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

Rashtriya Swasthya Bima Yojana (RSBY)- In the State of Uttar Pradesh

Policy Wordings

UIN- 55/IRDAI/HLT/BAGI/RSBY-GOVT SCHEME/V.I/16-17

Whereas, the State Nodal Agency (SNA- State Agency for Comprehensive Health Insurance (SACHI)) 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 aggregate annual premium in installments in accordance with Section 8 of the RSBY Tender Document dated 11th November 2016 released by Government of Uttar Pradesh ["RSBY Tender Document "] as consideration for such insurance, we the Bajaj Allianz General Insurance Company Ltd ["Company" or "Insurer"] hereby agrees to indemnify 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. **Beneficiary Family Unit** means each family unit of upto 5 members covered..

3. **Beneficiary/ies** mean the members of the Beneficiary Family Unit that are eligible to be enrolled by the Insurer under RSBY.

4. **Cashless Access Service** means the service provided by the Hospitals on behalf of the Company to the Beneficiary/ies covered under RSBY for the provision of Health care facilities without any cash payment by the Beneficiary/ies.

5. **Cashless facility** means a facility extended by the Company to the Beneficiary/ies where the payments, of the costs of treatment undergone by the Beneficiary/ies 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** means a condition 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, 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 **Medical** and or **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** and or **Surgical Procedures** 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:

i. Haemodialysis
ii. Parenteral Chemotherapy
iii. Radiotherapy
iv. Eye Surgery
v. Lithotripsy (kidney stone removal)
vi. Tonsillectomy
vii. D&C
viii. Dental surgery following an accident
ix. Surgery of Hydrocele
x. Surgery of Prostrate
xi. Gastrointestinal Surgery
xii. Genital Surgery
xiii. Surgery of Nose
xiv. Surgery of Throat
xv. Surgery of Ear
xvi. Surgery of Urinary System
xvii. Treatment of fractures/dislocation (excluding hair line fracture), contracture releases and minor reconstructive procedures of limbs which otherwise require hospitalization.
xviii. Laparoscopic therapeutic surgeries that can be done in day care
xix. Identified surgeries under general anesthesia
xx. Any disease/procedure mutually agreed upon.

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 Beneficiary/ies and or Head of **Family**, **t**he Policy shall be void for such Beneficiary/ies and RSBY **Beneficiary Family Unit,** and all premium paid hereon .as to those Beneficiary/ies 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 **Medical** and or **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 24 consecutive 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:—
(i) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests—
(ii) it needs ongoing or long-term control or relief of symptoms—
(iii) it requires your rehabilitation or for you to be specially trained to cope with it—
(iv) it continues indefinitely—
(v) it 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/ies has to stay in a hospital for more than 24 hours for a covered event.

2. **Insured** means the State Nodal Agency, which will pay the Premium on behalf of the **RSBY** Beneficiary Family Units enrolled in each district for each Policy Cover Period and in whose name the Policies will be issued or renewed.

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/ies 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/ies 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/ies 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** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which –

    i. is required for the medical management of the illness or injury suffered by the Beneficiary/ies;
    i. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    ii. must have been prescribed by a medical practitioner,
    iii. 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 Beneficiary/ies 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/ies 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/ies 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 Beneficiary/ies that are enrolled in that district/block including the details of the scope and extent of cover available to the Beneficiary/ies, the exclusions from the scope of the risk cover available to the Beneficiary/ies, 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/ies 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/ies is Hospitalised, provided that:
    i. Such Medical Expenses are incurred for the same condition for which the Beneficiary/ies'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/ies is discharged from hospital , provided that:
    i. Such Medical Expenses are incurred for the same condition for which the Beneficiary/ies Hospitalisation 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 Government 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 Uttar Pradesh.

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 Uttar Pradesh**; MNREGA households ; and households of unorganized workers Registered rickshaw pullers , Sanitation workers (Other than manual scavengers) and any other category of households notified by MoHFW/ **Government of Uttar Pradesh** as being eligible for the benefits under the RSBY.

40. **Smart Card** means the Electronic Identification card issued by the Company to the RSBY Beneficiary Family Unit, for utilization of the risk cover available to such RSBY Beneficiary Family Unit on a cashless basis as per the Policy.

41. **State Nodal Agency** means the nodal institution set up by Government of Uttar Pradesh for the purpose of implementing and monitoring RSBY.

42. **Medical** and or **Surgical Procedures** 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.
Beneficiary/ies

43. **Third Party Administrators or TPA** means any person who is registered under the IRDAI (Third Party Administrators - Health Services) Regulations,2016, or any amended provisions, from time to time, as notified 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 and health services to the Beneficiary/ies and the Company, upon a claim being made.
44. **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 “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 applicable only for Senior citizen is given in Appendix 17 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 48 hours post-delivery.
d. The identification of the mother or any other member of the Beneficiary Family Unit will be sufficient identification for the new born child to avail treatment

C. Package Rate-

If Hospitalisation is due to illness or Accidental Bodily Injury sustained or contracted during the Policy Period ["medical condition"], a flat per day rate as set out in Appendix 3 of RSBY tender documents will be paid depending on whether the Beneficiary/ies is admitted in the General ward or the Intensive care unit and the condition is defined in the package rates.

The package rates (in case of **Medical** and or **Surgical Procedures** or interventions or day care procedures) or flat per day rate (in case of **Medical** and or **Surgical Procedures**) 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) X-Ray and other Diagnostic Tests etc.
i) Food to the Patient,
j) Expenses for consultation, diagnostic tests 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 charges of Rs.100/- (payable to Beneficiary/ies at the time of discharge in cash by the hospital),
l) l) Any other expense related to the treatment of the 'patient In the Hospital.

D. Process for Cashless Treatment

The Beneficiary/ies 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 Family 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 healthcare 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. 1. Cashless Access in case package is fixed

Once the identity of the Beneficiary/ies and/ or his/her RSBY Beneficiary Family Unit is established by verifying the fingerprint of the patient (fingerprint of any other enrolled Beneficiary/ies of RSBY Beneficiary Family Unit 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/ies suffering Illness/Injury is admitted for covered procedure and package for such intervention is available.
b) Beneficiary/ies 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/ies fingerprint (any other enrolled family member of RSBY Beneficiary Family Unit 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.

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

Once the identity of the Beneficiary/ies and/ or his/her RSBY Beneficiary Family Unit is established by verifying the fingerprint of the Beneficiary/ies (fingerprint of any other enrolled Beneficiary/ies of same Beneficiary Family Unit can be taken in case of emergency/ critical condition of the Beneficiary/ies) 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 Medical 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/ies. 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/ies 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/ies was admitted.

E. EXCLUSIONS:

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

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/ies in connection with or in respect of:

i. Conditions that do not require Hospitalization: Condition that do not require hospitalisation and can be treated under Out Patient Care. Out Patient Diagnostic, **Medical** and or **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), Convalescence, general debility, "run down" condition or rest cure.

v. Fertility related procedures:- 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.

vi. Vaccination: 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. Circumcision (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident)

vii. War, Neuclear invasion: 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.

viii. Suicide: Any treatment for Intentional self-injury/suicide.

ix. 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 Company.

x. Any outpatient benefits for RSBY Beneficiary Family Unit 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/ies 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.

F. 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. In case of multiple policies which provide fixed benefits, on the occurrence of the insured event in accordance with the terms and conditions of the respective policies, each insurer shall make the claim payments independent of payments received by Beneficiary/ies under other similar policies.

ii. If two or more policies are taken by an 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 and within 48hrs the hospitals are issued proper communication of the claims settled with respect to every claim made, claims rejected and claims paid by Company.

b) In case a claim is being rejected, information related to query must be sent to hospital within 5 days 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. If any case not rejected within 15 days of receiving the claim it would be considered payable.

d) Where a claim is being investigated by the Company, the process shall be completed within 15 days of receipt of the claim.

e) In both cases i.e. where a claim is being settled or being investigated, the process shall be completed within one month of receipt of the claim by the Company.

f) 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 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.

5. The Company shall not be liable to make any payment under this Policy in respect of any claim:

i. If the cover under the Policy has been obtained by the Beneficiary/ies 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 Beneficiary/ies or by any other person acting on his/her 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 5 days of receiving the claim electronically. The final decision regarding rejection, even if the claim is being investigated shall be taken within 15 days. The Rejection letter shall state the details of the claim summary, rejection reason and details of the Grievance committee Redressal.

If any dispute or difference shall arise as to the quantum of claim amount to be paid by the Company 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.

If the TPA/Company shall disclaim/repudiate liability to the Beneficiary/ies for any claim hereunder and if the Beneficiary/ies 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.

7. All **Medical** and or **Surgical Procedures** under this Policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency.

8. 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.

9. 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.

10. Refund of Premium

a) The Insured will be entitled to a refund of premium if the claim ratio of allotted cluster 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 80% ,then the Company will return the difference between actual claim ratio and 80% to the Insured
c) Claims paid by Company will be verified by SNA for calculation of claim ratio.
d) In case the claim ratio ,as calculated above is higher than 80%, no refund shall be available to the Insurance Company
e) The claims data shall be updated by the Company within 30 days of the submission of claims by the Hospital
f) The refund amount will be returned within 90 days of the end of the Policy period

11. Termination of Policy

The Policy shall not be terminated by the company except on grounds of mis-representation, fraud, non-disclosure of material facts and or non-co-operation of the Beneficiary/ies.

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 RSBY Beneficiary Family Unit covered under the Policy.
In case of termination of cover to any RSBY Beneficiary Family Unit due to mis-representation, fraud, non-disclosure of material facts or non-co-operation of the Beneficiary/ies, the premium pertaining to that RSBY 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 effective date of 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 Insurance Company appointed by the Insured

12. Grievance Redressal

The Greivance Redressal process will be as laid down in the RSBY tender document dated 11th Nov 2016. If the Beneficiary/ies or RSBY Beneficiary Family 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

For The Bajaj Allianz General Insurance Company Limited

Authorised Signatory