Bajaj Allianz General Insurance Company Limited
G.E. Plaza, Airport Road, Yerewada, Pune- 411006. Reg. no 113.
CIN: U66010PN2000PLC015329

Rashtriya Swasthya Bima Yojana (RSBY) and Senior Citizens Health Insurance Scheme (SCHIS)- In the State of Mizoram

Policy Wordings
UIN- BAJHLGP18104V011718

Whereas, the **State Nodal Agency (SNA)** hereinafter referred to as the **Insured** has by a proposal and declaration dated as stated in the Schedule which shall be the basis of this contract and is deemed to be incorporated herein, has applied to Bajaj Allianz General Insurance Company Limited (herein after called the "Company") for the insurance hereinafter set forth in respect of RSBY Beneficiary Family Units named in the Policy Schedule and has agreed to pay premium in installments in accordance with Section 10 of the Tender Document for Implementation of "Rashtriya Swasthya Bima Yojana and Senior Citizens Health Insurance Scheme – In the State of Mizoram" dated 24th October 2017 released by State Government of Mizoram as consideration for such insurance, we the Company hereby agrees to RSBY Beneficiary Family Units named in the Schedule as per these Terms and Conditions.

A. DEFINITIONS:

1. **Accident** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Beneficiaries** mean the members of the Beneficiary Family Unit that are eligible to be enrolled by the Insurer under RSBY.
3. **Beneficiary Family Unit** means each family unit of up to 5 members.
4. **Cashless Access Service** means the service provided by the Hospitals on behalf of the Company to the Beneficiaries covered under RSBY for the provision of Health care facilities without any cash payment by the Beneficiary.
5. **Cashless facility** means a facility extended by the Company to the insured where the payments, of the costs of treatment undergone by the Beneficiaries in accordance with the Policy terms and conditions, are directly made to the Network provider by the Company to the extent pre-authorization approved.
6. **Condition precedent** means a Policy term or a condition upon which the Company's liability under the Policy is conditional upon
7. **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
8. **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.
9. **Day Care Treatment** refers to medical treatment, and/or surgical procedure which is:
    i. Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
    ii. Which would have otherwise required a hospitalization of more than 24 hours.

    Treatment normally taken on an out-patient basis is not included in the scope of this definition.
    Following treatment will be considered to be taken under Hospitalization Benefit:
    a. Haemo Dialysis
    b. Parenteral Chemotherapy
    c. Radiotherapy

d. Eye Surgery
e. Lithotripsy (kidney stone removal)
f. Tonsillectomy
g. D&C
h. Dental surgery following an accident
i. Surgery of Hydrocele
j. Surgery of Prostrate
k. Gastrointestinal Surgery
l. Genital Surgery
m. Surgery of Nose
n. Surgery of Throat
o. Surgery of Ear
p. Surgery of Urinary System
q. Treatment of fractures/dislocation (excluding hair line fracture), contracture releases and minor reconstructive procedures of limbs which otherwise require hospitalization.
r. Laparoscopic therapeutic surgeries that can be done in day care
s. Identified surgeries under General Anaesthesia.
t. Psychiatric & Pschosomatic illness
u. Any disease/procedure mutually agreed upon eg: Hepatitis B & C etc.
v. Screening and Follow up Care Including medicine cost but without Diagnostic Tests.

10. **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.
11. **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 RSBY Beneficiary Family Unit, and all premium paid hereon .as to those Beneficiaries and RSBY Beneficiary Family Unit, shall be forfeited to the Company,
12. **Empanelled Health Care Provider** means a Hospital , a nursing Home, a CHC (community Health centre in the State at the Block level), a PHC (Primary Health Centre in the state) , or any other Health Care provider, whether public or private empanelled by the Company.
13. **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.
14. **Family**
    a. A family would comprise the Head of the family, spouse, and up to three dependents.
    b. If the spouse of the head of the family is listed in the Beneficiary Database, the spouse shall mandatorily be part of the Beneficiary Family Unit.
    c. If the head of the family is absent at the time of enrolment, the spouse shall become the head of the family for the purpose of the RSBY.
    d. The head of the family shall nominate up to but not more than 3 dependants as part of the Beneficiary Family Unit, from the dependants that are listed as part of the family in the Beneficiary Database.
    e. If the spouse is dead or is not listed in the Beneficiary Database, the head of the family may nominate a fourth member as a dependant as part of the Beneficiary Family Unit.
    The size of the enrolled family unit for this Policy can be up to a unit of five for availing benefit under RSBY.

15. **Health Service provider** means the empanelled Third Party Administrator [TPA] of the Company.

16. **Hospital** means any institution established for in-patient care and day care treatment of illness Hand/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act. 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:
    i. has qualified nursing staff under its employment round the clock:

ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
iii. has qualified medical practitioner(s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out:
v. maintains daily records of patients and makes these accessible to the Company's authorized personnel.

17. **Hospitalisation** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.
18. **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.
19. **Illness means** a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.
    a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.
    b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:—it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests—it needs ongoing or long-term control or relief of symptoms— it requires your rehabilitation or for you to be specially trained to cope with it—it continues indefinitely—it recurs or is likely to recur.
20. **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.
21. **Inpatient care** means treatment for which the Beneficiary has to stay in a hospital for more than 24 hours for a covered event.
22. **Maternity expense** shall include –a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean section incurred during hospitalization). b) Expenses towards lawful medical termination of pregnancy during the Policy period.
23. **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 RSBY Beneficiary Family Unit.
24. **Medical Advise** means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.
25. **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.
26. **Medically Necessary** treatment is defined as any treatment, tests, medication, or stay in hospital or part o f a stay in hospital which –
    i. is required for the medical management of the illness or injury suffered by the insured;
    ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    iii. must have been prescribed by a medical practitioner,
    iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
27. **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.
28. **Non-Network Provider means a**ny hospital, day care centre or other provider that is not part of the network of Company.
29. **New Born Baby** means baby born during the Policy period and is aged upto 90 Days.
30. **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.

31. **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.
32. **Package Rates** means the fixed maximum charge per medical or surgical, procedure or intervention or day care treatment for Injury or Illness that are covered by the Company.
33. **Policy,** in respect of each district in the state means the policy issued by the Company to the State Nodal Agency describing the terms and conditions of providing risk cover to the Beneficiaries that are enrolled in that district, including the details of the scope and extent of cover available to the Beneficiaries, the exclusions from the scope of the risk cover available to the Beneficiaries, the Policy cover period of such Policy and the terms and conditions of the issue of such Policy
34. **Premium** means the premium to be paid by the State Nodal Agency to the Company in accordance with section 10 of the RSBY tender document dated 24th October 2017.
35. **Pre-Existing Disease**
    Any condition, ailment or injury or related condition(s) for which Beneficiaries had signs or symptoms, and / or were diagnosed, and / or for which medical advice / treatment was received within 48 months prior to the first Policy issued by the Company and renewed continuously thereafter.
36. **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 theBeneficiary's Hospitalisation was required, and
    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Company.
37. **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.
38. **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
39. **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.
40. **RSBY** means Rashtriya Swasthya Bima Yojana , a scheme Initiated by the Govt of India for the provision of Health Insurance services by an Company to the RSBY Beneficiary Family Units within defined districts of Government of Mizoram.
41. **RSBY Beneficiary Family Unit** means a beneficiary family Unit that is eligible to receive the benefit under the RSBY ,ie those Beneficiary Family Units that fall within any of the following categories : Below poverty line (BPL) households listed in the BPL list published by the State of Mizoram; MNREGA households ; and designated households of unorganized workers (ie Domestic workers, Beedi workers, sanitation workers, mine workers, rickshaw pullers, rag pickers, auto and taxi drivers, licensed railway porters, building & other construction workers and street vendors) and any other category of households notified by MoH&FW as being eligible for benefits under RSBY.
42. **SCHIS** means Senior Citizens Health Insurance Scheme.
43. **Senior Citizens** means a person who is enrolled as the beneficiary of RSBY and is aged 60 years and above.
44. **Smart Card** means the Electronic Identification card issued by the Company to the RSBY Beneficiary Family Unit, for utilization of the cover available to such RSBY Beneficiary Family Unit on a cash less basis.
45. **State Nodal Agency** means the nodal institution set up by Government of Mizoram for the purpose of implementing and monitoring RSBY.
46. **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.
47. **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.
48. **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.

B. Coverage and Benefits

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

a. Coverage for meeting expenses of hospitalization for **Medical** and or **Surgical Procedures**, including maternity benefit and new born care, to the enrolled families for up to INR 30,000/- per RSBY Beneficiary Family Unit per year, subject to limits, in any of the empanelled health care providers across India. The benefit to the **RSBY** Beneficiary Family Unit will be on floater basis ie. The total reimbursement of INR 30,000/- can be availed individually or collectively by members of the **RSBY** Beneficiary Family Unit per year.

b. Pre- existing conditions/ diseases shall be covered from the first day of the start of Policy, subject to exclusions provided in the Policy.

c. Coverage of health services related to surgical nature for defined procedures in Policy wording shall also be provided on a day care basis subject to exclusions provided in the Policy.

d. Provision for transport allowance of INR 100 per hospitalization subject to ceiling of INR 1000 will be provided by the hospital to the Beneficiary/ies at the time of discharge in cash.

e. Pre and post hospitalization costs (Expenses for consultation, diagnostic tests and medicines) up to 1 day prior to hospitalization and up to 5 days from date of discharge from the hospital shall be part of package rates.

f. Screening and follow up care shall be as separate day care packages and is different from pre and post hospitalization cover as mentioned above in point “e” of “B. Coverage and Benefits”.

g. Additional coverage of INR 30,000 per senior citizen in the eligible Beneficiary Family Unit. This package will be over and above the annual package of INR 30,000 per **RSBY** Beneficiary Family Unit provided under RSBY Scheme. Medical packages Additional coverage of INR 30,000 is applicable only for Senior citizen is given in Appendix 3A of the RSBY tender document.

h. Maternity and New born children will be covered as indicated below-

a. The Coverage for Maternity and New born children shall include Treatment taken in Hospital /nursing home arising out of childbirth ,including normal delivery /caesarean section and/or miscarriage or abortion induced by accident or other medical emergency subject to exclusion mentioned in Policy wording.
b. New children will be covered from birth up to the expiry of the Policy for all expenses incurred in taking treatment at the Hospital as inpatient .This benefit shall be part of the Basic Sum Insured and Subject to Maximum of 5 Beneficiary/ies, the new born children will be considered as part of the Beneficiary Family Unit member till the expiry of the Policy subject to exclusions mentioned in Policy wording.
c. The coverage shall be from day one of the inception of the Policy. Normal Hospitalisation for both mother and child should not be less than 24 hours post-delivery.

Note:

i. For the ongoing Policy period until its renewal, new born will be provided all benefits under RSBY and will NOT be counted as a separate member even if five members of the family are already enrolled.
ii. Verification for the newborn can be done by any of the existing family members who are enrolled in RSBY through the same smart card as that of the mother.

The Company will ensure cashless access service to the enrolled beneficiary through the Empanelled Hospital/Health Service provider subject to limits as are reasonably and necessarily incurred in respect thereof by or on behalf of such enrolled Beneficiary but not exceeding the Sum Insured of Rs 30,000/- in respect of all claims individually or collectively by enrolled members of the RSBY Beneficiary Family Unit during the Policy period.

The Expenses shall be paid/reimbursed to the Empanelled Health Care Provider/Beneficiaries as per the package cost as approved under the Rashtriya Swasthya Bima Yojana (RSBY) and as set out in Appendix 3 of the RSBY tender document and as accepted by the Empanelled Health Care Provider .
The Company's liability for all Beneficiaries together under one RSBY Beneficiary Family Unit for any medical or surgical procedure or listed day care procedure under the benefits package shall be no more than Rs.30000/- or the package rates for that medical or surgical procedure or intervention or listed day care procedure that is set out in Appendix 3 of RSBY tender document, whoever is the least. A separate set of package rates for Senior Citizens has been given in Appendix 3A of RSBY tender document.
If Hospitalisation is due to medical condition, a flat per day rate as set out in Appendix 3 will be paid depending on whether the beneficiary is admitted in the General ward or the Intensive care unit and the condition is defined in the package rates.

These package rates (in case of surgical procedures or interventions or day care procedures) or flat per day rate (in case of medical treatments) will include:

a) Registration Charges,
b) Bed charges (General Ward),
c) Nursing & Boarding Charges,
d) Surgeons, Anesthetists, Medical Practitioner, Consultants Fees,
e) Anesthesia, Blood Transfusion, Oxygen, OT Charges, Cost of Surgical Appliances etc
f) Medicines and Drugs,
g) Cost of Prosthetic Devices, Implant
h) X-Ray and other Diagnostic tests etc,
i) Food to the Patient,
j) Expenses incurred for consultation, diagnostic test and medicines up to 1 day before the admission of the patient and cost of diagnostic test and medicine up to 5 days of the discharge from the hospital for the same ailment / surgery
k) Transportation Charge of Rs. 100/- (payable to the beneficiary at the time of discharge in cash by the hospital)
l) Any other expense related to the treatment of the patient in the Hospital.

PROCESS FOR CASHLESS TREATMENT

The beneficiaries shall be provided treatment free of cost for all such ailments covered under the RSBY scheme within the limits / sub-limits and sum insured, i.e., not specifically excluded under the scheme. Subject to Maximum of Rs.30000/- per RSBY Beneficiary Unit, The Empanelled healthcare provider shall be reimbursed as per the package cost specified in the tender agreed for specified packages or as mutually agreed upon in case of unspecified packages. The Empanelled health care provider, at the time of discharge, shall debit the amount indicated in the package list. The machines and the equipment to be installed for usage of smart card shall conform to the guidelines issued by the Central Government. The software to be used thereon shall be the one approved by the Central Government.

A. Cashless Access in case package is fixed

Once the identity of the Beneficiary and/ or his/her RSBY Beneficiary family Unit is established by verifying the fingerprint of the patient (fingerprint of any other enrolled family member in case of emergency/ critical condition of the patient can be taken) and the smart card procedure given below shall be followed for providing the health care facility under package rates:

a) It has to be seen that enrolled Beneficiary suffering Illness/Injury is admitted for covered procedure and package for such intervention is available.
b) Beneficiary has balance in his/ her RSBY account.
c) Provisional entry shall be made for carrying out such procedure. It has to be ensured that no procedure is carried out unless provisional entry is completed on the smart card through blocking of claim amount.
d) At the time of discharge final entry shall be made on the smart card after verification of Beneficiary's fingerprint (any other enrolled family member in case of death) to complete the transaction.

e) All the payment shall be made electronically within One Month of the receipt of electronic claim in the prescribed format.

B. Pre-Authorization for Cashless Access in case no package is fixed

Once the identity of the Beneficiary and/ or his/her family RSBY Beneficiary family Unit is established by verifying the fingerprint of the Beneficiary (fingerprint of any other enrolled Beneficiary of same RSBY Beneficiary family Unit can be taken in case of emergency/ critical condition of the Beneficiary) and the smart card, following procedure shall be followed for providing the health care facility not listed in packages:

a) Request for hospitalization shall be forwarded by the Network provider after obtaining due details from the treating doctor in the prescribed format i.e. "request for authorization letter" (RAL). The RAL needs to be faxed/ emailed to the 24-hour authorization /cashless department at fax number/ email address of the Company along with contact details of treating physician, as it would ease the process. The medical team of Company would get in touch with treating physician, if necessary.
b) The RAL should reach the authorization department of Company within 6 hours of admission in case of emergency or 7 days prior to the expected date of admission, in case of planned admission.
c) In failure of the above "clause b", the clarification for the delay needs to be forwarded with the request for authorization.
d) The RAL form should be duly filled in, with entries clearly marked Yes or No. There should be no nil, or blanks, which will help in providing the outcome at the earliest.
e) Company guarantees payment only after receipt of RAL and the necessary medical details. Only after Company has ascertained and negotiated the package with provider, it shall issue the Authorization Letter (AL). This shall be completed within 12 hours of receiving the RAL.
f) In case the ailment is not covered or given medical data is not sufficient for the medical team of authorization department to confirm the eligibility, Company can deny the authorization or seek further clarification/ information.
g) The Company needs to file a report to nodal agency explaining reasons for denial of every such claim.
h) Denial of authorization (DAL)/guarantee of payment are by no means denial of treatment by the health facility**.** The Empanelled health care provider shall deal with such cases as per their normal rules and regulations.
i) Authorization letter [AL] will mention the authorization number and the amount guaranteed as a package rate for such procedure for which package has not been fixed earlier. Empanelled Healthcare Provider must see that these rules are strictly followed.
j) The guarantee of payment is given by the Company only for the necessary treatment cost of the ailment covered and mentioned in the request for Authorization letter (RAL) for hospitalization.
k) The entry on the smart card for blocking as well at discharge would record the authorization number as well as package amount agreed upon by the healthcare provider and Company. Since this would not be available in the package list on the computer, it would be entered manually.
l) In case the balance sum available is considerably less than the package cost, the healthcare provider should follow their norms of deposit/running bills etc. However, the Empanelled healthcare provider shall only charge the balance amount against the package from the beneficiary. Company upon receipt of the bills and documents would release the guaranteed amount.
m) Company will not be liable for payments in case the information provided in the "request for authorization letter" and subsequent documents during the course of authorization, is found incorrect or not disclosed.

Note: In cases where the Beneficiary is admitted in a healthcare provider during the current Policy period but is discharged after the end of the Policy period, the claim has to be paid by the company which is operating during the period in which Beneficiary was admitted.

HOSPITAL SERVICES – ADMISSION PROCEDURE – SPECIFICALLY FOR SCHIS BENEFICIARIES

Treatment at Hospitals and Claim Process: Beneficiary under SCHIS will be able to get cashless treatment in any of the empanelled hospitals. The process of taking treatment and raising of claims will be as follows:

a. The identity of the beneficiary and/ or his/her family member will be established by verifying the fingerprint of the patient (fingerprint of any other enrolled family member in case of emergency/ critical condition of the patient can be used for verification).
b. If the member who needs treatment is a senior citizen, i.e. aged 60 years or above, the Hospital shall mandatorily take pre-authorisation from the Company.
    i. Whether that beneficiary is also covered under SCHIS.
    ii. Whether there is balance left in the SCHIS cover to provide the particular treatment

iii. If the treatment to be provided is part of the "package list for senior citizens" then a pre-authorisation form will also need to be sent electronically by the hospital.
iv. If the treatment to be provided is part of the basic "package list of RSBY" then no approval is required for providing that particular treatment

c. Pre-authorisation will need to be provided within 12 hours by the Company. If no response is received by the hospital from the Company within 12 hours then the pre-authorisation will deemed to be given automatically.
d. The pre-authorisation code as provided by the Company will need to be entered by the hospital in the software
e. After discharge of the patient claims data will need to be sent to the Company by the hospital electronically.
f. Company will need to settle the claims within 30 days of receipt of the claims from the hospitals.
g. In case of Emergency, the pre-authorisation process will be followed only after the patient is admitted and stabilized.

C. EXCLUSIONS:

Exclusions for IPD & Day care procedures

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

i. Conditions that do not require Hospitalization: Conditions that do not require hospitalization and can be treated under Out-Patient Care. Out- patient diagnostic, medical and surgical procedures or treatments unless necessary for treatment of a disease covered under day care procedures will not be covered
ii. Further expenses incurred at Hospital or Nursing Home primarily for evaluation / diagnostic purposes only during the hospitalized period and expenses on vitamins and tonics etc. unless forming part of treatment for injury or disease as certified by the attending physician.
iii. Any dental treatment or surgery which is corrective, cosmetic or of aesthetic procedure, filling of cavity, root canal including wear and tear etc. unless arising from disease or injury and which requires Hospitalization for treatment.
iv. Congenital external diseases or defects or anomalies (Except as given in Appendix 3 of the RSBY tender document), unless requiring surgical intervention to maintain the functionality will not be excluded and they are as given :
Cleft lip, cleft palate, ectopic anus/anorectal malformation, undescended testis, hydrocele, thyroglossal cyst excision, correction of thyroglossal duct fistula, meningocele, Bening cystic hygroma, polydactylyl involving more than two fingers, Pre-auricular sinus, Branchial syst/fistula, hemangioma and lymphangioma.
v. Diseases / accident due to and or use, misuse or abuse of drugs / alcohol or use of intoxicating substances or such abuse or addiction etc.
vi. Convalescence, general debility, "run down" condition or rest cure.
vii. Any fertility, sub-fertility or assisted conception procedure, hormone replacement therapy, sex change or treatment which results from or is in any way related to sex change.
viii. Vaccination, inoculation or change of life or cosmetic or of aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.
ix. Circumcision (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident),
x. Injury or disease directly or indirectly caused by or arising from or attributable to war, invasion, act of foreign enemy, war like operations (whether war be declared or not) or by nuclear weapons / materials.
xi. Any treatment for Intentional self-injury/suicide.

Exclusions under maternity benefit clause:

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

i. Expenses incurred in connection with voluntary medical termination of pregnancy except induced by accident or other medical emergency to save the life of mother.
ii. Normal Hospitalization period is less than 48 hours from the time of delivery operations associated therewith for this benefit.
iii. Pre-natal expenses under this benefit; however treatment in respect of any complications requiring Hospitalization prior to delivery can be taken care under medical procedures.

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 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. **Payment of Claims and Claim Turnaround Time**
   The claim settlement process will be as stated below:
   a) The company will ensure that all claims raised by the hospital are settled and the payments made to the hospital within ONE MONTH of receipt of claim data by the Company.
   b) In case a claim is being rejected, the company will send information to the hospital within ONE MONTH of receiving the claim.
   c) Along with the claim rejection information, the company will also inform the hospital that it can appeal to the District Grievance Redressal Committee if required. The contact details of the District Grievance Redressal Committee will be provided along with each claim rejection letter.
   d) Where a claim is being investigated by the company, the process shall be completed within one month of receipt of the claim.
   e) The company may collect at their own cost complete claim papers from the provider, if required for audit purposes. This will not have any bearing on the claim settlement to the provider.

4. **Penalty linked to delay in Claim payment**
   If the Company does not settle the claim within 30 days of the claim being received by the Company the hospital shall be paid interest @ 1 % of claimed amount per 15 days of delay in settlement. The amount shall be paid to the hospitals in the same manner for payment of claims.

5. **Fraudulent Claims**
   The Company shall not be liable to make any payment under this Policy in respect of any claim:
   i. If the Policy has been obtained by Beneficiaries misrepresentation of material facts,
   ii. If such claim be in any manner be fraudulent or supported by any fraudulent means or device whether by the Beneficiaries or by any other person acting on his behalf.

6. **Repudiation of Claims**: The Company shall communicate reasons in writing the reasons for repudiation to the Designated Authority of the District/state/Nodal Agency and the Empanelled Health care provider within one month of receiving the claim electronically .The final decision regarding rejection, even if the claim is being investigated shall be taken within one month. The Rejection letter shall state the details of the claim summary, rejection reason and details of the Grievance committee Redressal

7. If any dispute or difference shall arise as to the quantum to be paid under the Policy, (liability under claim being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third

arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the (Indian) Arbitration and Conciliation Act, 1996.

It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has repudiated or not accepted liability under or in respect of the claim under this Policy.

It is hereby expressly stipulated and declared that in case of admission of claim with dispute as to quantum of amount admitted under the claim, it shall be a condition precedent to any right of action or suit upon this Policy that award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained.

It is also hereby further expressly agreed and declared that if the Company shall disclaim/repudiate liability to the Beneficiary for any claim hereunder and if the Beneficiary shall not within 12 calendar months from the date of such disclaimer/repudiation, have made the subject matter of a Suit or proceeding before a Court of Law or any other competent statutory forum/tribunal, then all benefits under the Policy shall be forfeited and the rights of Insured shall stand extinguished and the liability of the Company shall also stand discharged.

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

9. **Payment Of Premium**

The Company hereby agrees to collect the premium in installments as provided in the Insurance Rules including the cost of Smart Card and Service Tax from the Insured as per Clause 10 Payment of Premium and Registration Fee of the RSBY tender document dated 24th October 2017.

10. **Penalty for Delay in Premium Payment**

If the premium is not paid to the Company within six months of the commencement of the Policy, interest of 0.5% of the amount for every 15 days delay if the premium payment is delayed beyond 6 months of the start of the Policy shall be paid by the State Nodal Agency to the Company

11. **Refund of Premium**

The Insured will be entitled to a refund of premium if the claim ratio specified below is not reached at the full period of Insurance Policy. The premium refund shall be as per the formula below:

a. In case the claim ratio (hospital claims paid + INR 60 towards cost of cards/ premium received is less than 70% ,then the Company will return the difference between actual claim ratio and 70% to the SNA
b. In case the claim ratio, as calculated above is higher than 100%,no refund shall be available to the Company
c. The claims data shall be updated by the Company within 30 days of the submission of claims by the Hospital
d. The refund will be calculated as per the unit of tendering
    i. If separate premium rate have been determined for each district then refund will be calculated based on the performance of the Company in that district.
    ii. If the premium rate has been determined cluster wise then refund will be calculated based on the performance of the Company in that cluster.
    iii. If a single premium rate has been determined for all the district in the State then refund will be calculated based on performance of insurance companies in all the districts together

The refund amount will need to be returned within 90 days of the end of Policy period, if it is the last year of insurance contract with the same Company, otherwise the future payable premium should be adjusted to the tune of amount of refund due from the Company.

12. **Termination of Policy**

The Policy shall not be terminated by the company except on grounds of mis-representation, fraud, non-disclosure of material facts or non-co-operation of the insured. However the termination of cover shall be only in respect of the RSBY beneficiary family unit whose claim has been repudiated on grounds of mis-representation, fraud, non-disclosure of material facts or non-co-operation and shall not be applicable to the other family units covered under the Policy. In case of termination of cover to any beneficiary family unit due to mis-representation, fraud, non-disclosure of material facts or non-co-operation of the insured, the premium pertaining to that beneficiary family unit shall be forfeited.

However the Policy may be terminated by the insured by giving 15 days' notice to the company.. In such an event, the cover period of the Policy issued by the Company shall terminate on expiry of the termination notice period, unless the insured has issued a written request to the Company before the date to continue providing cover under the Policy issued by it. The Company shall upon written request of the insured continue to provide

the cover under the Policy until such time the Insured appoints a substitute Company and the cover provided by the substitute Company commences. The last effective date of the Policy shall be the termination date.
The Company will pay back to the Insured the unutilized amount of the premium, calculated until the termination date using a pro rata basis
The Company will settle all claims raised by Empanelled health care providers for all hospitalization upto and including the termination date
Upon Termination of the Policy and receipt of a written request from the Insured atleast 7 days prior to the termination date, the Company shall assign its rights and obligations other than accrued payment obligations and liabilities under its service agreement with the Empanelled Health Care providers and its agreement with other intermediaries in favour of the state Nodal Agency or the substitute Company appointed by the Insured

13. **Grievance Redressal**
The Greivance Redressal process will be as laid down in the RSBY tender document dated 24th October 2017. If the Beneficiary or RSBY Beneficiary Unit has a grievance on issues relating to enrolment or hospitalisation against the company, he/she will approach the District Grievance Redressal Committee [DGRC.] The DGRC should take a decision within 30 days of receiving the complaint. If either of the parties is not satisfied with the decision, they can appeal to State Grievance Redressal Commitee (SGRC) within 30 days of the decision of the DGRC. The SGRC shall decide the appeal within 30 days of receiving the appeal .The decision of the SGRC on such issues will be final.
In case of a rejection of claim, the Hospital will have to be informed within one month of receiving the claim. Along with the claim rejection information, the company will inform the Hospital that it can appeal to the DGRC/SGRC if required and the address of the DGRC/SGRC will be provided in the rejection letter.
The Hospital shall have the right of appeal to approach the company if they feel that the claim is payable .If the Company's decision is not agreeable in this regard, it can appeal to the DGRC/SGRC

14. **Penalty linked to Grievance Redressal**
The Company shall ensure that all orders of the grievance redressal committee is carried out within 30 days unless stayed by the next higher level. Any failure to comply with the direction of the Grievance Redressal Committee at any level will meet with a penalty of Rs. 25,000/- per decision for the first month and 50,000/- per month thereafter during which the decision remains un-complied. The amount shall be paid by the Company to the SNA.

In witness where of the undersigned being duly authorized by the company on behalf of the company has hereunto set his hand at ……on ……..day of……..20__.

For The Bajaj Allianz General Insurance Company Limited

Authorised Signatory