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भारतीय गैर न्यायिक

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रु. 100 ONE HUNDRED RUPEES

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भारत INDIA

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प्रशासन दादरा एवं नगर हवेली, संघ शासित प्रदेश
ADMN. OF DADRA & NAGAR HAVELI U.T.

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Silvassa Stamp of ₹ 100 Issued to Shri/Smt Union Territory Health Agency
No 15839 of Silvassa Handed over to
Date 26 SEP 2018

Treasury Officer
DNH-Silvassa

Insurance Contract
For the implementation of
Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (AB-PMJAY)

This Agreement is for the implementation of AB-PMJAY for providing the AB-PMJAY Cover (the **Insurance Contract**) is made at Silvassa on 27/09/2018

BETWEEN

(1) **THE UNION TERRITORY HEALTH AGENCY OF DAMAN AND DIU AND DADRA NAGAR HAVELI, ADMINISTRATION OF DAMAN AND DIU AND DADRA NAGAR HAVELI** represented by the Director, Medical & Health Services, Daman & Diu and Dadra Nagar Haveli and CEO of UTHA, having his principal office at Shri Vinoba Bhave Civil Hospital, Silvassa, Dadra Nagar Haveli hereinafter referred to as the **Union Territory Health Agency (UTHA)** which expression shall, unless repugnant to the context or meaning thereof, be deemed to mean and include its successors and permitted assigns);

AND

(2) **The ORIENTAL INSURANCE COMPANY LIMITED** an insurance company registered with the Insurance Regulatory & Development Authority having registration number and having its registered office at Vadodara (hereinafter referred to as the Insurer, which expression shall, unless repugnant to the context or meaning thereof, be deemed to mean and include its successors and permitted assigns).The UT Health Agency and the Insurer shall collectively be referred to as the Parties and individually as the Party.

Director Medical & Health Services D&NH, SILVASSA

ORIENTAL INSURANCE VALSAD-171600

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WHEREAS

A. The "Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana" (the **AB-PMJAY**), a Government of India scheme, requires to provide health insurance cover to the extent of ₹ 500,000 per annum on a family floater and cashless basis through an established network of health care providers to the AB-PMJAY Beneficiary Family Units (*defined below*).

B. The UT Administration of Daman & Diu and Dadra Nagar Haveli has decided to implement the AB-PMJAY to provide health insurance to defined categories of families that are eligible for the scheme in the UT's of Daman & Diu and Dadra Nagar Haveli.

C. The objective of AB-PMJAY is to reduce catastrophic health expenditure, improve access to quality health care, reduce unmet needs and reduce out of pocket healthcare expenditures of poor and vulnerable families falling under the deprivation criteria of D1, D2, D3, D4, D5 and D7, Automatically Included category and broadly 11 defined occupational un-organised workers (in Urban Sector) of the Socio-Economic Caste Census (SECC) database of the UT along with the Non SECC beneficiary family category added by the UT Administration of Daman & Diu and Dadra Nagar Haveli i.e Resident families whose annual income is below Rs.1 lakhs and All Families whose annual income is above Rs.1 lakhs referred to as AB-PMJAY Beneficiary Family Unit. These eligible AB-PMJAY beneficiary families will be provided coverage for secondary, tertiary and day care procedures (as applicable) for treatment of diseases and medical conditions through a network of Empanelled Health Care Providers (EHCP).

D. On 16.07.2018 the UT Health Agency commenced a bidding process by issuing tender documents (the **Tender Documents**), inviting insurance companies to submit their bids for the Implementation of the AB-PMJAY. Pursuant to the Tender Documents, the bidders submitted their bids on 06.08.2018 for the implementation of the AB-PMJAY.

Director-Medical & Health Services D&NH,SILVASSA

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AB-PMJAY Beneficiary Database refers to all AB-PMJAY Beneficiary Family Units, as defined in Category under the deprivation criteria of D1, D2, D3, D4, D5 and D7, Automatically Included category (viz as Households without shelter, Destitute-living on alms, Manual Scavenger Families, Primitive Tribal Groups and Legally released Bonded Labour) and 11 defined occupational un-organised workers (in Urban Sector) of the Socio-Economic Caste Census (SECC) 2011 database of the UT Administration along with the Non SECC beneficiary family category added by the UT Administration of Daman & Diu and Dadra Nagar Haveli i.e Resident families whose annual income is below Rs.1 lakhs and All Families whose annual income is above Rs.1 lakhs which are resident in the Service Area (UT of Daman & Diu and Dadra Nagar Haveli for which this Tender Document is issued)

AB-PMJAY Guidelines mean the guidelines issued by MoHFW / NHA from time to time for the implementation of the AB-PMJAY, to the extent modified by the Tender Documents pursuant to which the Insurance Contract has been entered into; provided that MoHFW/ NHA or the UT Health Agency may, from time to time, amend or modify the AB-PMJAY Guidelines or issue new AB-PMJAY Guidelines, which shall then be applicable to the Insurer.

Annexure means an annexure to this Insurance Contract

Appellate Authority shall mean the authority designated by the UT Health Agency which has the powers to accept and adjudicate on appeals by the aggrieved party against the decisions of any Grievance Redressal Committee set up pursuant to the Insurance Contract between the UT Health Agency and the Insurer.

Sum Insured shall mean the sum of Rs 5,00,000 per AB-PMJAY Beneficiary Family Unit per annum against which the AB-PMJAY Beneficiary Family Unit may seek benefits as per the benefit package proposed under the AB-PMJAY.

Beneficiary means a member of the AB-PMJAY Beneficiary Family Units who is eligible to avail benefits under the Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana .

Along with the AB-PMJAY beneficiary families, additional beneficiary families added by UT Administration is as below,

1) Resident families whose annual income is below Rs.1 lakhs.
2) All Families whose annual income is above Rs.1 lakhs.

Category 1) and 2) will also be known as Non SECC AB-PMJAY beneficiary families

Beneficiary Family Unit refers to those households (also refered to as families for the purpose of AB-PMJAY) including all its members figuring in the Socio-Economic Caste Census (SECC) database under the deprivation criteria of D1, D2, D3, D4, D5 and D7, Automatically Included category (viz as Households without shelter, Destitute-living on alms, Manual Scavenger Families, Primitive Tribal Groups and Legally released Bonded Labour) and broadly 11 defined occupational un-organised workers (in Urban Sector) of the Socio-Economic Caste Census (SECC) 2011 database of the UT Administration along with the Non SECC beneficiary family category added by the UT Administration of Daman & Diu and Dadra Nagar Haveli i.e Resident families whose annual income is below Rs.1 lakhs and All Families whose annual income is above Rs.1 lakhs referred to as AB-PMJAY Beneficiary Family Unit under the Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana .

Benefit Package refers to the package of benefits that the insured families would receive under the AB-PMJAY.

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E. Following a process of evaluation of financial bids submitted by bidders, the UT Health Agency accepted the Bid of the Insurer for the implementation of the AB-PMJAY. The UT Health Agency issued a notification of award dated 01.09.2018 (the **NOA**) and requested the Insurer to execute this Insurance Contract. The Insurer accepted the NOA on 04.09.2018.

F. The Insurer represents and warrants that it has the experience, capability and know-how required for carrying on health insurance business and has agreed to provide health insurance services and provision of the Risk Cover (*defined below*) to the Beneficiary Family Units (*defined below*) eligible under the AB-PMJAY for the implementation of the AB-PMJAY in all the districts in the UT of Daman & Diu and Dadra Nagar Haveli.

G. Subject to the terms, conditions and exclusions set out in this Insurance Contract and Policy (*defined below*), the Insurer undertakes that if during a Policy Cover Period (*defined below*) of such Policy any Beneficiary (*defined below*) covered by such Policy:

(i) undergoes a Medical Treatment (*defined below*) or Surgical Procedure (*defined below*) requiring Hospitalization (*defined below*) or a Day Care Treatment (*defined below*) or Follow-up Care (*defined below*) to be provided by an Empanelled Health Care Provider (*defined below*)

Then the Insurer shall pay the packages as defined to the Empanelled Health Care Provider in accordance with the terms of this Insurance Contract and such Policy, to the extent of the Sum Insured (*defined below*) under such Policy.

NOW THEREFORE IT IS AGREED AS FOLLOWS:

1. Definitions and Interpretations

Definitions

Unless the context requires otherwise, the following capitalized terms and expressions shall have the following meanings for the purpose of this Insurance Contract:

AB-PMJAY shall refer to Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana managed and administered by the Ministry of Health and Family Welfare, Government of India with the objective of reducing out of pocket healthcare expenses and improving access of validated Beneficiary Family Units to quality inpatient care and day care surgeries (as applicable) for treatment of diseases and medical conditions through a network of Empanelled Health Care Providers.

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Bid refers to the qualification and the financial bids submitted by an eligible Insurance Company pursuant to the release of this Tender Document as per the provisions laid down in this Tender Document and all subsequent submissions made by the Bidder as requested by the UTHA for the purposes of evaluating the bid.

Bidder shall mean any eligible Insurance Company which has submitted its bid in response to this Tender released by the UT Administration of Daman Diu & Dadra Nagar Haveli.

Cashless Access Service means a facility extended by the Insurer to the Beneficiaries where the payments of the expenses that are covered under the Risk Cover are directly made by the Insurer to the Empanelled Health Care Providers in accordance with the terms and conditions of this Insurance Contract, such that none of the Beneficiaries are required to pay any amounts to the Empanelled Health Care Providers in respect of such expenses, either as deposits at the commencement or at the end of the care provided by the Empanelled Health Care Providers.

CHC means a community health centre located at the block level in the UT.

Claim means a claim that is received by the Insurer from an Empanelled Health Care Provider, either online or through alternate mechanism in absence of internet connectivity.

Claim Payment means the payment of eligible Claim received by an Empanelled Health Care Provider from the Insurer in respect of benefits under the Risk Cover made available to a Beneficiary.

Clause means a clause of this Insurance Contract.

Day Care Treatment means any Medical Treatment and/or Surgical Procedure which is undertaken under general anesthesia or local anesthesia at an Empanelled Health Care Provider or Day Care Centre in less than 24 hours due to technological advancements, which would otherwise have required Hospitalization.

Days mean and shall be interpreted as calendar days unless otherwise specified.

Empanelled Health Care Provider means a hospital, a nursing home, a district hospital, a CHC, or any other health care provider, whether public or private, satisfying the minimum criteria for empanelment and that is empanelled by the Insurer in accordance with terms of this Contract for the provision of health services to the Beneficiaries.

Hospital IT Infrastructure means the hardware and software to be installed at the premises of each Empanelled Health Care Provider for the provision of Cashless Access Services, the minimum specifications of which have been set out in the Tender Documents.

Hospitalization means any Medical Treatment or Surgical Procedure which requires the Beneficiary to stay at the premises of an Empanelled Health Care Provider for 24 hours or more including day care treatment as defined above.

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ICU or **Intensive Care Unit** means an identified section, ward or wing of an Empanelled Health Care Provider which is under the constant supervision of dedicated Medical Practitioners and which is specially equipped for the continuous monitoring and treatment of patients who are in critical condition, require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the general ward.

Insurance Contract shall mean this contract between the UT Health Agency and the Insurer for the provision of the benefits under the Risk Cover, to the Beneficiaries and setting out the terms and conditions for the implementation of the AB-PMJAY.

Insurer means the successful bidder which has been selected pursuant to this bidding process and has agreed to the terms and conditions of the Tender Document and has signed the Insurance Contract with the UT Administration of Daman & Diu and Dadra Nagar Haveli.

IRDA means the Insurance Regulatory and Development Authority established under the Insurance Regulatory and Development Authority Act, 1999.

IRDA Solvency Regulations means the IRDA (Assets, Liabilities and Solvency Margin of Insurers) Regulations, 2000, as amended from time to time.

Law means all statutes, enactments, acts of legislature, laws, ordinances, rules, bye laws, regulations, notifications, guidelines, policies, and orders of any statutory authority or judgments of any court of India.

Material Misrepresentation shall mean an act of intentional hiding or fabrication of a material fact which, if known to the other party, could have terminated, or significantly altered the basis of a contract, deal, or transaction.

Medical Practitioner/Officer means a person who holds a valid registration from the medical council of any state/UT of India and is thereby entitled to practice medicine within its jurisdiction, acting within the scope and jurisdiction of his/her license.

Medical Treatment means any medical treatment of an illness, disease or injury, including diagnosis and treatment of symptoms thereof, relief of suffering and prolongation of life, provided by a Medical Practitioner, but that is not a Surgical Procedure. Medical Treatments include but not limited to: bacterial meningitis, bronchitis-bacterial/viral, chicken pox, dengue fever, diphtheria, dysentery, epilepsy, filariasis, food poisoning, hepatitis, malaria, measles, meningitis, plague, pneumonia, septicaemia, tuberculosis (extra pulmonary, pulmonary etc.), tetanus, typhoid, viral fever, urinary tract infection, lower respiratory tract infection and other such diseases requiring Hospitalization.

MoHFW shall mean the Ministry of Health and Family Welfare, Government of India.

NHA shall mean the National Health Agency set up the Ministry of Health and Family Welfare, Government of India with the primary objective of coordinating the implementation, operation and management of AB-PMJAY. It will also foster co-ordination and convergence with other similar schemes being implemented by the Government of India and State Governments/ UT Administration.

Package Rate means the fixed maximum charges for a Medical Treatment or Surgical Procedure or for any Follow-up Care that will be paid by the Insurer under Cover, which shall be determined in accordance with the rates provided in this Contract.

Party means either the Insurer or the UT Health Agency and **Parties** means both the Insurer and the UT Health Agency.

Policy Cover Period shall mean the standard period of 12 calendar months from the date of start of the Policy Cover or lesser period as stipulated by UTHA from time to time, unless cancelled earlier in accordance with this Insurance Contract.

Premium means the aggregate sum agreed by the Parties as the annual premium to be paid by the UT Health Agency to the Insurer for each Beneficiary Family Unit that is eligible for the scheme, as consideration for providing the Cover to such Beneficiary Family Unit under this Insurance Contract.

Risk Cover shall mean an annual risk cover of Rs. 5,00,000 covering inpatient care and day care surgeries (as applicable) for treatment of diseases and medical conditions through a network of Empanelled Health Care Providers (EHCP) for the eligible AB-PMJAY Beneficiary Family Units.

Risk Premium means the sum agreed by the Parties as the annual premium to be paid by the UT Health Agency to the Insurer for each Beneficiary Family Unit that is covered by the Insurer, as consideration for providing the Risk Cover to such Beneficiary Family Unit under this Insurance Contract and the Policy.

Schedule means a schedule of this Insurance Contract.

Scheme shall mean the Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana managed and administered by the UT Administration of Daman & Diu and Dadra Nagar Haveli

Selected Bidder shall mean the successful bidder which has been selected in the bid exercise and has agreed to the terms and conditions of the Tender Document and has signed the Insurance Contract with the UT Administration of Daman & Diu and Dadra Nagar Haveli.

Service Area refers to the entire UT of Daman & Diu and Dadra Nagar Haveli.
covered and included under this Contract for the implementation of AB-PMJAY.

Union Territory Health Agency (UTHA) refers to the agency/ body set up by the Department of Health and Family Welfare, UT Administration of Daman & Diu and Dadra Nagar Haveli for the purpose of coordinating and implementing the Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana in the UT Administration of Daman & Diu and Dadra Nagar Haveli.

Successful Bidder shall mean the bidder whose bid document is responsive, which has been pre-qualified and whose financial bid is the lowest among all the shortlisted and with whom the UT Administration intends to select and sign the Insurance Contract for this Scheme.

Sum Insured in respect of each Beneficiary Family Unit enrolled under a Policy, means at any time, the Insurer's maximum liability for any and all Claims made on behalf of such Beneficiary Family Unit during the Policy Cover Period against the Risk Cover.

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UT Administration refers to the Administration of Union Territories of Daman & Diu and Dadra Nagar Haveli in which the tender is issued.

Tender Documents refers to this Tender Document including Volume I "Instruction to Bidders", Volume II "About AB-PMJAY" and Volume III " Insurance Contract to be signed by the Insurance Company" including all amendments, modifications issued by the UTHA in writing pursuant to the release of the Tender Document.

Treatment (medically necessary) means any Medical Treatment, Surgical Procedure, Day Care Treatment or Follow-up Care, which:

(i) is required for the medical management of the illness, disease or injury suffered by the Beneficiary;
(ii) does not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;
(iii) has been prescribed by a Medical Practitioner; and
(iv) Conforms to the professional standards widely accepted in international medical practice or by the medical community in India.

Turn-around Time means the time taken by the Insurer in processing a Claim received from an Empanelled Health Care Provider and in making a Claim Payment including investigating such Claim or rejection of the such Claim.

Interpretation

a. Any grammatical form of a defined term herein shall have the same meaning as that of such term.

b. Any reference to an agreement, contract, instrument or other document (including a reference to this Insurance Contract) herein shall be to such agreement, instrument or other document as amended, varied, supplemented, modified or suspended at the time of such reference.

c. Any reference to an "agreement" includes any undertaking, deed, agreement and legally enforceable arrangement, whether or not in writing, and a reference to a document includes an agreement (so defined) in writing and any certificate, notice, instrument and document of any kind.

d. Any reference to a statutory provision shall include such provision as modified or re-enacted or consolidated from time to time.

e. Terms and expressions denoting the singular shall include the plural and vice versa.

f. Any reference to "persons" denotes natural persons, partnerships, firms, companies, corporations, joint ventures, trusts, associations, organizations or other entities (in each case, whether or not incorporated and whether or not having a separate legal entity).

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g. The term "including" shall always mean "including, without limitation", for the purposes of this Insurance Contract.

h. The terms "herein", "hereof", "hereinafter", "hereto", "hereunder" and words of similar import refer to this Tender as a whole.

i. Headings are used for convenience only and shall not affect the interpretation of this Insurance Contract.

j. The Schedules and Annexure to this Insurance Contract form an integral part of this Insurance Contract and will be in full force and effect as though they were expressly set out in the body of this Insurance Contract.

k. References to Recitals, Clauses, Schedules or Annexure in this Insurance Contract shall, except where the context otherwise requires, be deemed to be references to Recitals, Clauses, Schedules and Annexure of or to this Insurance Contract.

l. References to any date or time of day are to Indian Standard Time.

m. Any reference to day shall mean a reference to a calendar day.

n. Any reference to a month shall mean a reference to a calendar month.

o. Any reference to any period commencing from a specified day or date and till or until a specified day or date shall include both such days and dates.

p. Any agreement, consent, approval, authorization, notice, communication, information or report required under or pursuant to this Insurance Contract from or by any Party shall be valid and effectual only if it is in writing under the hands of a duly authorized representative of such Party.

q. The provisions of the Clauses, the Schedules and the Annexure of this Insurance Contract shall be interpreted in such a manner that will ensure that there is no inconsistency in interpretation between the intent expressed in the Clauses, the Schedules and the Annexure. In the event of any inconsistency between the Clauses, the Schedules and the Annexure, the Clauses shall prevail over the Schedules and the Annexure.

r. The Parties agree that in the event of any ambiguity, discrepancy or contradiction between the terms of this Insurance Contract and the terms of any Policy issued by the Insurer, the terms of this Insurance Contract shall prevail, notwithstanding that such Policy is issued by the Insurer at a later point in time.

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s. The rule of construction, if any, that an agreement should be interpreted against the Party responsible for the drafting and preparation thereof shall not apply to this Insurance Contract.

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PART I

TERMS AND CONDITIONS OF INSURANCE

2. AB-PMJAY Beneficiaries and Beneficiary Family Unit

a. The Parties agree that for the purpose of this Insurance Contract and any Policy issued pursuant to this Insurance Contract, all the persons that are eligible for the scheme as per SECC data and in the Service Area shall be eligible to become Beneficiaries,

b. All AB-PMJAY Beneficiary Family Units, as defined under the deprivation criteria of D1, D2, D3, D4, D5 and D7, Automatically Included category (in rural areas) and broadly defined occupational un-organised workers (in Urban Sector) of the Socio-Economic Caste Census (SECC) database of the UT Administration along with the Non SECC beneficiary family category added by the UT Administration of Daman & Diu and Dadra Nagar Haveli i.e Resident families whose annual income is below Rs.1 lakhs and All Families whose annual income is above Rs.1 lakhs (as updated from time to time) which are resident in the Service Area (UT of Daman & Diu and Dadra Nagar Haveli for which this Tender Document is issued) fall under one or more of the categories further detailed in **Schedule 1** of this Document shall be considered as eligible for benefits under the Scheme and be automatically covered under the Scheme.

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

d. Unit of coverage under the Scheme shall be a family and each family for this Scheme shall be called a AB-PMJAY Beneficiary Family Unit, which will comprise all members in that family. Any addition in the family will be allowed only as per the provisions approved by the Government.

e. The presence of name in the beneficiary list shall be the proof of eligibility of the Beneficiary Family Unit for the purpose of availing benefits under this Insurance Contract and a Policy issued pursuant to this Insurance Contract.

3. Risk Covers and Sum Insured

Risk Cover and Sum Insured

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

a. **Risk Cover (RC)** will include hospitalization / treatment expenses coverage including treatment for medical conditions and diseases requiring secondary and tertiary level of medical and surgical care treatment and also including defined day care procedures (as applicable) and follow up care along with cost for pre and post-hospitalisation treatment as defined.

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b. As on the date of commencement of the Policy Cover Period, the AB-PMJAY Sum Insured in respect of the Risk Cover for each AB-PMJAY Beneficiary Family Unit shall be **Rs. 5,00,000 (Rupees Five Lakh Only)** per family per annum on family floater basis. This shall be called the **Sum Insured**, which shall be fixed irrespective of the size of the AB-PMJAY Beneficiary Family Unit.

c. The Insurer shall ensure that the Scheme's RC shall be provided to each AB-PMJAY Beneficiary Family Unit on a family floater basis covering all the members of the AB-PMJAY Beneficiary Family Unit including Senior Citizens, i.e., the Sum Insured shall be available to any or all members of such Beneficiary Family Unit for one or more Claims during each Policy Cover Period. New family members may be added after due approval process as defined by the UT Administration.

d. Pre-existing conditions/diseases are to be covered from the first day of the start of policy, subject to the exclusions given in **Schedule 2**.

e. Coverage of health services related to surgical nature for defined procedures shall also be provided on a day care basis. The Insurance Company shall provide coverage for the defined day care treatments, procedures and medical treatments as given in **Schedule 3**.

f. Pre and Post Hospitalisation expenses: Expenses incurred for consultation, diagnostic tests and medicines before the admission of the patient in the same hospital and cost of diagnostic tests and medicines and up to 15 days of the discharge from the hospital for the same ailment/ surgery.

Benefit Package: AB-PMJAY Cover

a. The benefits within this Scheme under the Risk Cover are to be provided on a cashless basis to the AB-PMJAY Beneficiaries up to the limit of their annual coverage and includes:

   (i) Hospitalization expense benefits
   (ii) Day care treatment benefits (as applicable)
   (iii) Follow-up care benefits
   (iv) Pre and post hospitalization expense benefits
   (v) New born child/ children benefits

b. The details of benefit package including list of exclusions are furnished in **Schedule 2: 'Exclusions to the Policy' and Schedule 3: 'Packages and Rates'**.

c. For availing select treatment in any empanelled hospitals, preauthorisation is required to be taken for defined cases.

d. Except for exclusions listed in **Schedule 2**, services for any other surgical treatment services will also be allowed, in addition to the procedures listed in **Schedule 3**, of upto a limit of Rs. 1,00,000 to any AB-PMJAY Beneficiary, provided the services are within the sum insured available and pre-authorisation has been provided by the insurance company.

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e. The Insurer shall reimburse claims of public and private health care providers under the AB-PMJAY based on Package Rates determined as follows:
   (i) If the package rate for a medical treatment or surgical procedure requiring Hospitalization or Day Care Treatment (as applicable) is fixed in **Schedule 3**, then the Package Rate so fixed shall apply for the Policy Cover Period.
   (ii) If the package rate for a surgical procedure requiring Hospitalization or Day Care Treatment (as applicable) is not listed in **Schedule 3**, then the Insurer may pre-authorise an appropriate amount or the flat daily package rates for medical packages specified in **Schedule 3** shall apply.
   (iii) If the treatment cost is more than the benefit coverage amount available with the beneficiary families then the remaining treatment cost will be borne by the AB-PMJAY Beneficiary family as per the package rates defined in this document. Beneficiary will need to be clearly communicated in advance about the additional payment.
   (iv) The follow up care prescription for identified packages are set out in **Schedule 3**.
   (v) In case of AB-PMJAY Beneficiary is required to undertake multiple surgical treatment, then the highest package rate shall be taken at 100%, thereupon the 2nd treatment package shall taken as 50% of package rate and 3rd treatment package shall be at 25% of the package rate.
   (vi) Surgical and Medical packages will not be allowed to be availed at the same time.
   (vii) Certain packages as mentioned in **Schedule 3** will only be reserved for Public EHCPs as decided by the UTHA. They can be availed in Private EHCPs only after a referral from a Public EHCP is made.
   (viii) Certain packages as indicated in **Schedule 3** have differential pricing. Hospitals having entry level of NABH certification, located in the aspirational distrits as identified by NITI Aayog and running PG/ DNB course will be provided 10% higher package rates in each of the cases. Hospitals with full NABH accreditation shall be provided 15% higher package rates.

f. For the purpose of Hospitalization expenses as package rates shall include all the costs associated with the treatment, amongst other things:
   (i) Registration charges.
   (ii) Bed charges (General Ward).
   (iii) Nursing and boarding charges.
   (iv) Surgeons, Anaesthetists, Medical Practitioner, Consultants fees etc.
   (v) Anaesthesia, Blood Transfusion, Oxygen, O.T. Charges, Cost of Surgical Appliances etc.
   (vi) Medicines and drugs.
   (vii) Cost of prosthetic devices, implants etc.
   (viii) Pathology and radiology tests: radiology to include but not be limited to X-ray, MRI, CT Scan, etc.
   (ix) Diagnosis and Tests, etc
   (x) Food to patient.
   (xi) Pre and Post Hospitalisation expenses: Expenses incurred for consultation, diagnostic tests and medicines before the admission of the patient in the same

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hospital and cost of diagnostic tests and medicines and up to 15 days of the discharge from the hospital for the same ailment/ surgery.

(xii) Any other expenses related to the treatment of the patient in the hospital.

g. For the purpose of Day Care Treatment expenses shall include, amongst other things:
   (i) Registration charges;
   (ii) Surgeons, anaesthetists, Medical Practitioners, consultants fees, etc.;
   (iii) Anaesthesia, blood transfusion, oxygen, operation theatre charges, cost of surgical appliances, etc.;
   (iv) Medicines and drugs;
   (v) Cost of prosthetic devices, implants, organs, etc.
   (vi) Screening, including X-Ray and other diagnostic tests, etc.; and
   (vii) Any other expenses related to the Day Care Treatment provided to the Beneficiary by an Empanelled Health Care Provider.

h. Either Party may suggest the inclusion of additional Package for determination of rates following due diligence and procedures and based on the incidence of diseases or reported medical conditions and other relevant data. The Parties shall then agree on the package rates for such medical treatments or surgical procedures, as the case may be; but the decision of the UTHA in this regard shall be final and binding on the Insurer. The agreed package rates shall be deemed to have been included in **Schedule 3** with effect from the date on which the Parties have mutually agreed to the new package rates in writing.

i. The UTHA and Insurer shall publish the Package Rates on its website in advance of each Policy Cover Period.

j. As part of the regular review process, the Parties (the Insurer and EHCP) shall review information on incidence of common medical treatments or surgical procedures that are not listed in **Schedule 3** and that require hospitalization or day care treatments (as applicable).

k. No claim processing of package rate for a medical treatment or surgical procedure or day care treatment (as applicable) that is determined or revised shall exceed the sum total of Risk Cover for a AB-PMJAY Beneficiary Family Unit.

However, in case at the admission package rates for some medical treatment or surgical procedures may exceed the available Sum Insured, it would enable AB-PMJAY beneficiaries to avail treatment of such medical conditions or surgical procedures on their own cost / expenses at the package rate rather than on an open-ended or fee for service basis.

3.3 Benefits Available only through Empanelled Health Care Providers

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a. The benefits under the AB-PMJAY Risk Cover shall only be available to a AB-PMJAY Beneficiary through an EHCP after Aadhaar based identification as far as possible. In case Aadhaar is not available then other defined Government recognised ID will be used for this purpose. UT Administration shall share with the insurance company within 7 days of signing the agreement a list of defined Government IDs.

b. The benefits under the AB-PMJAY Cover shall, subject to the available AB-PMJAY Sum Insured, be available to the AB-PMJAY Beneficiary on a cashless basis at any EHCP.

c. Specialized tertiary level services shall be available and offered only by the EHCP empanelled for that particular service. Not all EHCPs can offer all tertiary level services, unless they are specifically designated by the UTHA for offering such tertiary level services.

4. Identification of AB-PMJAY Beneficiary Family Units

a. Identification of AB-PMJAY Beneficiary Family Units will be based on the deprivation criteria of D1, D2, D3, D4, D5 and D7, Automatically Included category and 11 broadly defined occupational un-organised workers (in Urban Sector) of the Socio-Economic Caste Census (SECC) database of the UT Administration along with the Non SECC beneficiary family category added by the UT Administration of Daman & Diu and Dadra Nagar Haveli i.e Resident families whose annual income is below Rs.1 lakhs and All Families whose annual income is above Rs.1 lakhs.

b. The beneficiaries will be identified using Aadhaar and/or Ration Card and / or any other specified identification document produced by the beneficiary at the point of contact. Once successfully identified, the beneficiary will be provided with a print of AB-PMJAY e-card which can be used as reference while availing benefits.

c. Detailed guidelines for beneficiary identification are provided at **Schedule 4**.

d. Enrollment of Non SECC Family Units:

i) Enrolment procedure:
The enrolment of the Non SECC beneficiary family of the UT Administration of Daman & Diu and Dadra Nagar Haveli as mentioned below,
   a) Resident families whose annual income is below 1 lakh
   b) All families whose annual income is above 1 lakh

The enrollment will be undertaken by the Insurance Company selected and approved by the UT Administration. The Insurer shall enroll beneficiaries and issue e cards. The process of enrolment is as per **Schedule 18.**

ii) Period of Enrolment:
The Period of Enrolment of Non SECC Families will be one year in both the UT's of Daman & Diu and Dadra Nagar Haveli. From the date of start of enrolment up to two months the premium would be charged as full and for the rest of the period it will be charged on pro rata basis.

iii) Enrolment Criteria :
The following documents would be required for enrolment of this scheme:

a) For resident families whose annual income is below 1 lakh –
Income Certificate issued by respective Mamlatdar (not more than 1 year old), Resident certificate/Proof any other 32 listed resident proof, Aadhaar Card (Optional)

b) For All families whose annual income is above 1 lakh –
Premium payment receipt given by insurer, Resident proof (any of the 32 listed resident proof) and Aadhaar Card (Optional).
The list of resident proof are provided in **Schedule 19.**

5. Empanelment of Health Care Providers

a. All public hospitals with inpatient facilities (Community Health Centre and above) shall deemed to be empanelled.

b. Private healthcare providers (both for profit and not for profit) which provide hospitalization and/or day care services (as applicable) would be eligible for empanelment under AB-PMJAY, subject to their meeting of certain requirements (empanelment criteria) in the areas of infrastructure, manpower, equipment (IT, help desk etc.) and services (for e.g. liaison officers to facilitate beneficiary management) offered, which can be seen at **Schedule 5** of this document.

c. At the time of empanelment, those Hospitals that have the capacity and which fulfill the minimum criteria for offering tertiary treatment services as prescribed by the UTHA would be specifically designated for providing such tertiary care packages.

d. The UTHA shall be responsible for empanelment and periodic renewal of empanelment of health care providers for offering services under the AB-PMJAY. The UTHA may undertake this function either directly or through the selected Insurance Company. However, the final decision regarding empanelment of hospital will rest with UTHA.

e. Under circumstances of any dispute, final decision related to empanelment of health care providers shall vest exclusively with the UTHA.

f. Detailed guidelines regarding empanelment of health care providers are provided at **Schedule 5**.

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6. Agreement with Empanelled Health Care Providers

a. Once a health care provider is found to be eligible for empanelment, the UTHA and the selected Insurance Company shall enter into a Provider Service Agreement with such health care provider substantially in the form to be provided for the medical treatments, surgical procedures, day care treatments (as applicable), and follow-up care for which such health care provider meets the infrastructure and personnel requirements.

b. This Provider Service Agreement shall be a tripartite agreement where the Insurer shall be the third party. Format for this Agreement is provided at **Schedule 6**.

c. The Agreement of an EHCP shall continue for a **period of at least 3 years** from the date of the execution of the Provider Services Agreement, unless the EHCP is de-empanelled in accordance with the **AB-PMJAY guidelines** and its agreement terminated in accordance with its terms.

d. The Insurer agrees that neither it nor its outsourced agency will enter into any understanding with the EHCP that are in contradiction to or that deviates from or breaches the terms of the Insurance Contract between the UTHA and the Insurer or tripartite Provider Service Agreement with the EHCP.

e. If the Insurer or its outsource agency or any if its representatives violates the provisions of **Clause 6.d.** above, it shall be deemed as a material breach and the UTHA shall have the right to initiate appropriate action against the Insurer or the EHCP or both.

f. As a part of the Agreement, the Insurer shall ensure that each EHCP has within its premises the required IT infrastructure (hardware and software) as per the AB-PMJAY guidelines. All Private EHCPs shall be responsible for all costs related to hardware and maintenance of the IT infrastructure. For all Public EHCPs the costs related to hardware and maintenance of the IT infrastructure shall be borne by the Insurance Company. The EHCPS may take Insurance Company's support may be sought for procurement of such hardware by the EHCPs, however the ownership of all such assets, hardware and software along with its licenses, shall irrevocably vest with the EHCP.

7. De-empanelment of Health Care Providers

a. The UTHA, either on its own or through Insurance Company, shall suspend or de-empanel an EHCP from the AB-PMJAY, as per the guidelines mentioned in **Schedule 5**

b. Notwithstanding a suspension or de-empanelment of an EHCP, the Insurer shall ensure that it shall honour all Claims for any expenses that have been pre-authorised or are legitimately due before the effectiveness of such suspension or de-empanelment as if such de-empanelled EHCP continues to be an EHCP.

8. Issuance of Policies

a. For the purpose of issuance of a policy, all eligible beneficiary family units in the entire UT of Daman & Diu and Dadra Nagar Haveli shall be covered under one policy. The Insurer shall issue a Policy before the commencement of the Policy Cover Period for such State.

b. The first Policy Cover Period under the Policy for a UT shall commence from the date 27/09/2018.

c. The terms and conditions set out in each Policy issued by the Insurer to the State Health Agency shall at a minimum include:

i. the Policy number;
ii. the Policy Cover Period under such Policy; and
iii. The terms and conditions for providing the Covers, which shall not deviate from or dilute in any manner the terms and conditions of insurance set out in this Insurance Contract.

d. Notwithstanding any delay by the Insurer in issuing or failure by the Insurer to issue a Policy for a UT in accordance with **Clause 8(a),** the Insurer agrees that the Policy Cover Period for the UT shall commence on the date determined and that it shall provide the eligible Beneficiaries in the UT with the Risk Cover from that date onwards.

e. In the event of any discrepancy, ambiguity or contradiction between the terms and conditions set out in the Insurance Contract and a Policy issued for a State/UT by the Insurer, the terms of the Insurance Contract shall prevail for the purpose of determining the Insurer's obligations and liabilities to the UTHA and the AB-PMJAY Beneficiaries

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9. Period of Insurance Contract and Policy

9.1 Term of the Insurance Contract with the Insurer

a. This Insurance Contract shall be for a period of maximum 1 year with starting date 28/09/2018

9.2 Policy Cover Period

In respect of each policy, the Policy Cover Period shall be for a period of 12 months from the date of commencement of such Policy Cover Period starting at 0000 hours on 28/09/2018, until 2359 hours on the date of expiration 27/09/2019. Provided that upon early termination of this Insurance Contract, the Policy Cover Period for the UT's of Daman & Diu and Dadra Nagar Haveli shall terminate on the date of such termination, wherein the premium shall be paid on pro-rata basis after due adjustment of any recoveries on account of termination.

For the avoidance of doubt, the expiration of the risk cover for any Beneficiary Family Unit in the UT of Daman & Diu and Dadra Nagar Haveli during the Policy Cover Period shall not result in the termination of the Policy Cover Period for the UT of Daman & Diu and Dadra Nagar Haveli.

9.3 Policy Cover Period for the AB-PMJAY Beneficiary Family Unit :-

a. During the first Policy Cover Period for a the UT of Daman & Diu and Dadra Nagar Haveli, the policy cover shall commence
From 0000 hours on the date indicated by the UTHA.
b. The end date of the policy cover for the UT of Daman & Diu and Dadra Nagar Haveli be 12 months from the date of start of the Policy Cover or the date on which the available Sum Insured in respect of that Cover becomes zero.
c. Policy Cover period for Non-SECC Families of UTs fo Daman & Diu & Dadra & Nagar Haveli.
    1. Resident families whose annual income is below Rs.1 lakhs. – The premium will be paid by respective UT Administration of Daman & Diu and Dadra Nagar Haveli. The policy cover shall commence from the same day of enrollment. In case of pro rata the calculation will be according to the period in balance.
    2. All Families whose annual income is above Rs.1 lakhs - The premium will be paid by the beneficiary family themselves one time and those registering after 2 months the rate should be calculated on pro rata basis. The policy cover shall commence from the same day of enrollment.

a. 9.4 Cancellation of Policy Cover

Upon early termination of the Insurance Contract between the UTHA and the Insurer, all Policies issued by the Insurer pursuant to the Insurance Contract shall be deemed cancelled with effect from the Termination Date subject to the Insurer fulfilling all its obligations at the time of Termination as per the provisions of the Insurance Contract.

For implications and protocols related to early termination, refer to **Clause 29**.

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3. Premium and Premium Payment

10.1 Payment of Premium

a. The payment of the premium to the insurance company by the UTHA will be done as per the following schedule:

No.	Central & State /UT Premium Split Ratio	Instalment 1 (On or before the commencement of the Policy Cover Period)	Instalment 2 (After completion of 2nd Quarter of the Policy Cover Period	Instalment 3 (After completion of 10 months of the Policy Cover Period
i.	**For SECC families**	45% of (Central Government Share)	45% of (Central Government Share)	10% of (Central Government Share)
ii	**For Non SECC Families of UT's**			
a	Resident families having annual income below 1 lakh	45% on receipt of invoice post enrollment	45% on receipt of invoice post completion of 2nd Quarter.	10% on completion of 3rd Quarter.
b	Resident families having annual income above 1 lakh	100% premium to be collected by the insurance company at the time of enrollment itself.		

I) Resident families whose annual income is below Rs.1 lakhs. – The premium will be paid by respective UT Administration of Daman & Diu and Dadra Nagar Haveli. The policy cover shall commence from the same day of enrollment.
In case of pro rata the calculation will be according to the period in balance.

II) All Families whose annual income is above Rs.1 lakhs - The premium will be paid by the beneficiary family themselves one time and those registering after 2 months the rate should be calculated on pro rata basis. The policy cover shall commence from the same day of enrollment.

b. The UTHA shall make the payment to the respective Insurance Companies through an Escrow Account.

c. Detailed premium payment guidelines of SECC families are provided at **Schedule 8.**
d. Detailed premium payment guidelines of non SECC families are provided at **Schedule 8.**

10.2 Refund of Premium and Payment of Additional Premium at the end of contract period

a. The UTHA shall issue a letter to the Insurer stating the Insurer's average Claim Ratio for all 12 months of Policy Cover Period for the UT. In the letter, the UTHA shall indicate the amount of premium that the Insurer shall be obliged to return. The amount of premium to be refunded shall be calculated based on the provisions of **Clause 10.2.b**.

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b. After adjusting a defined percent for expenses of management (including all costs excluding only service tax and any cess, if applicable) and after settling all claims, if there is surplus: 100 percent of leftover surplus should be refunded by the Insurer to the UTHA within 30 days. The percentage that will be need to be refunded will be as per the following:
    i. Administrative cost allowed 10% if claim ratio less than 60%.
    ii. Administrative cost allowed 15% if claim ratio between 60-70%.
    iii. Administrative cost allowed 20% if claim ratio between 70-80%.

c. All the surplus as determined through formula mentioned above should be refunded by the insurer to the UTHA within 30 days.

d. If the Insurer delays payment of or fails to pay the refund amount within 60 days of the date of expiration of the Policy Cover Period, then the Insurer shall be liable to pay interest at the rate of one percent of the refund amount due and payable to the UTHA for every 7 days of delay beyond such 60 day period.

e. If the Insurer fails to refund the Premium within such 90-day period and/ or the default interest thereon, the UTHA shall be entitled to recover such amount as a debt due from the Insurer through means available within law.

f. The UTHA is under no obligation to pay any further premium to the Insurer if claim ratio of the Insurer is up to 120 percent.

g. If the Insurer's average Claim Ratio for the full 12 months is in excess of 120 percent then the UTHA will be liable to pay 50% of additional claim cost in excess of the total Premium already paid by it and remaining 50% shall be borne by the insurance company. The total premium, including this additional claim cost, shall be borne by UTHA only till the ceiling limit of premium set under AB-PMJAY for Central and UT Administration's share. After the ceiling is reached claims cost will need to be borne entirely by the Insurer.

10.3 Taxes

The Insurer shall protect, indemnify and hold harmless the UT Health Agency, from any and all claims or liability to:

a. pay any service tax assessed or levied by any competent tax authority on the Insurer or on the Union Territory Health Agency for or on account of any act or omission on the part of Insurer; or

b. on account of the Insurer's failure to file tax returns as required by applicable Laws or comply with reporting or filing requirements under applicable Laws relating to service tax; or

c. arising directly or indirectly from or incurred by reason of any misrepresentation by or on behalf of the Insurer to any competent tax authority in respect of the service tax.

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10.4 Premium All Inclusive

Except as expressly permitted, the Insurer shall have no right to claim any additional amount from the Union Territory Health Agency in respect of:

a. the risk cover provided to each eligible Beneficiary Family Unit; or

b. the performance of any of its obligations under this Insurance Contract; or

c. Any costs or expenses that it incurs in respect thereof.

10.5 No Separate Fees, Charges or Premium

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

10.6 Approval of Premium and Terms and Conditions of Cover by IRDA

a. The Insurer shall, if required by the Health Insurance Regulations, obtain IRDA's approval for the Premium and the terms and conditions of the Covers provided under this Insurance Contract under the File & Use Procedure prescribed in the Health Insurance Regulations, within 75 days of the date of execution of this Insurance Contract.

b. The Insurer undertakes and agrees that it shall not:

(i) file an application with the IRDA for approval of the revision, modification or amendment of the Premium for or the terms and conditions of or for the withdrawal of any or all of the Covers; or

(ii) Revise, modify, amend or withdraw any or all of the Covers, whether with or without the IRDA's approval under the Health Insurance Regulations, at any time during the Term of this Insurance Contract.

(iii) The Insurer hereby irrevocably waives its right to seek the IRDA's approval for the revision, modification, amendment or withdrawal of any or all of the Covers under this Insurance Contract by filing an application under the File & Use Procedure.

4. Cashless Access of Services

a. The AB-PMJAY beneficiaries shall be provided treatment free of cost for all such ailments covered under the Scheme within the limits/ sub-limits and sum insured, i.e., not specifically excluded under the Scheme.

b. The insurer shall reimburse EHCP as per the package cost specified in this Document agreed for specified packages or as pre-authorised amount in case of unspecified packages.

c. The Insurer shall ensure that each EHCP shall at a minimum possess the Hospital IT Infrastructure required to access the AB-PMJAY Beneficiary Database and undertake verification based on the Beneficiary Identification process laid out, using unique AB-PMJAY Family ID on the AB-PMJAY Card and also ascertain the balance available under the AB-PMJAY Cover provided by the Insurer.

d. The Insurer shall provide each EHCP with an operating manual describing in detail the verification, pre-authorisation and claims procedures within 7 days of signing of agreement.

e. The Insurer shall train Ayushman Mitras that will be deputed in each EHCP (at the cost of the EHCP) that will be responsible for the administration of the AB-PMJAY on the use of the Hospital IT infrastructure for making Claims electronically and providing Cashless Access Services.

f. The EHCP shall establish the identity of the member of a AB-PMJAY Beneficiary Family Unit by Aadhaar Based Identification System (No person shall be denied the benefit in the absence of Aadhaar Card through use of alternate Government ID) and ensure:
   (i) That the patient is admitted for a covered procedure and package for such an intervention is available.
   (ii) AB-PMJAY Beneficiary has balance in her/ his AB-PMJAY Cover amount.
   (iii) Provisional entry shall be made on the server using the AB-PMJAY ID of the patient. It has to be ensured that no procedure is carried out unless provisional entry is completed through blocking of claim amount.
   (iv) At the time of discharge, the final entry shall be made on the patient account after completion of Aadhaar Card Identification Systems verification or any other recognised system of identification adopted by the UTHA of AB-PMJAY Beneficairy Family Unit to complete the transaction.

5. Pre-authorisation of Procedures

a. All procedures in **Schedule 3** that are earmarked for pre-authorisation shall be subject to mandatory pre-authorisation. In addition, in case of Inter-State portability, all procedures shall be subject to mandatory pre-authorisation irrespective of the pre-authorisation status in **Schedule 3.**

b. Insurer will not allow any EHCP shall, under any circumstances whatsoever, to undertake any such earmarked procedure without pre-authorisation unless under

Emergency. Process for emergency approval will be followed as per guidelines laid down under AB-PMJAY

c. Request for hospitalization shall be forwarded by the EHCP after obtaining due details from the treating doctor, i.e. "request for authorisation letter" (RAL). The RAL needs to be submitted online through the Scheme portal and in the event of any IT related problem on the portal, then through email or fax. The medical team of Insurer would get in touch with the treating doctor, if necessary.

d. The RAL should reach the authorisation department of the Insurer within 6 hours of admission in case of emergency.

e. In cases of failure to comply with the timelines stated in above **Clause 12.d**, the EHCP shall forward the clarification for delay with the request for authorisation.

f. The Insurer shall ensure that in all cases pre-authorisation request related decisions are communicated to the EHCP within 12 hours for all normal cases and within 1 hours for emergencies. If there is no response from the Insurer within 12 hours of an EHCP filing the pre-authorisation request, the request of the EHCP shall be deemed to be automatically authorised.

g. The Insurer shall not be liable to honour any claims from the EHCP for procedures featuring in **Schedule 3**, for which the EHCP does not have a pre-authorisation, if prescribed.

h. Reimbursement of all claims for procedures listed under **Schedule 3** shall be as per the limits prescribed for each such procedure unless stated otherwise in the pre-authorisation letter/communication.

i. The RAL form should be dully filled with clearly mentioned Yes or No. There should be no nil, or blanks, which will help in providing the outcome at the earliest.

j. The Insurer guarantees payment only after receipt of RAL and the necessary medical details. And only after the Insurer has ascertained and negotiated the package with the EHCP, shall issue the Authorisation Letter (AL). This shall be completed within 24 hours of receiving the RAL.

k. In case the ailment is not covered or the medical data provided is not sufficient for the medical team of the authorisation department to confirm the eligibility, the Insurer can deny the authorisation or seek further clarification/ information.

l. The Insurer needs to file a report to the UTHA explaining reasons for denial of every such pre-authorisation request.

m. Denial of authorisation (DAL)/ guarantee of payment are by no means denial of treatment by the EHCP. The EHCP shall deal with such case as per their normal rules and regulations.

n. Authorisation letter (AL) will mention the authorisation number and the amount authorized as a package rate for such procedure for which package has not been fixed earlier. The EHCP must see that these rules are strictly followed.

o. The authorisation is given only for the necessary treatment cost of the ailment covered and mentioned in the RAL for hospitalization.

p. The entry on the AB-PMJAY portal for claim amount blocking as well at discharge would record the authorisation number as well as package amount agreed upon by the EHCP and the Insurer.

q. In case the balance sum available is less than the specified amount for the Package, the EHCP should follow its norms of deposit/running bills etc. However, the EHCP shall only charge the balance amount against the package from the AB-PMJAY beneficiary. The Insurer upon receipt of the bills and documents would release the authorized amount.

r. The Insurer will not be liable for payments in case the information provided in the RAL and subsequent documents during the course of authorisation is found to be incorrect or not fully disclosed.

s. In cases where the AB-PMJAY beneficiary is admitted in the EHCP during the current Policy Cover Period but is discharged after the end of the Policy Cover Period, the claim has to be paid by the Insurer from the Policy which was operating during the period in which the AB-PMJAY beneficiary was admitted.

t. Detailed guidelines for hospitals transactions including pre-authorisation is provided at **Schedule 15.**

6. Portability of Benefits

a. The benefits of AB-PMJAY will be portable across the country and a beneficiary covered under the scheme will be able to get benefits under the scheme across the country at any EHCP.

b. Package rates of the hospital where benefits are being provided will be applicable while payment will be done by the insurance company that is covering the beneficiary under its policy.

c. The Insurer is required to honour claims from any empanelled hospital under the scheme within India and will settle claims within 30 days of receiving them.

d. To ensure true portability of AB-PMJAY, UT Administration shall enter into arrangement with ALL other States/UT's that are implementing AB-PMJAY for allowing sharing of network hospitals, transfer of claim & transaction data arising in areas beyond the service area.

e. Detailed guidelines of portability are provided at **Schedule 9.**

7. Claims Management

a. Claim Payments and Turn-around Time

The Insurer shall comply with the following procedure regarding the processing of Claims received from the Empanelled Health Care Providers:

a. The Insurer shall require the Empanelled Health Care Providers to submit their Claims electronically within 24 hours of discharge in the defined format to be prescribed by the NHA/UTHA/Insurer. However, in case of Public EHCPs this time may be relaxed as defined by UTHA.

b. The Insurer shall decide on the acceptance or rejection of any Claim received from an Empanelled Health Care Provider. Any rejection notice issued by the Insurer to the Empanelled Health Care Provider shall state clearly that such rejection is subject to the Empanelled Health Care Provider's right to file a complaint with the relevant Grievance Redressal Committee against such decision to reject such Claim.

c. If the Insurer rejects a Claim, the Insurer shall issue a written letter of rejection to the Empanelled Health Care Provider stating: details of the Claim summary; reasons for rejection; and details of the District Grievance Nodal Officer. The letter of rejection shall be issued to the UT Health Agency and the Empanelled Health Care Provider within 15 days of receipt of the electronic Claim. The Insurer should inform the Empanelled Health Care Provider of its right to seek redressal for any Claim related grievance before the District Grievance Redressal Committee in its letter of rejection.

If a Claim is rejected because the Empanelled Health Care Provider making the Claim is not empanelled for providing the health care services in respect of which the Claim is made, then the Insurer shall while rejecting the Claim inform the Beneficiary of an alternate Empanelled Health Care Provider where the benefit can be availed in future.

d. The Insurer shall be responsible for settling all claims **within 15 days after receiving all the required information/ documents**. The Insurer shall make the Claim Payment (based on the Package Rate or the Pre-Authorized Amount) within 15 days, if not rejected, including any investigation into the Claim received from the Empanelled Health Care Provider.

e. The Insurer shall make the full Claim Payment without deduction of tax, for all PHCs, CHCs, District Hospitals and other government sponsored hospitals, for private healthcare providers the Insurer shall make the full Claim Payment without deduction of tax, if the Empanelled Health Care Provider submits a tax exemption certificate to the Insurer within 7 days after signing the agreement with the Insurer making a Claim. If the Empanelled Health Care Provider fails to submit a tax exemption certificate to the Insurer, then the Insurer shall make the Claim Payment after deducting tax at the applicable rate.

f. If the Beneficiary is admitted by an Empanelled Health Care Provider during a Policy Cover Period, but is discharged after the end of such Policy Cover Period and the Policy is not renewed, then the arising Claim shall be paid in full by the Insurer subject to the available Sum Insured.

g. If a Claim is made during a Policy Cover Period and the Policy is not subsequently renewed, then the Insurer shall make the Claim Payment in full subject to the available Sum Insured.

h. The process specified in paragraphs (b) to (d) above in relation to Claim Payment or investigation of the Claim shall be completed such that the Turn-around Time shall be no longer than 15 days.

Without prejudice to the foregoing, during the subsistence of any delay by the UT Health Agency in making payment of the Premium for a Policy Cover Period, the Insurer shall have the right to delay making Claim Payments to the Empanelled Health Care Providers until the Premium is received, provided that the Insurer completes the processing of the Claims in accordance with paragraphs (b) to (d) above within the Turn- Around Time of 15 days.

If the Insurer fails to make the Claim Payment within a Turn-around Time of 15 days for a reason other than a delay by the UT Health Agency in making payment of the Premium that is due and payable, then the Insurer shall be liable to pay a penal interest to the Empanelled Health Care Provider at the rate of 1% of the Claim amount for every 15 days of delay.

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

j. The Insurer shall make Claim Payments to each Empanelled Health Care Provider against Claims received on a weekly basis and as far as possible through electronic transfer to such Empanelled Health Care Provider's designated bank account.

k. The Insurer shall ensure that there is an online web portal for processing of all claim payments.

l. All Claims investigations shall be undertaken by qualified and experienced Medical Practitioners appointed by the Insurer or its TPA, to ascertain the nature of the disease, illness or accident and to verify the eligibility thereof for availing the benefits under this Insurance Contract and relevant Policy. The Insurer's or the TPA's medical staff shall not impart or advise on any Medical Treatment, Surgical Procedure or Follow-up Care or provide any OPD Benefits or provide any guidance related to cure or other care aspects.

m. The Insurer shall submit details of:

(i) all Claims that are under investigation to the district nodal officer of the UT Health Agency on a monthly basis for its review;

(ii) every Claim that is pending beyond 15 days to the UT Health Agency, along with its reasons for delay in processing such Claim; and

(iii) Details of interest paid to the Empanelled Health Care Providers for every Claim that was pending beyond 15 days to the UT Health Agency.

n. The Insurer may collect at its own cost, complete Claim papers from the Empanelled Health Care Provider, if required for audit purposes. This shall not have any bearing on the Claim Payments to the Empanelled Health Care Provider.

o. The Insurer shall, at all times, comply with and ensure that its TPA is in compliance with the Health Insurance Regulations and any other Law issued or notified by the IRDA in relation to the provision of Cashless Access Services and Claims processing.

p. In case the insurer hires Third Party Administrator (TPA), it shall ensure that the TPA does not approve or reject any Claims on its behalf and that the TPA is only engaged in the processing of Claims. The TPA may however recommend to the Insurer on the action to be taken in relation to a Claim. However, the final decision on approval and rejection of Claims shall be made by the Insurer.

q. Guidelines for submission of claims, claims processing, handling of claim queries, and all other related details are furnished in **Schedule 9**.

b. Right of Appeal and Reopening of Claims

a. The Empanelled Health Care Provider shall have a right of appeal against a rejection of a Claim by the Insurer, if the Empanelled Health Care Provider feels that the Claim is payable. Such decision of the Insurer may be appealed by filing a complaint with the DGNO in accordance with **Clause 28** of this Insurance Contract.

b. The Insurer and/or the DGNO or the DGRC, as the case maybe, may re-open the Claim, if the Empanelled Health Care Provider submits the proper and relevant Claim documents that are required by the Insurer.

c. No Contributions

a. The Insurer agrees that any Beneficiary Family Unit or any of the Beneficiaries or any other third party shall be entitled to obtain additional health insurance or any other insurance cover of any nature whatsoever, including in relation to the benefits provided under this Insurance Contract and a Policy, either individually or on a family floater cover basis.

b. Notwithstanding that such Beneficiary Family Unit or any of the Beneficiaries or any third party acting on their behalf effect additional health insurance or any other insurance cover of any nature whatsoever, the Insurer agrees that:

(i) its liability to make a Claim Payment shall not be waived or discharged in part or in full based on a rateable or any other proportion of the expenses incurred and that are covered by the benefits under the Covers;

(ii) it shall be required to make the full Claim Payment in respect of the benefits provided under this Insurance Contract and the relevant Policy; and

(iii) If the total expenses incurred by the Beneficiary exceeds the available Sum Insured under the Covers, then the Insurer shall make payment to the extent of the available Sum Insured in respect of the benefits provided under this Insurance Contract and the relevant Policy and the other insurers shall pay for any excess expenses not covered.

8. No Duty of Disclosure

a. Notwithstanding the issue of the Tender Documents and any other information provided by the UT Health Agency prior to the date of this Insurance Contract, the Insurer hereby acknowledges that it does not rely on and has not been induced to enter into this Insurance Contract or to provide the Covers or to assess the Premium for providing the Covers on the basis of any statements, warranties, representations, covenants, undertakings, indemnities or other statements whatsoever and acknowledges that none of the UT Health Agency or any of its agents, officers, employees or advisors or any of the enrolled Beneficiary Family Units have given or will give any such warranties, representations, covenants, undertakings, indemnities or other statements.

b. Prior to commencement of each Policy Cover Period for any UT, the UT Health Agency or MoHFW undertakes to prepare or cause a third party to prepare the Beneficiary Database as correctly as possible. The Insurer acknowledges that, notwithstanding such efforts being made by the UT Health Agency, the information in the Beneficiary Database may not be accurate or correct and that the Beneficiary Database may contain errors or mistakes.

Accordingly, the Insurer acknowledges that the UT Health Agency makes no warranties, representations, covenants, undertakings, indemnities or other statements regarding the accuracy or correctness of the Beneficiary Database that will be provided by it to the Insurer.

c. The Insurer represents, warrants and undertakes that it has completed its own due diligence and is relying on its own judgment in assessing the risks and responsibilities that it will be undertaking by entering into this Insurance Contract and in providing the

Covers to the enrolled Beneficiary Family Units and in assessing the adequacy of the Premium for providing the Covers for the Beneficiary Family Units.

d. Based on the acknowledgements of the Insurer in this Clause, the Insurer:

(i) acknowledges and confirms that the UT Health Agency has made no and will make no material disclosures to the Insurer;

(ii) acknowledges and confirms that the UT Health Agency shall not be liable to the Insurer for any misrepresentation or untrue, misleading, incomplete or inaccurate statements made by the UT Health Agency or any of its agents, officers, employees or advisors at any time, whether made wilfully, negligently, fraudulently or in good faith; and

(iii) hereby releases and waives all rights or entitlements that it has or may have to:

– make any claim for damages and/or declare this Insurance Contract or any Policy issued under this Insurance Contract declared null and void; or

as a result of any untrue or incorrect statements, misrepresentation, mis- description or non-disclosure of any material particulars that affect the Insurer's ability to provide the Covers.

9. Fraud Control and Management

a. The insurer is expected to develop a comprehensive fraud control system for the scheme. For an indicative (not exhaustive) list of fraud triggers that may be automatically and on a real-time basis be tracked please refer to **Schedule 13**. The Insurer shall have capactities and track the indicative (not exhaustive) triggers and it can add more triggers to the list.

b. For all trigger alerts related to possible fraud at the level of EHCPs, the Insurer shall take the lead in immediate investigation of the case in close coordination and under constant supervision of the UTHA.

c. Investigations pursuant to any such alert shall be concluded within 15 days and all final decision related to outcome of the Investigation and consequent penal action, if the fraud is proven, shall vest solely with the UTHA.

d. The UTHA. shall take all such decision within the provisions of the Insurance Contract and be founded on the Principles of Natural Justice.

e. The UTHA.shall on an ongoing basis measure the effectiveness of anti-fraud measures in the Scheme through a set of indicators. For a list of such indicative (not exhaustive) indicators, refer to **Schedule 14**.

f. The Insurer shall be responsible for monitoring and controlling the implementation of the AB-PMJAY in the UT in accordance with **Clause 24**.

g. In the event of a fraudulent Claim being made or a false statement or declaration being made or used in support of a fraudulent Claim or any fraudulent means or device being used by any Empanelled Health Care Provider or the TPA or other intermediary hired by the Insurer or any of the Beneficiaries to obtain any benefits under this Insurance Contract or any Policy issued by the Insurer (each a Fraudulent Activity), then the Insurer's sole remedies as per the approval of UTHA shall be to:

(i) refuse to honour a fraudulent Claim or Claim arising out of Fraudulent Activity or reclaim all benefits paid in respect of a fraudulent Claim or any Fraudulent Activity relating to a Claim from the Empanelled Health Care Provider and/or the Beneficiary that has undertaken or participated in a Fraudulent Activity; and/or

(ii) de-empanel the Empanelled Health Care Provider, with approval of UTHA., that has made a fraudulent Claim or undertaken or participated in a Fraudulent Activity, with the procedure specified in **Schedule 5**;

(iii) terminate the services agreement with the intermediary appointed by the Insurer; and/or

provided that the Insurer has: issued a notice to the Union Territory Health Agency of its proposed exercise of any of these remedies; and such notice is accompanied by reasonable documentary evidence of such fraudulent activity. An indicative list of fraudulent triggers has been set out in **Schedule 13**.

The Union Territory Health Agency shall have the right to conduct a random audit of any or all cases in which the Insurer has exercised such remedies against an Empanelled Health Care Provider and/or any Beneficiary. If the UT Health Agency finds that the Insurer has wrongfully de-empanelled an Empanelled Health Care Provider, then the Insurer shall be required to reinstate such benefits to such Empanelled Health Care Provider.

h. The Insurer hereby releases and waives all rights or entitlements to:

(i) make any claim for damages and/or have this Insurance Contract or any Policy issued under this Insurance Contract declared null and void; or

as a result of any fraudulent Claim by or any Fraudulent Activity of any Empanelled Health Care Provider.

10. Representations and warranties of the Insurer

a. Representations and Warranties

The Insurer represents, warrants and undertakes that:

a. The Insurer has the full power, capacity and authority to execute, deliver and perform this Insurance Contract and it has taken all necessary actions (corporate, statutory or otherwise), to execute, deliver and perform its obligations under this Insurance Contract and that it is fully empowered to enter into and execute this Insurance Contract, as well as perform all its obligations hereunder.

b. Neither the execution of this Insurance Contract nor compliance with its terms will be in conflict with or result in the breach of or constitute a default or require any consent under:

(i) any provision of any agreement or other instrument to which the Insurer is a party or by which it is bound;

(ii) any judgment, injunction, order, decree or award which is binding upon the Insurer; and/or

(iii) the Insurer's Memorandum and Articles of Association or its other constituent documents.

c. The Insurer is duly registered with the IRDA, has duly obtained renewal of its registration from the IRDA and to the best of its knowledge, will not have its registration revoked or suspended for any reason whatsoever during the Term of this Insurance Contract. The Insurer undertakes that it shall continue to keep its registration with the IRDA valid and effective throughout the Term of this Insurance Contract.

d. The Insurer has conducted the general insurance (including health insurance) business in India for at least 3 financial years prior to the submission of its Bid and shall continue to be an insurance company that is permitted under Law to carry on the general insurance (including health insurance) business throughout the Term of this Insurance Contract.

e. In the financial year prior to the submission of its Bid, the Insurer has maintained its solvency ratio in full compliance with the requirements of the IRDA Solvency Regulations and the Insurer undertakes that it shall continue to maintain its solvency ratio in full compliance with the IRDA Solvency Regulations throughout the Term of this Insurance Contract.

f. The Insurer has complied with and shall continue to comply with all Laws, including but not limited to the rules or regulations issued by the IRDA in connection with the conduct of its business and the AB-PMJAY Guidelines issued by MoHFW and/or the UT Health Agency from time to time.

g. The Insurer has quoted the Premium and accepted the terms and conditions of this Insurance Contract:

(i) after the Insurer and its Appointed Actuary have duly satisfied themselves regarding the financial viability of the Premium; and

(ii) in accordance with the Insurer's underwriting policy approved its Board of Directors.

The Insurer shall not later deny issuance of a Policy or payment of a Claim on the grounds that: (x) the Premium is found financially unviable; or (y) the assumptions taken by the Insurer and/or its Appointed Actuary in the actuarial certificate submitted with its Bid have been breached; or (z) the Insurer's underwriting policy has been breached.

h. Without prejudice to **Clause 17.1 (e)** above, the Insurer is and shall continue to be capable of meeting its liabilities to make Claim Payments, servicing the Covers being provided by it under this Insurance Contract and has and shall continue to have sufficient infrastructure, trained manpower and resources to perform its obligations under this Insurance Contract.

i. The Insurer has at no time, whether prior to or at the time of submission of its Bid and at the time of execution of this Contract, been black-listed or been declared as ineligible from participating in government sponsored schemes (including the AB-PMJAY) by the IRDA.

j. After the issuance of each Policy, the Insurer shall not withdraw or modify the Premium or the terms and conditions of the Covers provided to the Beneficiaries during the Term of this Insurance Contract.

k. The Insurer abides and shall continue to abide by the Health Insurance Regulations and the code of conduct prescribed by the IRDA or any other governmental or regulatory body with jurisdiction over it, from time to time.

17.2 Continuity and Repetition of Representations and Warranties

The Insurer agrees that each of the representations and warranties set out in **Clause 17.1** are continuing and shall be deemed to repeat for each day of the Term.

17.3 Information regarding Breach of Representations and Warranties

The Insurer represents, warrants and undertakes that it shall promptly, and in any event within 15 days, inform the UT Health Agency in writing of the occurrence of a breach or of obtaining knowledge of a potential breach of any of the representations and warranties made by it in **Clause 17.1** at any time during the continuance of the Term.

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PART II

PROJECT OFFICE

18 Project Office and District Offices

18.1 Project Office at the Union Territory Level

The Insurer shall establish a Project Office at a convenient place at Silvassa for the UT of Dadra Nagar Haveli and at Daman for the UT of Daman & Diu for coordination with the UTHA on a regular basis within 15 days of signing of the contract.

18.2 District Offices

a. The Insurer shall set up an office in each of the districts of the UT of Daman & Diu at the district headquarters of such district i.e Diu (each a District Office) within 15 days of signing of the contract.

a. Each District Office shall be responsible for coordinating the Insurer's activities at the district level with the UTHA's district level administration.

18.3 Organizational Set up and Functions

a. In addition to the support staff for other duties, the Insurer shall recruit or employ experienced and qualified personnel exclusively for the purpose of implementation of the AB-PMJAY and for the performance of its obligations and discharge of its liabilities under the Insurance Contract:

(i) One Union Territory Coordinator who shall be responsible for implementation of the Scheme and performance of the Insurance Contract in the UT.
(ii) One full time District Coordinator for each of the districts who shall be responsible for implementation of the Scheme in each of the districts.
(iii) One full time district medical officer for each of the districts who shall be responsible for medical audits, fraud control etc.
(iv) One district grievance officer for each of the districts who shall be responsible for grievances in the district.

The Union Territory Coordinator shall be located in the Project Office and each District Coordinator shall be located in the relevant District Office.

Role of District Coordinator

- To coordinate and ensure smooth implementation of the Scheme in the district.
- To follow up with the EHCP to ensure that the IT infrastructure installed is fully functional at all times.
- Liaise with the district officials of the UTHA to addressing operational issues as and when they arise.

- Liaise with the District Grievance Redressal Cell for resolving all complaints.

b. In addition to the personnel mentioned above, the Insurer shall recruit or employ experienced and qualified personnel for each of the following roles within its organisation exclusively for the purpose of the implementation of the Scheme:

(i) To undertake Information Technology related functions which will include, among other things, collating and sharing claims related data with the UTHA and running of the website at the Union Territory level and updating data at regular intervals on the website. The website shall have information on AB-PMJAY in the local language and English with functionality for claims settlement and account information access for the AB-PMJAY Beneficiaries and the EHCP.
(ii) To implement the grievance redressal mechanism and to participate in the grievance redressal proceedings provided that such persons shall not carry out any other functions simultaneously if such functioning will affect their independence as members of the grievance redressal committees at different levels.
(iii) To coordinate the Insurer's Union Territory level obligations with the UT level administration of the UTHA.

c. In addition to the personnel mentioned above, the Insurer shall recruit or employ experienced and qualified personnel for each of the following roles within its organisation at the UT's /district level, exclusively for the purpose of the implementation of the AB-PMJAY:

(i) To undertake the Management Information System (MIS) functions, which include creating the MIS dashboard and collecting, collating and reporting data.
(ii) To generate reports in formats prescribed by the UTHA from time to time or as specified in the Scheme Guidelines, at monthly intervals.
(iii) Processing and approval of beneficiary identity verification requests, received from Ayushman Mitras at the hospitals, as per the process defined in the scheme. Scrutiny and approval of beneficiary identity verification requests if all the conditions are fulfilled, within 30 minutes of receiving the requests from Ayushman Mitras at the network hospital.
(iv) To undertake the Pre-authorisation functions under AB-PMJAY.
(v) To undertake paperless claims settlement for the Empanelled Health Care Providers with electronic clearing facility, including the provision of necessary Medical Practitioners to undertake investigation of claims made.
(vi) To undertake internal monitoring and control functions.
(vii) To undertake feedback functions which include designing feedback formats, collecting data based on those formats from different stakeholders like AB-PMJAY beneficiaries, the EHCPs etc., analysing the feedback data and recommending appropriate actions.
(viii) To coordinate the Insurer's district level obligations with the district level administration of the UTHA.

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d. The Insurer shall not be required to appoint the concerned personnel if it has outsourced any of the roles and functions listed in the above sections to third parties in accordance with **Clause 25**.

e. Provided, however, that the Insurer shall not outsource any roles or functions that are its core functions as a health insurer or that relate to its assumption of risk under AB-PMJAY Cover or that the Insurer is prohibited from outsourcing under the Insurance Laws, including but not limited to: implementation of the grievance redressal mechanism, managing its District Offices, undertaking pre-authorisation (other than in accordance with the Health Insurance Regulations), undertaking Claims Payments (other than in accordance with the Health Insurance Regulations).

f. The Insurer shall provide a list of all such appointments and replacement of such personnel to the UTHA within 30 days of all such appointments and replacements. The Insurer shall ensure that its employees coordinate and consult with the UTHA's corresponding personnel for the successful implementation of AB-PMJAY and the due performance of the Insurer's obligations and discharge of the Insurer's liabilities under the Insurance Contract and the Policies issued hereunder.

g. The Insurer shall complete the recruitment of such employees within 45 days of the signing of the Insurance Contract and in any event, prior to commencement of the Policy Cover Period.

19 Capacity Building Interventions

The insurer shall prepare a training plan and share with UTHA within 15 days of signing of the contract. The Insurer shall, at a minimum, conduct the following training and make them part of training plan:

Empanelled Health Care Provider Training

a. The Insurer shall provide training to the Ayushman Mitras for all EHCPs in a UT at least once every 6 months, that is, at least twice during each Policy Cover Period for such UT. Such training shall minimum include: list of covered procedures and prices, pre-authorisation procedures and requirements, IT training for making online Claims and ensuring proper installation and functioning of the Hospital IT Infrastructure for each Empanelled Health Care Provider.

b. The Insurer shall organize training workshops for each public EHCP (including Community Health Centres- CHCs and Primary Health Centres- PHCs) at the hospital premises at least once every 6 months, that is, at least twice during each Policy Cover Period for a UT and at any other time requested by the EHCP, to increase knowledge levels and awareness of the hospital staff.

c. If a particular EHCP frequently submits incomplete documents or incorrect information in Claims or in its request for authorisation as part of the pre-authorisation procedure, then the Insurer shall undertake a follow-up training for such EHCP.

d. The cost of all capacity building interventions associated with the implementation of the Capacity Building Programme shall be borne by the Insurer.

e. The Insurer shall submit to the UT Health Agency at the end of every 6 months, a detailed report specifying the capacity building and training conducted by the Insurer and the progress made by the Insurer against the Capacity Building Programme during those 6 months.

20 Other Obligations

20.1 Insurer's Obligations before start of the policy

The Insurer shall mandatorily complete the following activities before the start of policy in each State:

a. Sign contract with the empanelled hospitals

b. Ensure that requisite hardware and software is available in the empanelled hospitals

c. UT and district offices as mentioned above are set up and functional

d. Print sufficient number of booklets which have to be given to each Beneficiary Family Unit through various mechanisms including hospitals, common service centers, ASHA etc. The responsibility of distributing booklets will lie with the UTHA. Such booklets shall contain at least the following details:

(i) Details about AB-PMJAY;
(ii) Process for utilizing the Covers under AB-PMJAY;
(iii) List of Exclusions;
(iv) Start and end date of the Policy Cover Period for that UT;
(v) List of the Empanelled Health Care Providers along with addresses and contact details;
(vi) The names and details of the District Coordinator of the Insurer in that district;
(vii) Toll-free number of the call centre;
(viii) Process for filing complaints or grievances;
(ix) All other details required for smooth usage of the AB-PMJAY.

e. Ensuring availability of Policy number for the Policy for UT that is issued by the Insurer.

f. Ensuring that contact details of the District Coordinator of the Insurer, and the nodal officer of the other service providers appointed by the Insurer are provided to UTHA before the commencement of each Policy Cover Period.

20.2 Union Territory Health Agency's Obligations

The Union Territory Health Agency shall mandatorily complete the following activities before the start of the policy in the UT:

a. Provide the Beneficiary Database for each district in the format prescribed by the AB-PMJAY Guidelines to the insurer prior to the commencement of each Policy Cover Period at least 15 days prior to the scheduled date for start of policy.

b. Appoint the District Nodal Officers (DNOs) and other required staff for each district and work with the DNO appointed by it to create the requisite organization structure at the district level to effectively implement and manage the AB-PMJAY within 30 days of the signing of this Insurance Contract.

c. Set up UT and District level grievance committees as detailed out in this contract document.

d. Set up Claims review committee as mentioned in 24.3.1 (b) (I)

PART III

OTHER OBLIGATIONS REGARDING IMPLEMENTATION OF THE AB-PMJAY

21 Service beyond Service Area

To ensure true portability of the AB-PMJAY and to provide the Beneficiaries with seamless access to health care services across the Empanelled Health Care Providers anywhere across India. To ensure true portability of AB-PMJAY, UT Administration shall enter into arrangement with ALL other States/UT's that are implementing AB-PMJAY for allowing sharing of network hospitals, transfer of claim & transaction data arising in areas beyond the service area.

22 Plan for Provision of Services in the Absence of Internet Connectivity

The Insurer agrees that if, in the implementation of the Scheme and use of the prescribed technology and systems, there is an issue causing interruption in the provision of Cashless Access Services, the Insurer shall:

a. make all efforts to put in place an alternate mechanism to ensure continued provision of Cashless Access Services to the AB-PMJAY Beneficiaries;

b. take all necessary measures to fix the technology or related issues to bring the Cashless Access Services back onto the online platform within the earliest possible time in close coordination with the UTHA; and

c. furnish all data/information in relation to the cause of interruptions, the delay or other consequences of interruptions, the mitigating measures taken by the Insurer and any other related issues to the UTHA in the format prescribed by the UTHA at that point in time.

23 Management Information System

a. All Management Information System (MIS) shall be on a centralised web-based architecture designed by the MoHFW, GoI for the purposes of the Scheme.

b. The Insurer shall maintain a MIS dashboard that will act as a visual interface to provide at-a-glance views on key ratios and measures of data regarding the implementation of the Scheme.

c. The Insurer shall update the information on the MIS dashboard real time and shall provide the UTHA and any number of authorized representatives of the UTHA or its advisors/ consultants with access to the various modules on the MIS dashboard. The UTHA and the MoHFW, GoI shall have the right to download, print or store the data available on the MIS dashboard.

d. In addition, the Insurer shall submit reports to the UTHA regarding health-service usage patterns, Claims data and such other information regarding the delivery of benefits as may be required by the UTHA on a monthly basis.

e. In addition, the Insurer shall be responsible for submitting such other data and information as may be requested by the UTHA and/ or to the MoHFW, GoI and to submit such reports in formats as required by and specified by the UTHA from time to time.

f. All data generated by the Insurer in relation to the implementation and management of the Scheme and/or in performing its obligations under the Insurance Contract shall be the property of the UTHA and MoHFW, GoI. The Insurer undertakes to handover all such information and data to the UTHA within 10 days of the expiration or cancellation of the Policy for that State/UT and on the expiration or early termination of the Insurance Contract.

24 Monitoring and Control

24.1 Scope of Monitoring

a. Monitoring under AB-PMJAY shall include supervision and monitoring of all the activities under the AB-PMJAY undertaken by the Insurer and ensuring that the Insurer complies with all the provisions of the Insurance Contract signed with the Union Territory Health Agency (UTHA) and all contracts and sub-contracts/ agreements issued by the Insurer pursuant to the Insurance Contract with the UTHA for implementation of the Scheme.

b. Monitoring shall include but not be limited to:
   i. Overall performance and conduct of the Insurer.
   ii. Claims management process.
   iii. Grievance redressal process.
   iv. Any other aspect/ activity of the Insurer related to the implementation of the Scheme.

24.2 Monitoring Activities to be undertaken by the Insurer

General Monitoring Obligations

Under the AB-PMJAY, the Insurer shall monitor the entire process of implementation of the Scheme on an ongoing basis to ensure that it meets its obligations under its Insurance Contract with the UTHA. Towards this obligation the Insurer shall undertake, **but not be limited** to, the following tasks:

a. Ensure compliance to all the terms, conditions and provisions of the Scheme.

b. Ensure monitoring of processes for seamless access to cashless health care services by the AB-PMJAY beneficiaries under the provisions of the Scheme.

c. Ensure monitoring of processes for timely processing and management of all claims of the EHCPs.

d. Ensure fulfilment of minimum threshold levels as per the agreed Key Performance Indicators (KPIs).

e. Ensure compliance from all its sub-contractors, vendors and intermediaries hired/ contracted by the Insurer under the Scheme for the fulfilment of its obligations.

24.2.1 Medical Audit

Scope

a. The scope of medical audit under the Scheme shall focus on ensuring comprehensiveness of medical records and shall include but not be limited to:
   (i) Completeness of the medical records file.
   (ii) Evidence of patient history and current illness.
   (iii) Operation report (if surgery is done).
   (iv) Patient progress notes from admission to discharge.
   (v) Pathology and radiology reports.

b. If at any point in time the UTHA issues Standard Treatment Guidelines for all or some of the medical/ surgical procedures, assessing compliance to Standard Treatment Guidelines shall be within the scope of the medical audit.

Methodology

c. The Insurer shall conduct the medical audit through on-site visits to the concerned EHCPs for inspection of records, discussions with the nursing and medical staff.

d. The indicative process of conducting medical audits is set out below and based on this the Insurer shall submit its detailed audit methodology to the UTHA for approval:
   (i) The auditor shall check the data before meeting the EHCP authorities.
   (ii) The audit should preferably be conducted in the presence of the EHCP's physician/ treating doctor.

e. The medical audit will include a review of medical records in the format specified in **Schedule 10**.

Personnel

f. All medical audits should compulsorily be done by MBBS doctors or Specialists as required who are a part of the Insurer's or the Outsourced agency or is otherwise duly authorized to undertake such medical audit by the Insurer or the outsourced agency. The Insurer shall share the profiles of all such auditors hired/empanelled by it for medical audit purposes under the Scheme.

Frequency and Sample

g. The number of medical audits to be conducted by the Insurer will be a five percent of the total cases hospitalized in each of the EHCP in the current quarter. The sample shall be selected in a manner to ensure that over a period of one year every district and every EHCP is included at least once in the medical audits.

24.2.2 Hospital Audit

a. The Insurer will conduct hospital audit for every single EHCP visited by it as a part of the medical audit as described in **Clause 24.2.2** above.
b. Hospital audit shall be conducted as per the format prescribed in **Schedule 11**.
c. Hospital audit will focus on compliance to EHCP's obligations like operational help desk, appropriate signage of the Scheme prominently displayed, etc. details of which are captured.

24.3 Monitoring Activities to be undertaken by the UT Health Agency

24.3.1 Audits by the Union Territory Health Agency

a. Audit of the audits undertaken by the Insurer: The UTHA shall have the right to undertake sampled audits of all audits (Medical Audit and Hospital Audit) undertaken by the Insurer.

b. Direct audits: In addition to the audit of the audits undertaken by the Insurer referred in **Clause 24.3.1.a**, the UTHA shall have the right to undertake direct audits on a regular basis conducted either directly by it or through its authorized representatives/ agencies including appointed third parties. Direct audits shall include:

(i) Claims audit: For the purpose of claims audit, the UTHA shall constitute a **Claims Review Committee** (CRC) that shall look into 100 percent of the claims rejected or partially settled by the Insurer to assure itself of the legitimacy of the Insurer's decisions. Claims settlement decisions of the Insurer that are disputed by the concerned EHCP shall be examined in depth by the CRC after such grievance of the EHCP is forwarded by the concerned Grievance Redressal Committee (GRC) to the CRC.

CRC shall examine the merits of the case within 30 working days and recommend its decision to the concerned GRC. The GRC shall then communicate the decision to the aggrieved party (the EHCP) as per the provisions specified in the Clause of Grievance Redressal Mechanism.

During the claims audit the UTHA shall look into the following aspects (indicative, not exhaustive):

- Evidence of rigorous review of claims.

- Comprehensiveness of claims submissions (documentation) by the EHCPs.
- Number of type of queries raised by the Insurer during review of claims – appropriateness of queries.
- Accuracy of claims settlement amount.

(ii) Concurrent Audits: The UTHA shall have the right to set up mechanisms for concurrent audit of the implementation of the Scheme and monitoring of Insurer's performance under this Insurance Contract.

24.3.2 Spot Checks by the Union Territory Health Agency

a. The UTHA shall have the right to undertake spot checks of district offices of the Insurer and the premises of the EHCP without any prior intimation.

b. The spot checks shall be random and will be at the sole discretion of the UTHA.

23.3.3 Performance Review and Monitoring Meetings

a. The UTHA shall organize fortnightly meetings for the first three months and monthly review meetings thereafter with the Insurer. The UTHA shall have the right to call for additional review meetings as required to ensure smooth functioning of the Scheme.

b. Whereas the UTHA shall issue the Agenda for the review meeting prior to the meeting while communicating the date of the review meeting, as a general rule the Agenda shall have the following items:
   (i) Review of action taken from the previous review meeting.
   (ii) Review of performance and progress in the last quarter: utilization pattern, claims pattern, etc. This will be done based on the review of reports submitted by the Insurer in the quarter under review.
   (iii) KPI Results review – with discussions on variance from prescribed threshold limits, if any.
   (iv) Contracts management issue(s), if any.
   (v) Risk review, fraud alerts, action taken of fraud alerts.
   (vi) Inter insurance company claim settlement
   (vii) any other item.

c. All meetings shall be documented and minutes shared with all concerned parties.

d. Apart from the regularly quarterly review meetings, the UTHA shall have the right to call for interim review meetings as and when required on specific issues.

24.4 Key Performance Indicators for the Insurer

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a. A set of critical indicators where the performance level below the threshold limit set, shall attract financial penalties and shall be called **Key Performance Indicators** (KPI). For list of KPIs, see **Schedule 12**.

b. At the end of every 12 months, the UTHA shall have the right to amend the KPIs, which if amended, shall be applicable prospectively on the Insurer and the Insurer shall be obliged to abide by the same.

24.5 Measuring Performance

a. Performance shall be measured quarterly against the KPIs and the thresholds for each indicator.

b. Indicator performance results shall be reviewed in the quarterly review meetings and reasons for variances, if any, shall be presented by the Insurer.

c. All penalties imposed by the UTHA on the Insurer shall have to be paid by the Insurer within 60 days of such demand.

d. Based on the review the UTHA shall have the right to issue rectification orders demanding the performance to be brought up to the levels desired as per the AB-PMJAY Guidelines.

e. All such rectifications shall be undertaken by the Insurer within 30 days of the date of issue of such Rectification Order unless stated otherwise in such Order(s).

f. At the end of the rectification period, the Insurer shall submit an Action Taken Report with evidences of rectifications done to the UTHA.

g. If the UTHA is not satisfied with the Action Taken Report, it shall call for a follow up meeting with the Insurer and shall have the right to take appropriate actions within the overall provisions of the Insurance Contract between the UTHA and the Insurer.

24.6 Penalties

a. KPI performance related penalties are provided in the KPI table in **Schedule 12**.

b. Apart from the KPI related penalties, the UTHA shall impose the following penalties on the Insurer which have been referred to in the other clauses of this Contract and Tender Document:

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No.	Additional Defaults	Penalty
(i)	If premium refund is not made by the Insurer to the UTHA within 30 days of the communication for refund sent by the UTHA to the Insurer	1% penal interest for every week of delay or part thereof and if not received within 30 days, penal interest to be recovered through legal means
(ii)	If the premium is not paid to the Insurer, by the UTHA within 6 months of the commencement of the AB-PMJAY Cover	Interest @ 1% of the premium amount for every 7 days' delay shall be paid by the UTHA to the Insurer
(iii)	If claim payment to the hospital is delayed beyond defined period of 15 days.	An interest of 1% for every seven day of delay after 15 days
(iv)	For claims outside UT, if claim payment to the hospital is delayed beyond defined period of 30 days.	An interest of 1% for every seven day of delay after 30 days

25 Outsourcing of Non- core Business by Insurer to an Agency

a. The Insurer shall notify the UTHA of the agencies or service providers that it wishes to appoint within three days of NOA.

b. The agency or service provider to be appointed by the insurer shall be as per the latest regulations issued by IRDAI.

c. For the purpose of hiring an outsourced agency or service provider the Insurer shall enter into a Service Level Agreement with the concerned agency or service provider and within 14 days submit a redacted copy to the UTHA.

d. The Insurer in all cases shall ensure that the appointment and functioning of agency or service provider shall be in due compliance with latest regulations of IRDAI and any deviation in this manner shall be considered a case of breach of the contract.

e. The appointment of intermediaries or service providers shall not relieve the Insurer from any liability or obligation arising under or in relation to the performance of obligations under this Insurance Contract and the Insurer shall at all times remain solely responsible for any act or omission of its intermediaries or service providers, as if it were the acts or omissions of the Insurer.

f. The Insurer shall be responsible for ensuring that its service agreement(s) with intermediaries and service providers include provisions that vest the Insurer with appropriate recourse and remedies, in the event of non-performance or delay in performance by such intermediary or service provider.

g. The Insurer shall notify the UT Health Agency of the intermediaries or service providers that it wishes to appoint on or before the date of execution of this Insurance Contract.

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26 Reporting Requirements

a. The Insurer shall submit the following reports as per the scheduled provided in the table below:

No.	Report	Frequency	Deadline
(i)	Medical & Hospital Audit Reports	For each audit	Within 10 days of completing the audit
(ii)	Medical & Hospital Audit Summary Reports	Quarterly	Within 10th day of the month following the end of the quarter
(iii)	Claims/ Utilization Summary Reports	Monthly	Within 5th day of the month following the end of the month
(iv)	Overall Scheme Progress Reports	Monthly	Within 10th day of the month following the end of the quarter

b. All reports shall be uploaded by the Insurer online on the UTHA web portal.

c. The Insurer shall receive auto-acknowledgement immediately on submission of the report.

d. The UTHA shall review all progress reports and provide feedback, if any, to the Insurer.

e. All Audits reports shall be reviewed by the UTHA and based on the audit observations, determine remedial actions, wherever required.

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PART IV

COORDINATION AND GRIEVANCE REDRESSAL

27 Coordination Committee

27.2 Constitution and Membership

a. The UTHA shall, within 15 days of the date of execution of this Insurance Contract, establish a coordination committee (the **Coordination Committee**) which shall meet quarterly to perform its functions.

b. The Coordination Committee shall be constituted as follows:
   (i) Secretary (Health) DD & DNH. -Chairperson
   (ii) Director Health Services DD & DNH. -Member
   (iii) Deputy Secretary (Health) -Member
   (iv) Mission Director NHM. -Member
   (v) The UT Nodal Officer and one other member nominated by the UTHA.
   (vi) The UT Coordinator of the Insurance Company and one other member from the Corporate/ regional office of the Insurer.
   State may add additional members, if required.

27.3 Roles and Responsibilities

The key functions and role of the **Coordination Committee** shall include but not be limited to:

a. Ensuring smooth interaction and process flow between the UTHA and the Insurer.

b. Reviewing the implementation and functioning of the Scheme and initiating discussions between the Parties to ensure efficient management and implementation of the Scheme.

c. Reviewing the performance of the Insurer under the Insurance Contract.

d. Any other matter that the Parties may mutually agreed upon.

28 Grievance Redressal

A robust and strong grievance redressal mechanism has been designed for AB-PMJAY. The District authorities shall act as a frontline for the redressal of Beneficiaries' / Providers / other Staekholder's grievances. The District authorities shall also attempt to solve the grievance at their end. The grievances so recorded shall be numbered consecutively and the Beneficiaries / Providers or any other aggrieved party shall be provided with the number assigned to the grievance. The District authorities shall provide the Beneficiaries / Provider or any other aggrieved party with details of the follow-up action taken as regards

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The grievance as per the process laid down. The District authorities shall also record the information in pre-agreed format of any complaint / grievance received by oral, written or any other form of communication.

Under the Grievance Redressal Mechanism of AB-PMJAY, set of three tier Grievance Redressal Committees have been set up to attend to the grievances of various stakeholders at different levels. Details of Grievance Redressal mechanisms and guidelines for this purpose are provided at **Schedule 16**.

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PART V

OTHER TERMS AND CONDITIONS

29 Term and Termination

29.1 Term

This Insurance Contract shall become effective on the date of its execution and shall continue to be valid and in full force and effect until:

a. expiration of the Policy Cover Period under each Policy issued under this Insurance Contract;

b. the discharge of all the Insurer's liabilities for all Claims made by the Empanelled Health Care Providers on or before the date of expiration of the Policy Cover Period for each Policy. For the avoidance of doubt, this shall include a discharge of the Insurer's liability for all amounts blocked for the Beneficiaries before the date of expiration of such Policy Cover Period; and

c. The discharge of all the Insurer's liabilities to the Union Territory Health Agency, including for refund of any Premium for any of the previous Policy Cover Periods.

The Insurer undertakes that it shall discharge all its liabilities in respect of all such Claims raised in respect of each Policy and all of its liabilities to the Union Territory Health Agency within 45 days of the date of expiration of the Policy Cover Period for that Policy.

The period of validity of this Insurance Contract shall be the **Term**, unless this Insurance Contract is terminated earlier.

29.2 Termination by the Union Territory Health Agency

a. The Union Territory Health Agency shall have the right to terminate this Insurance Contract upon the occurrence of any of the following events (each an **Insurer Event of Default**), provided that such event is not attributable to a Force Majeure Event:

(i) the Insurer fails to duly obtain a renewal of its registration with the IRDAI or the IRDAI revokes or suspends the Insurer's registration for the Insurer's failure to comply with applicable Insurance Laws or the Insurer's failure to conduct the general or health insurance business in accordance with applicable Insurance Laws or the code of conduct issued by the IRDAI; or

(ii) the Insurer's average Turn-around Time over a period of 90 days is in excess of 45 days per Claim provided all premium due is paid by the UTHA in time to the Insurer; or

(iii) If at any time any payment, assessment, charge, lien, penalty or damage herein specified to be paid by the Insurer to the UTHA, or any part thereof, shall be in

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Arrears and unpaid within 60 days of receipt of a written notice from the UTHA requesting payment thereof; or

(iv) the Insurer is otherwise in material breach of this Insurance Contract that remains uncured despite receipt of a 60-day cure notice from the UTHA; or

(v) any representation, warranty or undertaking given by the Insurer proves to be incorrect in a material respect or is breached; or

(vi) The Insurer has successively infringed the terms and conditions of the Insurance Contract and/or has failed to rectify the same even after the expiry of the notice period for rectification of such infringement then it would amount to material breach of the terms of the Insurance Contract by the Insurer; or

(vii) The Insurer has failed to perform or discharge any of its obligations in accordance with the provisions of the Insurance Contract with UTHA unless such event has occurred because of a Force Majeure Event, or due to reasons solely attributable to the UTHA without any contributory factor of the Insurer; or

(viii) The Insurer engaging or knowingly has allowed any of its employees, agents, tenants, contractor or representative to engage in any activity prohibited by law or which constitutes a breach of or an offence under any law, in the course of any activity undertaken pursuant to the Insurance Contract; or

(ix) The Insurer has been adjudged as bankrupt or become insolvent; or

(x) Any petition for winding up of the Insurer has been admitted and liquidator or provisional liquidator has been appointed or the Insurer has been ordered to be wound up by Court of competent jurisdiction, except for the purpose of amalgamation or reconstruction with the prior consent of the UTHA, provided that, as part of such or reconstruction and the amalgamated or reconstructed entity has unconditionally assumed all surviving obligations of the Insurer under the Insurance Contract; or

(xi) The Insurer has abandoned the Project Office(s) of the AB-PMJAY and is non-contactable; or

(xii) Performance against KPI is below the threshold specified in **Schedule 10** for two consecutive quarters; or

(xiii) Intentional or unintentional act of undisputedly proven fraud committed by the Insurer.

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

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

c. UTHA will provide prorata premium for the period for which insurer has provided the policy within 30 days of end of policy. In case excess premium with respect to pro-rata policy has been already received by the insurer then insurer will need to return the

excess premium excluding the premium due for the pro-rata period within 30 days of end of policy.

29.3 Union Territory Health Agency Event of Default

a. The Insurer shall be entitled to terminate this Insurance Contract upon the occurrence of a material breach of this Insurance Contract by the Union Territory Health Agency that remains uncured despite receipt of a 60 day cure notice from the Insurer (a **Union Territory Health Agency Event of Default**), provided that such event is not attributable to a Force Majeure Event.

b. Upon the occurrence of a Union Territory Health Agency Event of Default (non-payment of first installment of premium within 180 days of start of policy), the Insurer may, without prejudice to any other right it may have under this Insurance Contract, in law or at equity, issue a Preliminary Termination Notice to the Union Territory Health Agency. If the Union Territory Health Agency fails to remedy or rectify the Union Territory Health Agency Event of Default stated in the Preliminary Termination Notice issued by the Insurer within 60 days of receipt of the Preliminary Termination Notice, the Insurer will be entitled to terminate this Insurance Contract by issuing a Final Termination Notice.

29.4 Termination Date

The **Termination Date** upon termination of this Insurance Contract for:

a. an Insurer Event of Default, shall be the date of issuance of the Final Termination Notice;

b. a Union Territory Health Agency Event of Default, shall be the date falling 120 Business Days from the date of the Final Termination Notice issued by the Insurer; and

c. A Force Majeure Event shall be the date of expiration of the written notice.

29.5 Consequences of Termination

Upon termination of this Insurance Contract, the Insurer shall:

a. Continue to provide the benefits in respect of the Covers to the Beneficiaries until the Termination Date.

b. Pay to the Union Territory Health Agency on the Termination Date (where termination is due to an Insurer Event of Default or a Force Majeure Event), a sum that shall be calculated as follows for the Union Territory :

$$TC = P \times N \times \frac{UT}{365}$$

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Where:

TC is the sum to be paid by the Insurer to the Union Territory Health Agency on the Termination Date in respect of the Union Territory ;

P is the Premium per Beneficiary Family Unit that has been or has to be paid by the Union Territory Health Agency to the Insurer for the Policy Cover Period in which the Termination Date occurs;

N is the total number of Beneficiary Family Units covered in the Union Territories , for whom the Premium has been or has to be paid by the Union Territory Health Agency to the Insurer for the Policy Cover Period in which the Termination Date occurs; and

UT is the unexpired term of the Policy for that Union Territory, calculated as the number of days between the Termination Date and the date of expiration of the Policy Cover Period (had such Policy continued).

Such payment shall be made by the Insurer to the Union Territory Health Agency exclusive of all applicable taxes and duties. The Insurer shall bear and pay all applicable taxes and duties in respect of such amount.

c. Continue to be liable for all Claims made by the Empanelled Health Care Providers on or before the Termination Date, including:

   (i) all amounts blocked for treatment of the Beneficiaries before the Termination Date, where the Beneficiaries were discharged after the Termination Date; and

   (ii) all amounts that were pre-authorized for Claim Payment before the Termination Date, where the pre-authorization has occurred prior to the Termination Date but the Beneficiaries were discharged after the Termination Date.

The Insurer undertakes that it shall discharge its liabilities in respect of all such Claims raised within 45 days of the Termination Date.

29.6 Migration of Policies Post Termination

a. At least 120 days prior to the expiration of this Insurance Contract or the Termination Date, the UTHA may issue a written request to the Insurer seeking a migration of the Policies for all the districts in the Service Area (**Migration Request**) to another insurance company (**New Insurer**).

b. Once the UTHA has issued such a Migration Request:

   (i) The UTHA shall have the right to identify the New Insurer to whom the Policies will be migrated up to 30 days prior to the expiration date or the Termination Date.
   (ii) The UTHA shall also have the right to withdraw the Migration Request at any time prior to the 30 day period immediately preceding the expiration date or the

Termination Date. If the UTHA chooses to withdraw the Migration Request, then the remaining provisions of this **Clause 29.6** shall not apply from the date of such withdrawal and this Insurance Contract shall terminate forthwith upon the withdrawal of the Migration Request.

c. Upon receiving the Migration Request, the Insurer shall commence preparing Claims data, and current status of implementation of training provided to Empanelled Health Care Providers and any other information sought by the UTHA in the format prescribed by the SHA at that point in time.

d. Within 7 days of receiving notice of the New Insurer, the Insurer shall promptly make available all of the data prepared by it to the New Insurer.

e. The Insurer shall not be entitled to:
   (i) refuse to honour any Claims made by the EHCPs on or before the date of expiration or the Termination Date until the migration process has been completed and the New Insurer assumes all of the risks under the Policies for the Service Area; or
   (ii) cancel the Policies for the Service Area until the migration process has been completed and the New Insurer assumes all of the risks under the Policies for the Service Area; or
   (iii) charge the UTHA, the New Insurer or any third person with any commission, additional charges, loading charges or otherwise for the purpose of migrating the Policies to the New Insurer.

f. The Insurer shall be entitled to retain the proportionate Premium for the period between the date on which a termination notice has been issued and the earlier to occur of: (x) the date on which the New Insurer assumes all the risks under the Policies; and (y) the date of withdrawal of the Migration Request (the **Migration Termination Date**).

29.7 Hand-Over Obligations

Without prejudice to the provisions of **Clause 30.6**, on expiration of the Term or on the Termination Date, the Insurer shall:

a. assign all of its rights, but not any payment or other obligations or liabilities, under its Services Agreements with the Empanelled Health Care Providers and any other agreements with its intermediaries or service providers for the implementation of AB-PMJAY in favour of the Union Territory Health Agency or to the New Insurer, provided that the Insurer has received a written notice to this effect at least 30 days' prior to the date of expiration of the Term or the Termination Date;

b. hand-over, transfer and assign all rights and title to and all intellectual property rights in all data, information and reports in favour of the UT Health Agency or to the New Insurer, whether such data, information or reports have been collected, collated,

created, generated or analysed by the Insurer or its intermediaries or service providers on its behalf and whether such data, information and reports is in electronic or physical form;

30 Force Majeure

30.1 Definition of Force Majeure Event

A **Force Majeure Event** shall mean the occurrence in the Union Territory of Daman & Diu and Dadra Nagar Haveli of any of the following events after the date of execution of this Insurance Contract, which was not reasonably foreseeable at the time of execution of this Insurance Contract and which is beyond the reasonable control and influence of a Party (the **Affected Party**) and which causes a delay and/or inability for that Party to fulfill its obligations under this Insurance Contract:

a. fire, flood, atmospheric disturbance, lightning, storm, typhoon, tornado, earthquake, washout or other Acts of God;

b. war, riot, blockade, insurrection, acts of public enemies, civil disturbances, terrorism, sabotage or threats of such actions; and

c. strikes, lock-out or other disturbances or labour disputes, not involving the employees of such Party or any intermediaries appointed by it,

but regardless of the extent to which the conditions in the first paragraph of this **Clause 30.1** are satisfied, Force Majeure Event shall not include:

a. a mechanical breakdown; or

b. weather conditions which should reasonably have been foreseen by the Affected Party claiming a Force Majeure Event and which were not unusually adverse; or

c. non-availability of or increase in the cost (including as a result of currency exchange rate fluctuations) of suitably qualified and experienced labour, equipment or other resources, other than the non-availability of equipment due to an event that affected an intermediary of the Insurer and that, if it had happened to the Insurer hereunder, would have come within the definition of Force Majeure Event under **Clause 30.1**; or

d. economic hardship or lack of money, credit or markets; or

e. events of physical loss, damage or delay to any items during marine, air or inland transit to the Union Territory of Daman & Diu and Dadra Nagar Haveli unless the loss, damage or delay was directly caused by an event that affected a intermediary of the Insurer and that, if it had happened to the Insurer hereunder, would have come within the definition of Force Majeure Event under **Clause 30.1**; or

f. late performance or other breach or default by the Insurer (including the consequences of any breach or default) caused by the acts, omissions or defaults of any intermediary

appointed by the Insurer unless the event that affected the intermediary and caused the act, omission or default would have come within the definition of Force Majeure Event under **Clause 30.1** if it had affected the Insurer; or

g. a breach or default of this Insurance Contract (including the consequences of any breach or default) unless it is caused by an event that comes within the definition of Force Majeure Event under **Clause 30.1**; or

h. the occurrence of a risk that has been assumed by a Party to this Contract; or

i. any strike or industrial action that is taken by the employees of the Insurer or any intermediary appointed by the Insurer or which is directed at the Insurer; or

j. the negligence or wilful recklessness of the Insurer, the intermediaries appointed by it, their employees or other persons under the control and supervision of the Insurer.

30.2 Limitation on the Definition of Force Majeure Event

Any event that would otherwise constitute a Force Majeure Event pursuant to **Clause 30.1** shall not do so to the extent that the event in question could have been foreseen or avoided by the Affected Party using reasonable *bona fide* efforts, including, in the case of the Insurer, obtaining such substitute goods, works, and/or services which were necessary and reasonable in the circumstances (in terms of expense and otherwise) for performance by the Insurer of its obligations under or in connection with this Insurance Contract.

30.3 Claims for Relief

a. If due to a Force Majeure Event the Affected Party is prevented in whole or in part from carrying out its obligations under this Insurance Contract, the Affected Party shall notify the other Party accordingly (**Force Majeure Notice**).

b. The Affected Party shall not be entitled to any relief for or in respect of a Force Majeure Event unless it has notified the other Party in writing of the occurrence of the Force Majeure Event as soon as reasonably practicable and in any event within 7 days after the Affected Party knew, or ought reasonably to have known, of the occurrence of the Force Majeure Event and it has complied with the requirements of **Clause 30.3** of this Insurance Contract.

c. Each Force Majeure Notice shall:

(i) fully describe the Force Majeure Event;

(ii) specify the obligations affected by the Force Majeure Event and the extent to which the Affected Party cannot perform those obligations;

(iii) estimate the time during which the Force Majeure Event will continue; and

(iv) specify the measures proposed to be adopted to mitigate or minimise the effects of the Force Majeure Event.

d. As soon as practicable after receipt of the Force Majeure Notice, the Parties shall consult with each other in good faith and use reasonable endeavours to agree appropriate mitigation measures to be taken to mitigate the effect of the Force Majeure Event and facilitate continued performance of this Insurance Contract.

If Parties are unable to arrive at a mutual agreement on the occurrence of a Force Majeure Event or the mitigation measures to be taken by the Affected Party within 15 days of receipt of the Force Majeure Notice, then the other Party shall have a right to refer such dispute to grievance redressal in accordance with **Clause 28**.

e. Subject to the Affected Party having complied with its obligations under **Clause 30.3**, the Affected Party shall be excused from the performance of the obligations that is affected by such Force Majeure Event for the duration of such Force Majeure Event and the Affected Party shall not be in breach of this Insurance Contract for such failure to perform for such duration; provided however that no payment obligations (including Claim Payments) shall be excused by the occurrence of a Force Majeure Event.

30.4 Mitigation of Force Majeure Event

Upon receipt of a Force Majeure Notice, each Party shall:

a. mitigate or minimise the effects of the Force Majeure Event to the extent reasonably practicable; and

b. take all actions reasonably practicable to mitigate any loss suffered by the other Party as a result of the Affected Party's failure to carry out its obligations under this Insurance Contract.

30.5Resumption of Performance

When the Affected Party is able to resume performance of the obligations affected by the Force Majeure Event, it shall give the other Party a written notice to that effect and shall promptly resume performance of its affected obligations under this Insurance Contract.

30.6Termination upon Subsistence of Force Majeure Event

If a Force Majeure Event continues for a period of 4 weeks or more within a continuous period of 365 days, either Party may terminate this Insurance Contract by giving the other Party 90 days' written notice.

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31 ASSIGNMENT

31.1 Assignment by Insurer

Except as approved in advance by the Union Territory Health Agency in writing, this Insurance Contract, no Policy and no right, interest or Claim under this Insurance Contract or Policy or any obligations or liabilities of the Insurer arising under this Insurance Contract or Policy or any sum or sums which may become due or owing to the Insurer, may be assigned, transferred, pledged, charged or mortgaged by the Insurer.

31.2 Assignment by Union Territory Health Agency

The Union Territory Government may assign or transfer all or any part of its rights or obligations under this Insurance Contract or any Policy without the prior consent of the Insurer.

31.3 Effect of Assignment

If this Insurance Contract or any Policy or any rights, obligations or liabilities arising under this Insurance Contract or such Policy are assigned or transferred in accordance with this **Clause 31**, then this Insurance Contract and such Policy shall be fully binding upon, inure to the benefit of and be enforceable by the Parties hereto and their respective successors and permitted assigns.

Any assignment not expressly permitted under this Insurance Contract shall be null and void and of no further force and effect.

31.4 Assignment by Beneficiaries or Empanelled Health Care Providers

a. The Parties agree that each Policy shall specifically state that no Beneficiary shall have the right to assign or transfer any of the benefits or the Covers made available to it under this Insurance Contract or any Policy.

b. The Parties agree that the Empanelled Health Care Providers may assign, transfer, pledge, charge or mortgage any of their rights to receive any sums due or that will become due from the Insurer in favour of any third party.

Without limiting the foregoing, the Parties acknowledge that the public Empanelled Health Care Providers in the Service Area that are under the management of Rogi Kalyan Samitis may assign all or part of their right to receive Claims Payments from the Insurer in favour of the Rogi kalyan samiti.

On and from the date of receipt of a written notice from the public Empanelled Health Care Providers in the Service Area or from UT Administration of Daman & Diu and Dadra Nagar Haveli, the Insurer shall pay all or part of the Claims Payments to the person(s) so notified.

32 Confidentiality of Information and Data Protection

Insurer will treat all non-public, especially health, treatment and payment related information as confidential and such party shall not disclose or use such information in a manner contrary to the purposes of this Agreement.

All the beneficiary and transaction data generated through the scheme shall be kept securely by the insurer and will not be shared with any other agency than the ones defined in the agreement.

33 Intellectual Property Rights

Each party will be the owners of their intellectual property rights (IPR) involved in this project and will not have any right over the IPR of the other party. Both parties agree that for the purpose of fulfilling the conditions under this contract they may allow the other party to only use their IPR for the contract period only. However, after the end of the contract no parties will have any right over the IPR of other party.

34 Entire Agreement

This Insurance Contract entered into between the Parties represents the entire agreement between the Parties setting out the terms and conditions for the provision of benefits in respect of the AB-PMJAY Cover to the Beneficiaries that are covered by the Insurer.

35 Relationship

a. The Parties to this Insurance Contract are independent contractors. Neither Party is an agent, representative or partner of the other Party. Neither Party shall have any right, power or authority to enter into any agreement or memorandum of understanding for or on behalf of, or incur any obligation or liability of, or to otherwise bind, the other Party.

b. This Insurance Contract shall not be interpreted or construed to create an association, agency, joint venture, collaboration or partnership between the Parties or to impose any liability attributable to such relationship upon either Party.

c. The engagement of any intermediaries or service providers by the Insurer shall not in any manner create a relationship between the Union Territory Health Agency and such third parties.

36 Variation or Amendment

a. No variation or amendment of this Insurance Contract shall be binding on either Party unless and to the extent that such variation is recorded in a written document executed by both Parties but where any such document exists and is so signed, neither Party shall allege that such document is not binding by virtue of an absence of

consideration.

b. Notwithstanding anything to the contrary in **Clause 34(a)** above, the Insurer agrees that the MoHFW and the Union Territory Health Agency shall be free to issue AB-PMJAY Guidelines from time to time (including pursuant to the issuance of recommendations of the Working Group constituted by the MoHFW) and the Insurer shall comply with all such AB-PMJAY Guidelines issued during the Term, whether or not the provisions or terms of such AB-PMJAY Guidelines have the effect of varying or amending the terms of this Insurance Contract.

37 Severability

If any provision of this Insurance Contract is invalid, unenforceable or prohibited by law, this Insurance Contract shall be considered divisible as to such provision and such provision shall be inoperative and the remainder of this Insurance Contract shall be valid, binding and of the like effect as though such provision was not included herein.

38 Notices

Any notice given under or in connection with this Insurance Contract shall be in writing and in the English language. Notices may be given, by being delivered to the address of the addressees as set out below (in which case the notice shall be deemed to be served at the time of delivery) by courier services or by fax (in which case the original shall be sent by courier services).

To: **Insurer**
Attn: Mr. / Ms.
E-Mail:
Phone:
Fax:

To: **Union Territory Health Agency**
Attn: Mr. / Ms.
E-Mail:
Phone:
Fax:

39 No waiver

Except as expressly set forth in this Insurance Contract, no failure to exercise or any delay in exercising any right, power or remedy by a Party shall operate as a waiver. A single or partial exercise of any right, power or remedy does not preclude any other or further exercise of that or any other right, power or remedy. A waiver is not valid or binding on the Party granting that waiver unless made expressly in writing.

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40 Governing Law and Jurisdiction

a. This Insurance Contract and the rights and obligations of the Parties under this Insurance Contract shall be governed by and construed in accordance with the Laws of the Republic of India.

b. The courts in [UT' of Daman & Diu and Dadra Nagar Haveli] shall have the exclusive jurisdiction over any disputes arising under, out of or in connection with this Insurance Contract.

IN WITNESS WHEREOF, the Parties have caused this Insurance Contract to be executed by their duly authorized representatives as of the date stated above.

SIGNED, SEALED and DELIVERED

For and on behalf of for and on behalf of
UT Administration of

Daman & Diu and Dadra Nagar Haveli.

Represented by

Director Medical & Health Services,
Daman & Diu and Dadra Nagar Haveli/CEO (AB-PMJAY)

In the presence of:

(1) Dr. Mahesh Kakadiya

(2) STERLING NUNES

SIGNED, SEALED and DELIVERED

The Oriental Insurance Company ltd.

Represented by

ASST. DIVL. MANAGER

In the presence of:

(1) Mr. Umesh R. Patel

(2)