAY. 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 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. Details of Grievance Redressal mechanisms and guidelines are published and revised by NHA from time to time, Company shall ensure adherence to these guidelines while conducting grievance redressal.

14. **Compliance with the Orders of the Grievance Redressal Committees**
    - i The Company 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 Company fails to comply with the order of any Grievance Redressal Committee within such 30-day period, the Company shall be liable to pay a penalty of Rs. 25,000 per week or part thereof

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