

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- BAJHGSP24060V012324

Whereas, the **State Health Agency (SHA), Gujarat**, hereinafter referred to as the **Insured** has by a proposal and declaration 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 Vatsalaya (MAV) Yojana covering Beneficiary Family Units named in the Policy Schedule and has agreed to pay premium in installments in accordance with Work Order 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 issued by State Health Agency, State Government of Gujarat on 15th May, 2023 as consideration for such insurance, we the Company hereby agrees to indemnify the Beneficiary Family Unit" under "AB-PMJAY, MA and MAV Yojana 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 this Policy documents or not, shall to be read as per Tender Document for Implementation of AB PMJAY-MA Yojana (Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PMJAY), Mukhyamantri Amrutam and Mukhyamantri Amrutam Vatsalaya Yojana In the State of Gujarat released by State Health Agency, State Government of Gujarat dated 15th May, 2023 .

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. **Beneficiary Family Unit or AB-PMJAY, MA and MAV** Beneficiary Database 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 Government along with the existing MA and MAV enrolled Beneficiary Families not figuring in the SECC Database of the State Referred to as AB PMJAY-MA Beneficiary Family Unit in the Tender Document.
3. **AB PMJAY-MA Yojana Guidelines** mean the guidelines issued by MoHFW and/or NHA/ or SHA from time to time for the implementation of the AB-PMJAY, MA and MAV Yojana to the extent modified by the Tender Documents pursuant to which the Insurance Contract needs to entered into; provided that MoHFW and/or NHA or the State Health Agency may, from time to time, amend or modify the AB-PMJAY, MA and MAV Guidelines or issue new AB-PMJAY, MA and MAV Guidelines, which shall then be applicable to the Insurer. This includes all the guidelines issued by MoHFW and/or NHA/ or SHA for the implementation of AB PMJAY-MA.
4. **Annexure/Schedule** means an annexure/schedule to 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 shall mean** all laws, brought into force and effect by Government of India or the Government of Gujarat, including rules, regulations and notifications made thereunder, and judgments, decrees, injunctions, writs and orders of any court of record, applicable to this Policy and RFP.

8. **Beneficiary** means a member of the AB-PMJAY, MA and MAV Beneficiary Family Units who is eligible to avail benefits under the Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana, Mukhyamantri Amrutam and Mukhyamantri Amrutam Vatsalya Yojana.
9. **Benefit Risk Cover** or **Benefit Cover** refers to the annual basic cashless hospitalisation coverage of Rs. 1,00,000/- on family floater basis, that the Beneficiary Family Unit/insured families would receive under the Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana, Mukhyamantri Amrutam and Mukhyamantri Amrutam Vatsalya Yojana.
10. **Benefit Package or Health Benefit Package** refers to the bundled package of services required to treat a condition/ailment/ disease that Beneficiary Family Unit/insured families would receive under AB PMJAY-MA and detailed in Schedule 3 (a) of Insurance Contract.
11. **Cashless Access Service** means a facility extended by the Insurer to the Beneficiaries where the payments of the expenses that are covered under the Benefit Risk Cover are directly made by the Insurer to the Empanelled Health Care Providers in accordance with the terms and conditions of this Policy and 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.
13. **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.
14. **Clause** means a clause of Insurance Contract.
15. **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.
16. **Condition precedent** means a Policy term or a condition upon which the Company's liability under the Policy is conditional upon.
17. **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
18. **Days** mean and shall be interpreted as calendar days unless otherwise specified.
19. **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.
20. **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.
21. **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.
22. **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,
23. **Empanelled Health Care Provider** means a Hospital, a nursing home, a district hospital, a CHC, or any other health care provider, whether public or private, satisfying the minimum criteria for empanelment and that is empanelled by the Insurer in accordance with terms of Insurance Contract for the provision of health services to the Beneficiaries under AB PMJAY-MA Yojana.
24. **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
25. **Health Service provider** means the empanelled Third Party Administrator [TPA] of the Company.

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27. **Health Insurance:** The term health insurance is a type of insurance that covers medical expenses.
28. **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"
29. **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.
30. **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.
31. **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.
32. **Inpatient care** means treatment for which the Beneficiary has to stay in a hospital for more than 24 hours for a covered event.
33. **Insurance Contract** shall mean the draft contract agreement as specified in Tender Document (read with any modification made thereto vide work order or any document) which needs to be executed between Insurer and State Health Agency, Gujarat. 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 AB PMJAY-MA Yojana
34. **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
35. **Material Breach** means breach of any term and condition as enlisted in this Policy Wordings /Insurance Contract caused due to any act and/or omission by the Insurer's willful misconduct and/or negligence.
36. **MA Yojana** shall refer to Mukhyamantri Amrutam Yojana managed and administered by the Health and Family Welfare Department, Government of Gujarat for the Below Poverty Line (BPL) families 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.
37. **MA Vatsalya Yojana** shall refer to Mukhyamantri Amrutam Vatsalya Yojana managed and administered by the Health and Family Welfare Department, Government of Gujarat based on certain annual income limit of the families or a family belonging to a particular category 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.
38. **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.
39. **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.
40. **Medical Advise** means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.
41. **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.

42. **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 Insurance Contract.
43. **Medically Necessary Treatment:** Medically necessary treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
- is required for the medical management of the illness or injury suffered by the insured;
 - must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
 - must have been prescribed by a medical practitioner;
 - must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
44. **MoHFW** shall mean the Ministry of Health and Family Welfare, Government of India.
45. **Network Provider** means Empanelled Health Care Provider empaneled by the Insurer in accordance with terms of this Policy/ **Insurance Contract** for the provision of health services to the Beneficiaries under AB PMJAY-MA Yojana..
46. **Non-Network Provider** means any hospital, day care centre or other provider that is not a Network Provider or part of the network of Company.
47. **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.
48. **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.
49. **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.
50. **Package Rate** means the fixed maximum charges for a Medically Necessary 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 Insurance Contract.
51. **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 Insurance Contract entered between SHA and Insurer, unless cancelled earlier in accordance with Insurance Contract.
52. **Pre-Existing Disease**
means any condition, ailment or injury or disease
- That is/are diagnosed by a Medical Practitioner/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.
53. **Pre-hospitalization Medical Expenses means expenses** incurred immediately before the Beneficiary is Hospitalised, provided that:
- Such Medical Expenses are incurred for the same condition for which the Beneficiary's Hospitalisation was required, and
 - The In-patient Hospitalization claim for such Hospitalization is admissible by the Company.
54. **Post-hospitalization Medical Expenses means** Expenses incurred immediately after the Beneficiary is discharged from hospital , provided that:
- Such Medical Expenses are incurred for the same condition for which the Beneficiary's Hospitalisation was required, and
 - The In-patient Hospitalization claim for such Hospitalization is admissible by the Company.
55. **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
56. **REQUEST FOR PROPOSAL or RFP or Tender Document:** Request for Proposal dt. 15th May 2023 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

57. **Risk Cover** shall mean an annual risk cover of Rs. 1,00,000/- (Rupees one lakh only) on family floater basis, covering in-patient care and daycare surgeries for treatment of diseases and medical conditions pertaining to secondary and / or tertiary treatment as defined in Schedule 3 (a), of Tender document through a network of Empanelled Health Care Providers (EHCP) for the AB PMJAY-MA Beneficiary Family Units validated by the State Government or the designated State Health Agency (SHA) (Clause 1.1.b of tender document)
58. **Service Area** refers to all the districts in the State of Gujarat covered and included under this Tender Document for the implementation of AB-PMJAY, MA and MAV.
59. **State Government** refers to the duly elected Government in the State/ Union Territory in which the tender is issued.
60. **State Health Agency (SHA)** refers to the agency/ body set up by the 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.
61. **Policy Schedule** means a schedule of this Policy..
62. **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.
63. **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.
64. **Sum Insured** shall mean the sum of Rs 1,00,000 per AB PMJAY-MA Beneficiary Family Unit per annum against which the AB PMJAY-MA Beneficiary Family Unit may seek benefits as per the Benefit Package under the AB PMJAY-MA Yojana.
65. **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.
66. **Turn-around Time** means the time taken by the Insurer 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 Policy/Insurance Contract.
67. **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-PM JAY	Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana
AL	Authorization Letter (from the Insurer)
BFU	Beneficiary Family Unit
CGRMS	Central Grievance Redressal Management System
CGIP	Composite Gross Insurance Premium for AB-PM JAY
CRC	Claims Review Committee
DAL	Denial of Authorization Letter
DGRC	District Grievance Redressal Committee
DGNO	District Grievance Nodal Officer
EHCP	Empanelled Health Care Provider
INR	Indian National Rupees
LCGIP	Lowest Composite Gross Insurance Premium
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	Notification of Award

PMAM	Pradhan Mantri Arogya Mitra
AB PMJAY-MA	Ayushman Bharat Pradhan Mantri Jan Arogya Yojana, Mukhyamantri Amrutam and Mukhyamantri Amrutam Vatsalya Yojana
RAL	Request for Authorization Letter (from the EHCP)
RC	Risk Cover
RSBY	Rashtriya Swasthya Bima Yojana
SECC	Socio Economic Caste Census
SGRC	State Grievance Redressal Committee
SGNO	State Grievance Nodal Officer
SHA	State Health Agency
UCN	Unique Complaint Number
UT	Union Territories

SECTION B: COVERAGE AND BENEFITS

The Company will 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 hereinbelow:

AB PMJAY Beneficiaries and Beneficiary Family Unit-

- 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.
- 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 Insurance Contract under 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 Policy issued pursuant to Insurance Contract.

Benefits under AB-PMJAY, MA and MAV - Risk Cover

- 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 Insurance Contract .
- As on the date of commencement of the Policy Cover Period, the AB PMJAY-MA Yojana Sum Insured in respect of the **Risk Cover for each AB PMJAY-MA Beneficiary Family Unit shall be Rs. 1,00,000 (Rupees One 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-MA Beneficiary Family Unit.
- 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 Insurance Contract which are reproduced in Section C hereinafter.
- 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 Insurance Contract.
- 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:
 - Hospitalization expense benefits
 - Day care treatment benefits (as applicable)
 - Follow-up care benefits
 - Pre- and post-hospitalization expense benefits
 - New-born child/ children benefits (**Health Cover Only**)
 - Transportation cost of Rs.300 during each hospitalization
- Pre and Post Hospitalisation expenses:** Expenses incurred for consultation, diagnostic tests and medicines before the admission of the Beneficiary/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 HBP's Schedule 3 (a) & 3 (a.a) of the Insurance Contract.

7. For availing selected treatment in any Empanelled Health Care Provider, pre-authorisation is required to be taken for defined cases.
8. Except for exclusions listed in Section C of this Policy read with Schedule 2 to the Insurance Contract, treatment/procedures will also be allowed, in addition to the procedures listed in Schedule 3 to the Insurance Contract, 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. 10,00,000 (wherein liability of Insurer shall be limited up to Rs. 1,00,000 only). Operations pertaining to Unspecified Procedure are to be governed as per Unspecified Packages Guidelines provided under Schedule 3 (b) of Insurance Contract
9. for exclusions listed in Section C read with schedule 2 to the Scheme, 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-MA Beneficiary (called 'Unspecified Procedure') within the overall limit of Rs. 10,00,000 (Insurance liability up to Rs. 1,00,000 only). Operations pertaining to Unspecified Procedure are to be governed as per Unspecified Packages Guidelines provided under Schedule 3 (b).
10. The Insurer shall reimburse claims of Empanelled Health Care Provider under the AB-PMJAY, MA and MAV based on Package Rates determined as follows:
 - a. If the package rate for a Medically Necessary Treatment or surgical procedure requiring Hospitalization or Day Care Treatment (as applicable) is fixed in Schedule 3 to the Insurance Contract, 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 Insurance Contract, then the Insurer may preauthorize an appropriate amount based on rates for similar procedures defined in Schedule 3 to the Insurance Contract 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 Insurance Contract 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. AB PMJAY-MA is a cashless scheme, where no Beneficiary should be made to pay for availing treatment in any AB PMJAY-MA Empanelled Health Care Provider. However, upon exhaustion of the Beneficiary AB PMJAY-MA wallet of Rs.10.00 Lakhs (wherein liability of Insurer is limited up to Rs. 1,00,000 only), 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 Insurance Contract 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 Insurance Contract 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.
 - f. Certain packages as mentioned in Schedule 3 to the Insurance Contract 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 Insurance Contract } which will be over and above the rates defined in Schedule 3 to the Insurance Contract.
11. 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. Transportation 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.
12. 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. Transportation 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.
13. Revision/Stratification of Package Rates during Term of the Policy/Insurance 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) of Insurance Contract 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.
14. The SHA and Insurer shall publish the Package Rates on its website in advance of each Policy Cover Period.
15. 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 of the Insurance Contract and that require hospitalization or day care treatments (as applicable).
- a. If NHA/ SHA during the currency of Policy/Insurance 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.
16. 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 and 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 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 the Insurance Contract agreed for specified packages or as pre-authorized 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 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.
- e. 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, MA and MAV 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 Insurance Contract 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-authorization irrespective of the pre-authorization status in Schedule 3 to the Insurance Contract.

- b. Insurer will not allow any EHCP, under any circumstances whatsoever, to undertake any such earmarked procedure without pre-authorization 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 3 hours of admission in case of emergency.
- e. In cases of failure to comply with the timelines stated in above Clause d. above, the EHCP shall forward the clarification for delay with the request for authorisation.
- f. The Insurer shall ensure that in all cases pre-authorization request related decisions are communicated to the EHCP as per TAT mentioned in Schedule 12.B.2 to the Insurance Contract. If there is no response from the Insurer within prescribed TAT of EHCP filing the pre-authorization 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 Insurance Contract.
- g. The Insurer shall not be liable to honour any claims from the EHCP for procedures featuring in Schedule 3 to the Insurance Contract, for which the EHCP does not have a pre-authorization, if prescribed.
- h. Reimbursement of all claims for procedures listed under Schedule 3 to the Insurance Contract shall be as per the limits prescribed for each such procedure unless stated otherwise in the pre-authorization 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-authorization 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 Insurance Contract, the Company shall not be liable under the Scheme to make any payment and provide any benefits under this Policy / Insurance Contract in respect of any expenses whatsoever incurred by any Beneficiaries in connection with or in respect of:

1. Condition that does not require Hospitalization and can be treated under Out Patient Care
2. 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.
3. 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 / tumour / cyst requiring hospitalisation for bone treatment.
4. Any assisted reproductive techniques, or infertility related procedures, unless featuring in the National Health Benefit Package list.
5. Vaccination and immunization
6. 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.
7. 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)
8. 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 Policy and the rights and obligations of the Parties under this Policy 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 Policy.
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 the Insurance Contract or 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-MA 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 Empaneled Health Care Provider/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 Empaneled Health Care Provider/hospital under the Scheme within India and will settle claims within 30 days of receiving them.
 - d. To ensure true portability of AB PMJAY-MA, 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 Insurance Contract.

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 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 SHA for submission of claims. Claims submitted beyond 45 days of discharge of patients will not be admissible. However, in case of Public EHCPs this time may be relaxed as defined by SHA. Please refer Schedule 21 of Insurance Contract.
- 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 Insurance Contract.
- 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 Insurance Contract
- 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 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 Insurance Contract.
- 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 Policy/Insurance 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 3 * hours: of raising preauthorization request (all auto approvals beyond 3 hours will be considered non- compliance)	95% Compliance	<ul style="list-style-type: none"> · 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 Insurance Contract) <p><i>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</i></p>

			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	<p>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.</p> <p>If the compliance in the month falls below 85% of number claims, it will be treated as one instance of SPD trigger</p> <p><i>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</i></p>
			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

*3 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

- Occurs 8 (eight) times during any one year of the Policy

In this event, Policy 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 Insurance 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 Insurance Contract, if penalty amount is 10% of the total Insurance Contract value, Policy 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

in this case (4-1=3) days + (15-10=5) days, hence TAT determined is 3+5=8 days

Example 2:

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 raises another query on Day 11

EHCP complies with second query on Day 14

EHCP accepts approves the claim on Day 16

Payment on Day 17

in this case (4-1=3) days + (11-10=1) days+ (17-14=3) days, hence TAT determined is 3+1+3=7 days

3. Right of Appeal and Reopening of Claims

- 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 Insurance Contract. SHA may relax these timelines for public hospitals.
- 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. A Force Majeure Event

A Force Majeure Event shall mean the occurrence in the State of Gujarat of any of the following events during the Policy Period, which was not reasonably foreseeable at the time of issuance of this Policy and which is beyond the reasonable control and influence of a Party (the Affected Party) and which causes a delay and/or inability for that Party to fulfil its obligations under this Policy and Insurance Contract:

- fire, flood, atmospheric disturbance, lightning, storm, typhoon, tornado, earthquake, washout or other Acts of God;
- war, riot, blockade, insurrection, acts of public enemies, civil disturbances, terrorism, sabotage or threats of such actions; and
- strikes, lock-out or other disturbances or labour disputes, not involving the employees of such Party or any intermediaries appointed by it,

but regardless of the extent to which the conditions in the first paragraph of this **clause** are satisfied, Force Majeure Event shall not include:

- mechanical breakdown; or

- b. weather conditions which should reasonably have been foreseen by the Affected Party claiming a Force Majeure Event and which were not unusually adverse; or
- c. non-availability of or increase in the cost (including as a result of currency exchange rate fluctuations) of suitably qualified and experienced labour, equipment or other resources, other than the non-availability of equipment due to an event that affected an intermediary of the Insurer and that, if it had happened to the Insurer hereunder, would have come within the definition of Force Majeure Event under **clause**; or
- d. economic hardship or lack of money, credit or markets; or
- e. events of physical loss, damage or delay to any items during marine, air or inland transit to the State of Gujarat unless the loss, damage or delay was directly caused by an event that affected a intermediary of the Insurer and that, if it had happened to the Insurer hereunder, would have come within the definition of Force Majeure Event under **clause**; or
- f. late performance or other breach or default by the Insurer (including the consequences of any breach or default) caused by the acts, omissions or defaults of any intermediary appointed by the Insurer unless the event that affected the intermediary and caused the act, omission or default would have come within the definition of Force Majeure Event under **clause** if it had affected the Insurer; or
- g. a breach or default of this Insurance Contract (including the consequences of any breach or default) unless it is caused by an event that comes within the definition of Force Majeure Event under clause; or
- h. the occurrence of a risk that has been assumed by a Party to this Insurance Contract; or
- i. any strike or industrial action that is taken by the employees of the Insurer or any intermediary appointed by the Insurer or which is directed at the Insurer; or
- j. The negligence or willful recklessness of the Insurer, the intermediaries appointed by it, their employees or other persons under the control and supervision of the Insurer.

5. Limitation on the Definition of Force Majeure Event

Any event that would otherwise constitute a Force Majeure Event pursuant to **A Force Majeure Event clause** above shall not do so to the extent that the event in question could have been foreseen or avoided by the Affected Party using reasonable bona fide efforts, including, in the case of the Insurer, obtaining such substitute goods, works, and/or services which were necessary and reasonable in the circumstances (in terms of expense and otherwise) for performance by the Insurer of its obligations under or in connection with this IPolicy.

6. Claims for Relief

- a) If due to a Force Majeure Event the Affected Party is prevented in whole or in part from carrying out its obligations under this Policy, the Affected Party shall notify the other Party accordingly (Force Majeure Notice).
- b) The Affected Party shall not be entitled to any relief for or in respect of a Force Majeure Event unless it has notified the other Party in writing of the occurrence of the Force Majeure Event as soon as reasonably practicable and in any event within 7 days after the Affected Party knew, or ought reasonably to have known, of the occurrence of the Force Majeure Event and it has complied with the requirements of **A Force Majeure Event clause** of the Insurance Contract.
- c) Each Force Majeure Notice shall:
 - a. fully describe the Force Majeure Event;
 - b. specify the obligations affected by the Force Majeure Event and the extent to which the Affected Party cannot perform those obligations;
 - c. estimate the time during which the Force Majeure Event will continue; and
 - d. specify the measures proposed to be adopted to mitigate or minimise the effects of the Force Majeure Event.
- d) As soon as practicable after receipt of the Force Majeure Notice, the Parties shall consult with each other in good faith and use reasonable endeavours to agree appropriate mitigation measures to be taken to mitigate the effect of the Force Majeure Event and facilitate continued performance of this Policy.
- e) If Parties are unable to arrive at a mutual agreement on the occurrence of a Force Majeure Event or the mitigation measures to be taken by the Affected Party within 15 days of receipt of the Force Majeure Notice, then the other Party shall have a right to refer such dispute to grievance redressal in accordance with **clause 26 of Tender document**.
- f) Subject to the Affected Party having complied with its obligations under this clause, the Affected Party shall be excused from the performance of the obligations that is affected by such Force Majeure Event for the duration of such Force Majeure Event and the Affected Party shall not be in breach of this Insurance Contract for such failure to perform for such duration; provided

however that no payment obligations (including Claim Payments) shall be excused by the occurrence of a Force Majeure Event.

7. 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 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 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 Policy and the other insurers shall pay for any excess expenses not covered.

8. 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, 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 Insurance Contract. The Insurer shall have capacities and track the indicative (not exhaustive) triggers and it can add more triggers to the list.
- 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 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 Insurance Contract.
- g. The Insurer shall be responsible for monitoring and controlling the implementation of the AB-PMJAY, MA in the State in accordance with Clause 23 of the Insurance Contract.
- 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 the Insurance Contract or 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 Insurance Contract;
 - 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-empowered an Empowered Health Care Provider, then the Insurer shall be required to reinstate such benefits to such Empowered Health Care Provider.

- i. The Insurer hereby releases and waives all rights or entitlements to:
 - i. make any claim for damages and/or have the 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 Empowered Health Care Provider.

6. Portability Guidelines

An Empowered 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 empowered 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 **Insurance Contract** 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

In this regard the guidelines in Schedule 8 to the Insurance Contract will be followed.

8. Migration of Policies Post Termination

- a. At least 120 days prior to the expiration of the Policy 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** shall not apply from the date of such withdrawal and this Policy 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 Empowered 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. No Separate Fees, Charges or Premium

The Insurer shall not charge any Beneficiary Family Unit or any of the Beneficiaries with any separate fees, charges, commission or premium, by whatever name called, for providing the benefits under this Policy.

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

- a. The SHA shall issue a letter to the Insurer stating the Insurer's average Claim Ratio for the entire Term of Policy Cover Period for the State. If the Policy 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 Insurance Contract**.
- 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 Insurance Contract.
- 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 Insurance Contract** 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 (Rs.1052/- per family per annum) 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 Insurance Contract** and Refund of Premium by Insurer shall be as per **Clause 10.2 of the Insurance Contract**. Under no circumstances, any party shall claim to correlate these two activities.

11. Grievance Redressal

A robust and strong grievance redressal mechanism has been designed for AB-PMJAY, MA and MAV. 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-MA, 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/SHA from time to time, Insurer shall ensure adherence to these guidelines while conducting grievance redressal.