Bajaj Allianz General Insurance Company Limited
Bajaj Allianz House, Floor, Airport Road, Yerawada, Pune 411006
Reg. no 113. CIN: U66010PN2000PLC015329

Rashtriya Swasthya Bima Yojana (RSBY) - Gujarat

Policy Wordings

UIN - 3/IRDAI/HLT/BAGI/RSBY-GOVT SCHEME/V.I/16-17

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 8 of the RSBY Tender Document dated 4th Feb 2016 released by Government of Gujarat 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. **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.
4. **Cashless facility** means a facility extended by the Company to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the Policy terms and conditions, are directly made to the Network provider by the Company to the extent pre-authorization approved.
5. **Condition precedent** means a Policy term or a condition upon which the Company's liability under the Policy is conditional upon
6. **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
7. **Contribution** is essentially the right of the Company to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a ratable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.
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, where 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 insurance 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. Hysterectomy
j. Surgery of Hernia
k. Surgery of Hydrocele
l. Surgery of Prostrate
m. Gastrointestinal Surgery
n. Genital Surgery
o. Surgery of Nose
p. Surgery of Throat
q. Surgery of Ear
r. Surgery of Appendex
s. Surgery of Urinary System
t. Treatment of fractures/dislocation (excluding hair line fracture), contracture releases and minor reconstructive procedures of limbs which otherwise require hospitalization.
u. Laparoscopic therapeutic surgeries.
v. Any surgery under General Anaesthesia.
w. Or any such disease/procedure agreed by TPA/Company before treatment.
x. Screening and follow up care Including medicine cost but without diagnostic tests upto a maximum of Rs. 100 per visit and subject to a maximum of Rs 1500 per family per year. One visit will be for up to seven consecutive days. This will be part of INR 30,000 limit.
y. Screening and follow up care Including medicine cost but with diagnostic tests upto a maximum of Rs. 150 per visit and subject to a maximum of Rs 1500 per family per year. One visit will be for up to seven consecutive days. This will be part of INR 30,000 limit.

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. **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 insurance company's authorized personnel.
15. **Hospitalisation** means admission in a Hospital for a minimum period of 24 Inpatient Care consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24consecutive hours.

16. **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.
17. **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 comes back or is likely to come back.
18. **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 words.
19. **Inpatient care** means treatment for which the Beneficiary has to stay in a hospital for more than 24 hours for a covered event.
20. **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.
21. **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.
22. **Medical Advise** means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.
23. **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.
24. **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.
25. **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.
26. **Non-Network Provider means a**ny hospital, day care centre or other provider that is not part of the network of Company.
27. **New Born Baby** means baby born during the Policy period and is aged between 1 day and 90 Days, both days inclusive
28. **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.
29. **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.
30. **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.
31. **Policy,** in respect of each district/block in the state means the policy Schedule and these Terms and Conditions 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/block 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

32. **Premium** means the premium to be paid by the State Nodal Agency to the Company in accordance with section 8 of the RSBY tender document
33. **Pre-Existing Disease**
    Any condition, ailment or injury or related condition(s) for which Beneficiary had signs or symptoms, and / or were diagnosed, and / or received medical advice / treatment within 48 months to prior to the first Policy issued by the Company.
34. **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.
35. **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.
36. **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
37. **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.
38. **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/blocks of Government of Gujarat.
39. **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 Government of Gujarat; MNREGA households ; and households of unorganized workers (ie Domestic workers, Beedi workers ,Building and other construction workers, street vendors , postmen , licensed Railway porters , vendors ,hawkers ,cycle rickshaw pullers ,mine workers ,rag pickers ,safai karmacharis ,auto and taxi drivers) and any other category of households notified by MoLE (Ministry of Labour and Employment ,Govt of India)
40. **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
41. **State Nodal Agency** means the nodal institution set up by Government of Gujarat for the purpose of implementing and monitoring RSBY.
42. 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.
43. **Subrogation** shall mean the right of the Company to assume the rights of the Beneficiaries to recover expenses paid out under the Policy that may be recovered from any other source.
44. **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.
45. **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

1. Subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon, the Company undertakes that if during the period stated in the Schedule any Beneficiary of enrolled member of RSBY Beneficiary Family Unit shall contract or suffer from any illness (herein after called DISEASE) including pre-existing disease or sustain any bodily injury through accident (hereinafter called INJURY) and if such disease or injury shall require any covered Beneficiary upon the advice of a duly qualified Medical

Practitioner or of a duly qualified Medical Practitioner who is expert in conducting Surgical Procedure (hereinafter called SURGEON) to incur

a. Hospitalization Expenses for Medical/Surgical Procedure including maternity benefit and new born care at any Network Provider as an inpatient.
b. Expenses for defined day care treatment / surgical procedures as stated in Appendix 2 of the RSBY Tender Document as attached.
c. Expenses for diagnostic tests and medicines upto one day before the admission of the patient and cost of diagnostic test and medicine upto five days of the discharge from the Hospital for the same ailment/surgery.
d. Transportation expenses on actual basis subject to maximum of Rs.100/- per visit with an annual ceiling of Rs.1000/-.
e. Day care expense on Screening and follow up care.

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.

It is further agreed and declared RSBY benefits on cashless basis to each senior citizen who is RSBY Beneficiary family member, with a top up sum insured of Rs. 30,000/- as an additional amount for secondary and tertiary treatment amount over and above the floater sum insured of Rs. 30000/-per family unit . This add-on cover of Rs.30,000/- per senior citizen will be for treatment of senior citizen only of RSBY Beneficiary family but the senior citizen are also eligible for cover under the primary floater of Rs.30000/-

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 Appendix3 of RSBY tender document, whoever is the least.

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.

The package rate will include:

a) Registration Charges,
b) Bed charges (General Ward),
c) Nursing & Boarding Charges,
d) Surgeons, Anesthetists, Medical Practitioner, Consultants Fees,
e) Anesthesia, Blood Oxygen, OT Charges, Cost of Surgical Appliances,
f) Medicines and Drugs,
g) Cost of Prosthetic Devices, Implant X-Ray and Diagnostic tests,
h) Food to the Patient,
i) Any other expense related to the treatment of the patient in the Hospital.

2. <u>Coverage for Maternity and New born children</u>

The Coverage for Maternity and New born children shall include Treatment taken in Hospital /nursing home arising out of childbirth ,including normal delivery /ceasarean section and/or miscarriage or abortion induced by accident or other medical emergency.

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 Beneficiaries, the new born children will be considered as part of the RSBY Beneficiary Unit family member till the expiry of the Policy. Normal Hospitalisation for both mother and child should not be less than 48 hours post-delivery .The identification of the mother or any other member of the family will be sufficient identification for the new born child to avail treatment

<u>PROCESS FOR CASHLESS TREATMENT</u>

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.

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
ii. Out- patient diagnostic, medical and surgical procedures or treatments unless necessary for treatment of a disease covered under day care procedures.
iii. 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.
iv. 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.
v. Congenital external diseases or defects or anomalies (Except as given in Appendix 3 of the RSBY tender document), Convalescence, general debility, "run down" condition or rest cure.
vi. 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.
vii. 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.
viii. Circumcision (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident),
ix. 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.
x. Any treatment for Intentional self-injury/suicide.
xi. Any treatment for received in convalescent home, convalescent hospital, health hydro, nature care clinic, or similar establishments or as mutually agreed between the State and the insurance agency(ies).
xii. Any outpatient benefits for the RSBY family units covered under the policy

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. **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.

3. **Penalty linked to delay in Claim payment**
If the Company does not settle the claim within 30 days of the claim being preferred 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.

4. **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 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.

5. **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

6. If at the time when any claim arises under this Policy there is in existence any other insurance whether it be effected by or on behalf of any Beneficiary in respect of whom the claim may have arisen covering the same loss, liability, compensation, costs or expenses the Company shall not be liable to pay or contribute more than its ratable proportion of any loss, liability, compensation, costs or expenses.

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 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.

8. If the TPA/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 receipt of the notice of such disclaimer/repudiate, have made the subject matter of a Suit in a Court of Law,, then the claim shall for all purposes be deemed to have been forfeited and or abandoned and shall not thereafter be recoverable hereunder.

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

10. **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 8 Payment of Premium and Registration Fee of the RSBY tender document dated 4th Feb 2016.

11. 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 Insurance company

12. Refund of Premium

a. 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
b. 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 Insured
c. In case the claim ratio, as calculated above is higher than 70%,no refund shall be available to the Insurance Company
d. The claims data shall be updated by the Company within 30 days of the submission of claims by the Hospital
e. The refund amount will be returned within 90 days of the end of the Policy period

13. 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

14. Grievance Redressal

The Greivance Redressal process will be as laid down in the RSBY tender document dated 4th Feb 2016. 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 Commitee {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

15. **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………………………..200…….

For The Bajaj Allianz General Insurance Company Limited

Authorised Signatory

16. Grievance Redressal Procedure

Bajaj Allianz General Insurance has always been known as a forward looking customer centric organization. We take immense pride in the spirit of service and the culture of keeping customer first in our scheme of things. In order to provide you with top-notch service on all fronts, we have provided you with multiple platforms via which you can always reach one of our representatives.

Level 1 In case you have any concern, you may please reach out to our Customer Experience Team through any of the following options: • Our Website @ https://general.bajajallianz.com/Corp/aboutus/general-insurance-customer-service.jsp • Call us on our Toll free no 1800 209 5858 • Mail us on bagichelp@bajajallianz.co.in • Write to Bajaj Allianz General Insurance Co. Ltd. Bajaj Allianz House, Airport Road, Yerwada Pune- 411006
Level 2 In case you are not satisfied with the response given to you by our team, you may write to our Grievance Redressal Officer **Mr. Jerome Vincent** at ggro@bajajallianz. co.in
Level 3 If in case, your grievance is not resolved and you wish to talk to our care specialist, please Give a missed on +91 80809 45060 OR SMS <WORRY> To 575758 and our care specialist will call you back
If you are still not satisfied with the solutions provided, write to Mr. Ankit Goenka, Head of Customer experience directly at head. customerservice@ bajajallianz.co.in.
Grievance Redressal Cell for Senior Citizens Bajaj Allianz introduces a dedicated team for all the senior citizens, so no more wait time, no more standing in long queue. Senior citizens can now contact us on 1800-103-2529 or write to us at seniorcitizen@bajajallianz.co.in

In case your complaint is not fully addressed by the insurer, You may use the Integrated Greivance Management System (IGMS) for escalating the complaint to IRDAI or call 155255 . Through IGMS you can register your complain online and track its status. For registration please visit IRDAI website www.irda.gov.in.
If the issue still remains unresolved, You may, subject to vested jurisdiction, approach Insurance Ombudsman for the redressal of the grievance.

Office Details	Jurisdiction of Office Union Territory,District)
AHMEDABAD - Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - Smt. Neerja Shah Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
BHOPAL - Shri Guru Saran Shrivastava Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chattisgarh
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa

Office Details	Jurisdiction of Office Union Territory,District)
CHANDIGARH - Dr. Dinesh Kumar Verma Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI - Shri M. Vasantha Krishna Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Tey-nampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI - Shri Kiriti .B. Saha Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Aruna-chal Pradesh, Nagaland and Tripura
HYDERABAD - Shri I. Suresh Babu Office of the Insurance Ombudsman, 6-2-46, 1st floor, “”Moin Court””, Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry
JAIPUR - Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.

Office Details	Jurisdiction of Office Union Territory,District)
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, MaKerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry. he-a part of Pondicherry
KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands
LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhab-dra,Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao,Sita-pur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi,Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar,Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar
MUMBAI - Shri Milind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri,Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad,Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Sham-li, Rampur,Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur

Office Details	Jurisdiction of Office Union Territory,District)
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand
PUNE - Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor,C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region

Note: Address and contact number of Governing Body of Insurance Council

Secretary General - Governing Body of Insurance Council
Jeevan Seva Annexe, 3rd Floor, S.V. Road, Santacruz (W), Mumbai - 400 054
Tel No: 022-2610 6889, 26106245, Fax No. : 022-26106949, 2610 6052, E-mail ID: inscoun@vsnl.net