

**Tender Document for Selection of Insurance Company
for the implementation of
Ayushman Bharat – Mahatma Gandhi Rajasthan
SwasthayaBimaYojana(AB-MGRSBY)**

In the State of Rajasthan

October, 2019

Volume I:
Instruction to Bidders

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Abbreviations

AB-MGRSBY	Ayushman Bharat – Mahatma Gandhi Rajasthan SwasthayaBimaYojana
AL	Authorization Letter (from the Insurer)
BFU	Beneficiary Family Unit
BPL	Below Poverty Line
CCGMS	Central Complaints Grievance Management System
CHC	Community Health Centre
CGIP	Composite Gross Insurance Premium for AB-MGRSBY
CRC	Claims Review Committee
DAL	Denial of Authorization Letter
DGRC	District Grievance Redressal Committee
DGNO	District Grievance Nodal Officer
DEC	District Empanelment Committee
EHCP	Empanelled Health Care Provider
INR	Indian National Rupees
IRDAI	Insurance Regulatory Development Authority of India
MoHFW	Ministry of Health & Family Welfare, Government of India
NGRC	National Grievance Redressal Committee
NHA	National Health Agency
NFSA	National Food Security Act
NOA	Notice of Award
RAL	Request for Authorization Letter (from the EHCP)
RC	Risk Cover
RSBY	RashtriyaSwasthyaBimaYojana
SEC	State Empanelment Committee
SECC	Socio Economic Caste Census
SGRC	State Grievance Redressal Committee
SGNO	State Grievance Nodal Officer
RSHAA	Rajasthan State Health Assurance Agency
UCN	Unique Complaint Number

Details At A Glance

Project title	AYUSHMAN BHARAT – MAHATMA GANDHI RAJASTHAN SWASTHAYA BIMA YOJANA (AB-MGRSBY)
Objectives of the project	The objective of AB-MGRSBY is to reduce out of pocket hospitalisation expenses, reduce unmet needs and improve access of identified families to quality inpatient care and day care surgeries for treatment of diseases and medical conditions through a network of Empanelled Health Care Providers (EHCP).
Bid Procedure	Single Stage: Two part open competitive e-Bid procedure through http://eproc.rajasthan.gov.in
Bid Evaluation Criteria (Selection Method)	Least Cost Based Selection (LCBS) i.e. lowest-1 (L1) method.
Websites for downloading the bidding document, corrigendums, addendums etc.	- Websites: http://sppp.rajasthan.gov.in, http://eproc.rajasthan.gov.in, www.rajswasthya.nic.in. - Document Fee: Rs.50000/- (fifty thousand) in form of banker's cheque or demand draft or bank guarantee, in specified format, of a scheduled bank or deposit through RTGS, in favor of CEO, RSHAA payable at Jaipur on or before opening of proposal. - RISL processing fee: Rs.1000.00 (one thousand only) in form of Demand Draft/Banker's Cheque in favor of MD, RISL payable at Jaipur.
Estimated Cost of Project	Rupees 2000.00 Crores (Thousand Crores only).
Bid Security and mode of payment	Amount (INR): 40 Crores in form of banker's cheque or demand draft or bank guarantee, in specified format, of a scheduled bank or deposit through eGRAS in favor of CEO, RSHAA payable at Jaipur.
Period of sale of bidding documents (Start/End Date)	- From: 18/10/2019 12:00 noon - to 07/11/2019 up to 12:01 pm
Submissions required	Bid Security, Document Fees, RISL Processing Fees. Qualification Bid: Formats Qual-1 to Qual-8 as per Clause 7.7.1 of Volume I of the Tender Document. Financial Bid: Form Fin-1 and Form Fin-2 as per Clause 7.7.2 of Volume I of the Tender Document.

Contact details for all queries	Name: Sh. Naresh Kr. Thakral Designation: CEO, RSHAA Address: SwasthayaBhawan, TilakMarg, C-Scheme, Jaipur Pin code : 302005 Tel No.: 0141-2221590 Email: md-nrh-m-rj@nic.in
Detail for RTGS (if applicable)	• Bank Name –HDFC Bank Ltd • IFSC Code – HDFC0001585 • A/C No. – 50100252362032 • A/C Holder Name – Rajasthan State Health Assurance Agency.
Language of bid	English
Currency of bid	Indian National Rupees (INR)
Eligibility to bid	a. The Bidder should be a registered private or public owned insurance company incorporated under The Companies Act, 1956 and/or 2013, in India. b. The Bidder should be registered with the Insurance Regulatory Development Authority of India (IRDAI) to carry out health insurance business for at least the last three completed financial years. c. The Bidder shall have overall done the group health cover policy of at least 1,00,000 families in any two of the last three financial years. d. The Bidder shall have Gross Direct Premium Income from Health business of at least Rs. 200 crores in India in each of the last three completed financial years. e. The Bidder should unconditionally accept the terms and conditions of this Tender Document.
Manner, Start/End Date for the submission of bids	• e_Bids • From: 18/10/2019 12:00 noon • to 07/11/2019 up to 12:01 pm

Submission of Banker's Cheque/Demand Draft/RTGS for document cost, Bid Security and Processing Fee	- From: 08 /11/2019 12:00 noon - To next day after end date for submission as mentioned above to 08/11/2019 upto 02:00 pm
Insurance Contract period	Two years extendable for another one year.
Validity of the bids	180 days from last date for submission of the bid documents, excluding the last date of submission.
Address for bid submission	Office of CEO, RSHAA, Swasthaya Bhawan, Tilak Marg, C-Scheme, Jaipur. Pin code : 302005.
Important Dates:	
Date of release of Tender Document	18/10/2019
Last date of receiving queries	Within 5 days of the release of the Tender Document. (23/10/2019)
Pre-bid meeting	Within 7 days of the release of the Tender Document. (25/10/2019 at 11 am at Swasthya Bhawan, Tilak Marg, Jaipur)
Issue of Addendum / revised Tender Document (if required)	Within 10 days of the release of the Tender Document (only if required) On the following website: http://sppp.rajasthan.gov.in , http://eproc.rajasthan.gov.in , www.rajswasthaya.gov.in
Last date of bid submission	Within 21 days of the release of the Tender Document, that is, 12:01 pm on 07/11/2019 on http://eproc.rajasthan.gov.in
Date and time of technical bid evaluation	08/11/2019 at 04:00 pm
Date and time of Financial Bid opening	To be conveyed to responsive bidders once technical bid is finalized.
Acceptance of Notice of Award	Within 3 days of the issue of Notice of Award.

Disclaimer

The information contained in this Tender Document or subsequently provided to the Bidders, whether verbally or in documentary or any other form, by or on behalf of the Department of Health and Family Welfare, Government of Rajasthan, hereinafter referred to as the State Government, acting through the Rajasthan State Health Assurance Agency (RSHAA), or any of its employees or advisors, is provided to the Bidders on the terms and conditions set out in this Tender Document along with all its Volumes and such other terms and conditions subject to which such information is provided.

The purpose of this Tender Document is to provide the Bidder with information to assist the formulation of their bid. This Tender Document does not purport to contain all the information each Bidder may require. This Tender Document may not be appropriate for all persons and it is not possible for the State Government or the RSHAA or its representatives, to consider the objectives, financial situation and particular needs of each Bidder who reads or uses this Tender Document. Each Bidder should conduct its own investigations and analysis and should check the accuracy, reliability and completeness of the information in this Tender Document, and where necessary obtain independent advice from appropriate sources. Neither the State Government nor the RSHAA nor their employees or their consultants make any representation or warranty as to the accuracy, reliability or completeness of the information in this Tender Document. The State Government shall incur no liability under any law including the law of contract, tort, the principles of restitution, or unjust enrichment, statute, rules or regulations as to the accuracy, reliability or completeness of the Tender document. The statements and explanations contained in this Tender document are intended to provide an understanding to the Bidders about the subject matter of this Tender and should not be construed or interpreted as limiting in any way or manner the scope of services and obligations of the Bidders that will be set forth in the Insurer's Contract or the State Government's rights to amend, alter, change, supplement or clarify the scope of work, or the Insurance Contract to be signed pursuant to this Tender Document the terms thereof or herein contained. Consequently, any omissions, conflicts or contradictions in the Bidding Documents, including this Tender Document, are to be noted, interpreted and applied appropriately to give effect to this intent, and no claims on that account shall be entertained by the State Government.

This Tender Document does not constitute an agreement and does not constitute either an offer or invitation by the State Government or the RSHAA to the Bidders or any other person.

Information provided in the Tender Document to the Bidders is on a wider range of matters, some of which may depend upon interpretation of law. The information given is not intended to be an exhaustive account of statutory requirements and should not be regarded as complete or authoritative statements of law. The State Government or the RSHAA accepts no responsibility for the accuracy, or otherwise, of any interpretation or opinion on law expressed in this Tender Document.

The State Government may, in its absolute discretion but without being under any obligation to do so, update, amend or supplement the information, assessment or assumptions contained in this Tender Document.

The issue of this Tender Document does not imply that the State Government is bound to appoint an Insurer as the Successful Bidder, and the State Government reserves the right to reject all or any of the Bidders or Bids or not to enter into an agreement for the implementation of the AB-MGRSBY in the State of Rajasthan, without assigning any reason whatsoever.

Each Bidder shall bear all its costs associated with or relating to the preparation and submission of its Bid including but not limited to preparation, copying, postage, delivery fees, expenses affiliated with any demonstration or presentation which may be required by the State Government or any other costs incurred in connection with or relating to its Bid. All such costs and expenses will be borne by the Bidders and the State Government and its employees and advisors shall not be liable, in any manner whatsoever, for the same or for any other costs or other expenses incurred by any Bidder in preparation or submission of its Bid, regardless of the conduct or outcome of the Bidding Process.

The entire Tender Document is in three volumes: *Volume I – Instruction to Bidders*, *Volume II – About AB-MGRSBY* and *Volume III – Insurance Contract to be signed by the Insurance Company*.

This document is *Volume I* of the Tender Document, ‘Instruction to Bidders’.

Definitions and Interpretations

Addendum or Addenda means document issued in continuation or as modification or as clarification to certain points in the Tender Documents. The bidders would need to consider the main document as well as any addenda issued subsequently for responding to the bid.

AB-MGRSBY shall refer to Ayushman Bharat – Mahatma Gandhi Rajasthan Swasthaya Bima Yojana (AB-MGRSBY), a scheme managed and administered by the Department of Health and Family Welfare, Government of Rajasthan through Rajasthan State Health Assurance Agency 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 for treatment of diseases and medical conditions through a network of Empanelled Health Care Providers for the risk covers defined in Section 4 of Volume II of this Tender Document.

Basic Sum Insured shall mean sum of Rs5.00 lakhs per family per year. This cover shall be segmented into **Rs. 50, 000 for secondary illnesses and Rs. 4,50,000 for tertiary illness** per family per annum on family floater basis. This shall be called the **Basic Sum Insured**, which shall be fixed irrespective of the size of the AB-MGRSBY Beneficiary Family Unit, against which the beneficiary family unit may seek benefits as per the benefit package proposed under the AB-MGRSBY.

Beneficiary means a member of the AB-MGRSBY Beneficiary Family Units who is eligible to avail benefits under the Ayushman Bharat – Mahatma Gandhi Rajasthan Swasthaya Bima Yojana. Referred to as AB-MGRSBY Beneficiary henceforth in the document.

Beneficiary Family Unit or AB-MGRSBY Beneficiary Family Unit refers to a family who is covered under National Food Security Act 2013 and/or eligible family of AYUSHMAN BHARAT- PRADHAN MANTRI JAN AROGYA YOJNA from the eligible categories of Socio-Economic Caste Census (SECC) which are resident of Rajasthan and have linked their eligibility with the identity card as decided by GoR shall be considered as eligible for benefits under the Scheme and be automatically covered under the Scheme. In addition to this, additional categories which gets covered under the scheme in connection to **clause 2.2 of vol I** shall also be considered as beneficiary family units from the date of their coverage under the scheme. Date of coverage shall be decided as per directions of RSHAA. Unit of coverage under the Scheme shall be a family and each family for this Scheme shall be called a AB-MGRSBY Beneficiary Family Unit, which will comprise all members in that family whose names are mentioned in the ID Card as decided by GOR. In addition to this, children of that family up to the age of one year will also be considered the member of that family even without having name in the ID Card.

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

Benefit Cover refers to the annual basic cashless hospitalisation coverage of Rs5.00 lakhs per family per year. This cover shall be segmented into **Rs. 50, 000 for secondary illnesses and Rs. 4,50,000 for tertiary illness** per family per annum on family floater basis that the insured families would receive under the Ayushman Bharat – Mahatma Gandhi Rajasthan Swasthaya Bima Yojana.

Bid refers to the qualification bid 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 Rajasthan State Health Assurance Agency for the purposes of evaluating the Bid.

Bid Validity Period shall mean the period of 180 days from the Bid Due Date (excluding the Bid Due Date) for which each bid shall remain valid.

Bidder shall mean any eligible Insurance Company which has submitted its bids in response to this Tender Document released by the State Government.

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

EHCP or Empanelled Health Care Providers shall mean and refer to those public or private health care providers who are empanelled by the RSHAA for providing services to the Beneficiaries under the Ayushman Bharat – Mahatma Gandhi Rajasthan Swasthaya Bima Yojana.

IEC shall mean Information Education and Communication and refer to all such efforts undertaken by the Rajasthan State Health Assurance Agency, the State Government that are aimed at promoting information and awareness about the Ayushman Bharat – Mahatma Gandhi Rajasthan Swasthaya Bima Yojana and its benefits to the potential beneficiaries in particular and to the general population at large.

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 State Government.

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.

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

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 RSHAA from time to time.

Risk Cover shall mean an annual risk cover of 5.00 lakhs per family per year. This cover shall be segmented into **Rs. 50, 000 for secondary illnesses and Rs. 4,50,000 for tertiary illness** per family per annum on family floater basis covering in-patient care (IPD) and day care surgeries for treatment of diseases and medical conditions pertaining to secondary and / or tertiary treatment through a network of Empanelled Health Care Providers (EHCP) for the AB-MGRSBY Beneficiary Family Units validated by the State Government or Rajasthan State Health Assurance Agency (RSHAA).

Rajasthan State Health Assurance Agency (RSHAA) refers to the agency/ body set up by the Department of Medical, Health and Family Welfare, Government of Rajasthan for the purpose of coordinating, managing and implementing the Ayushman Bharat – Mahatma Gandhi Rajasthan Swasthaya Bima Yojana in the State of Rajasthan.

Successful Bidder shall mean the Bidder (Insurance Company) whose bid document is responsive, which has been prequalified and whose financial bid is the lowest among all the shortlisted and with

whom the State Government intends to select and sign the Insurance Contract for this Scheme.

Scheme shall mean the Ayushman Bharat – Mahatma Gandhi Rajasthan Swasthaya Bima Yojana managed and administered by the Department of Medical, Health and Family Welfare, Government of Rajasthan through RSHAA.

Selected Bidder shall mean the successful bidder who 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 State Government.

Service Area refers to all the districts in the State of Rajasthan covered and included under this Tender Document for the implementation of AB-MGRSBY.

Secondary and Tertiary illness: Secondary and Tertiary illness means the condition covered in Volume II (Annex 2.3) and Volume III (Schedule 3).

Rajasthan State Health Assurance Agency (RSHAA) refers to the agency/ body set up by the Department of Medical, Health and Family Welfare, Government of Rajasthan for the purpose of coordinating, managing and implementing the Ayushman Bharat – Mahatma Gandhi Rajasthan Swasthaya Bima Yojana in the State of Rajasthan.

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

**Tender Document for the
Selection of Insurance Company
for the implementation of
Ayushman Bharat – Mahatma Gandhi Rajasthan Swasthaya Bima
Yojana**

In the State of Rajasthan

**Volume I
Instruction to Bidders**

Volume I: Instruction to Bidders

1. Context

1.1 The name of the Scheme is the “AYUSHMAN BHARAT MAHATMA GANDHI RAJASTHAN SWASTHAYA BIMA YOJANA” and shall hereafter be referred to as the AB-MGRSBY or “SCHEME”.

1.2 The scheme aims to reduce the out of pocket healthcare expenditures and to improve access of poor and vulnerable families who are included in the National Food Security Act 2013 and/ or SECC Database under D1, D2, D3, D4, D5 and D7 category (in case of Rural Population), Automatically Included category and 11 broadly defined occupational unorganised workers (in Urban Sector) of the Socio-Economic Caste Census (SECC) database of the State Government to provide quality inpatient care and day care surgeries for treatment of diseases and medical conditions pertaining to secondary and / or tertiary treatment through a network of Empanelled Health Care Providers (EHCP), to the beneficiaries for the risk covers as defined below.

1.3 The following benefits will be covered for the eligible AB-MGRSBY beneficiary families under the SCHEME.

- a. Hospitalization expenses coverage including treatment for medical conditions and diseases requiring secondary and tertiary level of medical and surgical care treatment including defined day care surgeries and follow –up care.
- b. Pre and post hospitalisation cover.
- c. Risk Cover (RC) of Rs. 5.00 lakhs per family per year. This cover shall be segmented into **Rs. 50, 000 for secondary illnesses and Rs. 4,50,000 for tertiary illness** per family per annum on family floater basis per eligible AB-MGRSBY Beneficiary Family Unit per annum under AB-MGRSBY.

Eligible family will include all members within identified relationships as included in the identity card as decided by Government of Rajasthan under AB-MGRSBY Database and updated from time to time.

For further details about the Scheme including risk cover, benefit packages and procedures covered, premium payment details, proposed roles and responsibilities of the Insurer and all other relevant details, refer to Volume II of this Tender Document.

2. Purpose and Scope of this Tender Document

2.1 The purpose of this Tender Document is to select the most competent and competitive Insurance Company to provide the *Benefit Risk Cover* under the Scheme

referred to in **1.3** above and in detail in **Volume II** of this Tender Document.

Beneficiaries and Geographical Coverage: The Scheme is intended to provide the benefit to all eligible AB-MGRSBY Beneficiary Families included in database currently and updated from time to time by the State Government, subject to the compliance of AB-MGRSBY Guidelines. Therefore, bids are invited from interested and eligible Insurance Companies to cover approximately 1.10 crorenumber of eligibleAB-MGRSBY Beneficiary Family Units in the State of Rajasthan

- 2.2 In addition to the number of eligible AB-MGRSBY Beneficiary Family Units as given above, ~~the~~Government of India/ StateGovernment may add more beneficiaries to the Scheme as part of additional sponsored categoryafter mutual consent with insurer. The premium for add-on beneficiary families will be borne by the StateGovernment /Golrespectively. The unit of coverage for Benefit Risk Cover will be aAB-MGRSBY Beneficiary Family Unit, which will include all family members as further defined in **Volume II** of this Tender Document.
- 2.3 The RSHAA hereby invites applications from interested and eligible Insurance Companies to participate in the tendering process as per the terms, conditions and guidelines of this Tender Document.
- 2.3.1 Bid is being invited for the entire State.
- 2.3.2 The lowest bidder whether from public or private insurance company will be the winner (L-1).

3. Eligibility of Bidders

3.1 Qualification Criteria

- 3.1.1 Only those insurance companies that are registered with the Insurance Regulatory and Development Authority of India (IRDAI) for the last three consecutive financial years and holding the valid licence to provide insurance services as on the date of issue of this Tender Document and meeting the criteria as defined below shall be eligible to submit a Bid in response to this Tender Document.
- 3.1.2 The minimum qualification criteria as per the guidelines laid down by Ministry of Health & Family Welfare, Government of India are as follows:
- The Bidder should be a registered private or public owned insurance company incorporated under The Companies Act, 1956 and/or 2013, in India.
 - The Bidder should be registered with the IRDAI to carry out health insurance business for at least` last three completed financial years.For the avoidance of doubt, for the purposes of this Tender and determining health insurance

business, health insurance business will exclude personal accident and travel cover, whether explicitly stated or not.

- iii. The Bidder shall have overall done the group health policy cover(excluding personal accident or travel cover) of at least 1,00,000 families in any two of the last three completed financial years.
- iv. The Bidder shall have Gross Direct Premium Income from HealthInsurance (excluding personal accident or travel cover)of at least Rs. 200 crores in India in any two of the last three completed financial years.
- v. The Bidder should unconditionally accept the terms and conditions of this Tender Document.

3.1.3 If any Bidder fails to meet the minimum Qualification Criteria, its Bid shall be summarily rejected.

3.2 Consortium Not Allowed

3.2.1 Consortium applications are not allowed under this Tender Document.

3.2.2 The Bid submitted by any consortium shall be rejected including individual applications of any company which has applied as a part of the Consortium.

4. Grounds for Rejecting the Bid

4.1 Fraud and Corruption

4.1.1 Each Bidder and its officers, employees, agents and advisers shall observe the highest standard of ethics during the Bidding Process.

4.1.2 Without prejudice to the rights of the RSHAA under **Clause 4.1**, if a Bidder is found by the RSHAA to have directly or indirectly or through an agent, engaged or indulged in any corrupt practice, fraudulent practice, coercive practice, undesirable practice and / or restrictive practice during the Bidding Process, such Bidder shall not be eligible to participate in any tender or bid process conducted by the State Government or any of the other ministries, departments, State owned enterprises or undertakings of the State Government or the RSHAA for a period of three years from the date that such an event occurs.

4.1.3 For the purpose of this **Clause 4.1**, the following terms will have the meanings given to them below:

a. **corrupt practice** means:

- (i) Offering, giving, receiving or soliciting, directly or indirectly, of value to influence the

actions of any person connected with the Bidding Process. For the avoidance of doubt, offering of employment to, or employing, or engaging in any manner whatsoever, directly or indirectly, any official of the State Government or the RSHAA who is or has been associated in any manner, directly or indirectly, with the Bidding Processor has dealt with matters concerning the Scheme or arising from it at any time prior to the expiry of one year from the date such official resigns or retires from or otherwise ceases to be in the service of the State Government or the RSHAA, will be deemed to constitute influencing the actions of a Person connected with the Bidding Process; or

- (ii) engaging in any manner whatsoever, whether during the Bidding Processor before or after the execution of the Insurance Contract, as the case may be, any Person in respect of any matter relating to the Scheme, the Bidding Processor or the Insurance Contract, who at any time has been or is a legal, financial or technical advisor of the State Government or the RSHAA on any matter concerning the Scheme.
- b. **Fraudulent practice** means any act or omission, including a misrepresentation, that knowingly or recklessly misleads, or attempts to mislead, a person to obtain a financial or any other benefit or to avoid an obligation.
- c. **Coercive practice** means impairing or harming, or threatening to impair or harm, directly or indirectly, any person or the property of the person to influence improperly the actions of a person.
- d. **undesirable practice** means:
 - (i) establishing contact with any person connected with or employed or engaged by the RSHAA or its advisors with the objective of canvassing, lobbying or in any manner influencing or attempting to influence the Bidding Process; or
 - (ii) Having a Conflict of Interest (as defined in **Clause 4.2** below).
- e. **restrictive practice** means forming a cartel or arriving at any understanding or arrangement amongst Bidders with the objective of restricting or manipulating full and fair competition in the Bidding Process.

4.2 Conflict of Interest

- 4.2.1 A Bidder shall not have any conflict of interest (a Conflict of Interest) that affects the Bidding Process.
- 4.2.2 A Bidder that is found to have a Conflict of Interest shall be disqualified and the bid submitted shall become null and void.

4.2.3 A Bidder shall be deemed to have a Conflict of Interest affecting the Bidding Process, if:

- a. such Bidder or an Affiliate of such Bidder controls, is controlled by or is under common control with any other Bidder or any Affiliate thereof; provided that this disqualification shall not apply if:
 - (i) the person exercising Control is the Government of India, a State government, other government company or entity controlled by a government, a bank, pension fund or a financial institution; or
 - (ii) any direct or indirect ownership interest in such other Bidder or Affiliate
- b. such Bidder or its Affiliate receives or provides any direct or indirect subsidy, grant, concessional loan, subordinated debt or other funded or non-funded financial assistance from or to any other Bidder or such other Bidder's Affiliate; or
- c. such Bidder has the same legal representative for purposes of this Bidding Process as any other Bidder; or
- d. such Bidder or its Affiliate has a relationship with another Bidder or such other Bidder's Affiliate, directly or through common third party or parties, that puts either or both of them in a position to have access to the others' information about, or to influence the Bid of either or each other.

4.3 Misrepresentation by the Bidder

4.3.1 The RSHAA shall have the right to reject any bid if:

- a. at any time, a material misrepresentation is made by the Bidder; or
- b. The Bidder does not provide, within the time specified by the RSHAA, any additional information sought by the RSHAA for the purposes of evaluating the Bid.

4.3.2 The RSHAA has the right to reject any Bid if it is found that during the evaluation or at any time before signing the Insurance Contract or after its execution and during the period of its subsistence thereof the Bidder, in the opinion of the RSHAA, has made a material misrepresentation or has given any materially incorrect or false information, the Bidder shall be disqualified forthwith, if not yet selected as the Successful Bidder by issuance of the Notice of Award (NOA). If the Bidder has already been issued the NOA or it has entered into the Insurance Contract, as the case may be, the same shall, notwithstanding anything to the contrary contained therein or in this Tender Document, be liable to be terminated, by a communication in writing by the RSHAA to the Bidder, without the RSHAA being liable in any manner whatsoever to the Bidder.

4.4 Other Grounds Declaring a Bid Ineligible

4.4.1 If the bidder has:

- a. been black-listed/debarred to bid for government sponsored health insurance schemes by Government of India or Government of Rajasthan and such black-listing/debarring subsists as on the last date of bid submission; or
- b. failed to comply with the Insurance Laws and such non-compliance continues as on the last date of bid submission ;or
- c. any contract for the implementation of a government sponsored health insurance scheme has been terminated by at least four government /s or government instrumentalities for breach by such Bidder, in any of the three (3) years immediately prior to the last date of bid submission, then such an Insurance Company shall not be eligible to submit a Bid.

4.4.2 A Bid submitted by any such Insurance Company shall be rejected by the RSHAA at any stage that the RSHAA acquires any such knowledge and undertakes its due diligence.

4.5 RSHAA's Right to Evaluate Eligibility

4.5.1 The RSHAA reserves the right to require a Bidder to submit documentary evidence, in the form and manner that the RSHAA deems appropriate, to prove that it continues to satisfy the Eligibility Criteria at anytime:

- a. after the last date of bid submission ;or
- b. prior to or after the issuance of the NOA or execution of the Insurance Contract, if such a Bidder is selected as the Successful Bidder.

4.5.2 The RSHAA reserves the right to verify all statements, information and documents submitted by Bidders in response to the Tender Document. Any such verification or lack thereof by the RSHAA will neither relieve the Bidders of their obligations or liabilities nor affect any rights of the RSHAA under this Tender Document.

4.5.3 If the RSHAA is of the opinion that the Bidder does not satisfy the Qualification Criteria, then the RSHAA shall have the right to:

- a. disqualify the Bidder and reject its Bid; or
- b. revoke the NOA or terminate the Insurance Contract after acceptance of its Bid by issuing a written notice to the Bidder.

4.5.4 The RSHAA's determination of a Bidder's eligibility shall be final and binding. The RSHAA shall not be liable, in any manner whatsoever, to the Bidder for a rejection of its Bid, the revocation of the NOA issued to it or the termination of the Insurance Contract executed with it.

4.5.5 If the RSHAA terminates the Insurance Contract in accordance with -

Clause 4.4 and /or **Clause 4.5**, then the Insurer shall be liable to repay the Premium received by it on pro-rata basis and take other measures upon such termination, in accordance with the provisions of the Insurance Contract, including liability to pay penal charges, if any, levied by the RSHAA.

5. Clarifications and Pre-Bid Meeting

5.1 Clarifications and Queries

- 5.1.1 If a Bidder requires any clarification on the Tender Document, it may notify the RSHAA in writing, provided that all queries or clarification requests should be received on or before the due date and time mentioned in the Data Sheet.
- 5.1.2 The RSHAA shall endeavour to respond to any request for clarification or modification of the Tender Document that it receives, no later than the date specified in the Tender Notice and the Data Sheet.
- 5.1.3 The responses to such queries shall be published on the Scheme website / e-tender portal (as appropriate) of the State Government or the RSHAA / the Scheme within the time frame indicated in the Data Sheet.
- 5.1.4 It shall be the duty of the Bidders to regularly check the relevant website(s)/ e-tender portal (as appropriate) for the response to the queries or requests for clarifications. The RSHAA's written responses (including an explanation of the query but not identification of its source) will be made available to all the Bidders on the relevant website/ e-tender portal (as appropriate) specified in the Data Sheet.
- 5.1.5 The RSHAA reserves the right not to respond to any query or provide any clarification, in its sole discretion, and nothing in this Clause shall be taken to be or read as compelling or requiring the RSHAA to respond to any query or to provide any clarification.
- 5.1.6 The RSHAA may of its own initiative, if deemed necessary, issue interpretations, clarifications and amendments to all the Bidders. All clarifications, interpretations and amendments issued by RSHAA shall be issued on or before the date specified in the Data Sheet on the relevant website.
- 5.1.7 Verbal clarifications and information given by the RSHAA, or any other person for or on its behalf shall not in any way or manner be binding on the RSHAA.
- 5.1.8 Should the RSHAA deem it necessary to amend the Tender Document as a result of one or more queries or request(s) for clarification or modification, it will do so following the procedure set out in **Clause 6.1**.

5.2 Pre-Bid Meeting

- 5.2.1 The RSHAA shall organize a Pre-Bid meeting with all interested Bidders before the last date of bid submission (the Pre-Bid Meeting) to provide an understanding of the Bidding Process, the Scheme, the terms of the Insurance Contract and the services to be provided by the Insurer and to understand any queries, issues or suggestions that the Bidders may put forward.
- 5.2.2 The Pre-Bid Meeting will be convened on the date and time specified in the Tender Notice and the Data Sheet.
- 5.2.3 A Bidder may nominate up to three representatives to participate in a Pre-Bid Meeting, provided that the Bidder has notified the RSHAA of its representatives along with its authority letter to the RSHAA at least two days prior to the Pre-Bid Meeting.
- 5.2.4 The Bidders are requested to submit any query or seek clarifications in writing, to reach the RSHAA not later than the date specified in the Data Sheet, so that the RSHAA can address the issues comprehensively at the Pre-Bid Meeting.
- 5.2.5 Without prejudice to the foregoing Clauses, the Bidders will be free to seek clarifications and make suggestions for consideration of the RSHAA in the course of the Pre-Bid Meeting.
- 5.2.6 The RSHAA shall endeavour to provide text of the questions raised and the responses, along with the minutes of the Pre-Bid Meeting and such further information as it may, in its sole discretion, consider appropriate for facilitating a fair, transparent and competitive Bidding Process, within the date specified in the Data Sheet.
- 5.2.7 Any oral clarification or information provided by or on behalf of the RSHAA at the Pre-Bid Meeting will not have the effect of modifying the Tender Document in any manner, unless the RSHAA issues an Addendum for the same or the RSHAA issues written interpretations and clarifications in accordance with **Clause 6.1**. All such Addendum will be published on the relevant website/ e-tender portal (as appropriate).
- 5.2.8 Attendance of the Bidders at the Pre-Bid Meeting is not mandatory and failure to attend the Pre-Bid Meeting will not be a ground for disqualification of any Bidder.

6. Amendments to the Tender Documents

6.1 Issuance of Addenda

- 6.1.1 Up until the date that is specified in the Data Sheet, the RSHAA may, for any reason, whether at its own initiative or in response to a query raised or clarification

requested by Bidder at the Pre-Bid Meeting, amend the Tender Document by issuing an Addendum.

6.1.2 The Bidders are required to read the Tender Document with any Addendum that may be issued in accordance with this **Clause 6.1**.

6.1.3 Each Addendum shall be binding on the Bidders, whether or not the Bidders convey their acceptance of the Addendum.

6.1.4 Any oral statement made by the RSHAA or its advisors regarding the Bidding Process, the Tender Document or the Scheme or on any other matter related to the Scheme, shall not be considered as amending the Tender Document.

6.2 Issuance of Revised Tender Documents

6.2.1 The RSHAA shall use its best efforts to issue the Addendum or the revised Tender Documents reflecting all the amendments and changes agreed to by the RSHAA, on the date specified in the Bid Schedule. The Addendum or the revised Tender Documents issued by the RSHAA shall be definitive and binding.

6.2.2 The RSHAA will assume that the information contained in or provisions of the revised Tender Documents have been taken into account by the Bidder in its Bid.

6.2.3 The RSHAA assumes no responsibility for the failure of a Bidder to submit the Bid in accordance with the terms of the revised Tender Documents or amendments issued or for any consequent losses suffered by the Bidder.

6.3 Extension of the Last Date of Bid Submission

In order to afford the Bidders reasonable time in which to take the Addenda and taking the revised Tender Documents into account in preparing the Bid or to compensate for the time taken by the RSHAA in addressing any technical issues or errors in accessing its website, the RSHAA may, at its sole discretion, extend the Last Date of Bid Submission by issuing a written notice to interested Bidders published on the relevant website/ e-tender portal.

6.4 Availability of Information

6.4.1 The information relating to or in connection with the Scheme, the Bidding Process and the Tender Document, including all notices issued by the RSHAA to all Bidders in accordance with this Tender Document; queries and responses or clarifications; minutes of the Pre-Bid Meeting, addenda and/ or the revised Tender Documents shall be uploaded on the Scheme website/ e-tender portal specified in the Data Sheet and remain published until the last date of bid submission.

6.4.2 If, at any time prior to the last date of bid submission, a Bidder faces any technical issue or technical error in accessing the website specified in the Data Sheet, the Bidder may seek assistance from the RSHAA by sending an e-mail request to software.bsbyraj@gmail.com

6.4.3 The RSHAA shall make best efforts to respond to e-mail request(s) in 6.4.2 and resolve the technical issue or error or provide an alternative solution to the Bidder, within not later than 7 days of receipt of such request(s).

6.5 Correspondence with Bidders

6.5.1 Save as expressly provided in these Tender Documents, the RSHAA will not entertain any correspondence with the Bidders, whether in connection with the acceptance or rejection of their Bids or otherwise.

7. Preparation of Bids

7.1 Interpretation of Tender Documents

7.1.1 The entire Tender Document with all its Volumes (**Volume I, Volume II and Volume III**) must be read as a whole.

7.1.2 If the Bidder finds any ambiguity or lack of clarity in the Tender Documents, the Bidder must inform the RSHAA at the earliest and under any circumstances not later than the last date for receiving queries mentioned.

7.1.3 The RSHAA will then direct the Bidders regarding the interpretation of the Tender Documents.

7.2 Cost of Bidding

7.2.1 Bidders shall bear all direct and indirect costs associated with the preparation of their respective Bids, carrying out their independent assessments, due diligence and verification of information provided by the RSHAA.

7.2.2 The RSHAA shall not be responsible or liable for any direct or indirect cost, regardless of the outcome of the Bidding Process, including cancellation of the Bid Process by the RSHAA for any reason whatsoever.

7.3 Language of the Bid

7.3.1 The Bid prepared by the Bidder and all correspondence and documents related to the Bid exchanged between the Bidder and the RSHAA shall be only in the English language.

7.3.2 Any printed literature/ document furnished by the Bidder, if asked for by the RSHAA

as a part of the bid submission documents as provided in **Clause 7.7**, may be written in another language, as long as such literature is accompanied by a translation of its pertinent passages in English in which case, for the purposes of interpretation of the Bid, the English translation shall prevail. In all such cases, the translated literature/ document shall be duly notarized by a public notary. Supporting materials which are not translated into English may not be considered by the RSHAA during the bid evaluation.

7.4 Due Diligence by the Bidder

- 7.4.1 The Bidder is expected to examine all instructions, forms, terms, specifications and other information in the Tender Documents at its own cost.
- 7.4.2 The RSHAA shall not be liable to the Bidder for any consequences pursuant to the Bidder's failure to undertake its own due diligence and reliance solely on the information provided in this Tender Document.

7.5 Validity of Bids

- 7.5.1 Each Bid shall remain invalid for a period of 180 days from the last date of bid submission (excluding the last date of bid submission). A Bid valid for a shorter period shall be rejected as being non-responsive.
- 7.5.2 In exceptional circumstances, the RSHAA may request the Bidders to extend the Bid validity period prior to the expiration of the Bid validity period. All such request and the responses shall be made in writing.
- 7.5.3 An extension of the Bid validity period will not entitle a Bidder to modify its Bid.

7.6 Premium

- 7.6.1 The Bidders are, as a part of their Financial Bid, required to quote the Premium:
 - a. for providing Benefit Risk Cover Benefit per eligible AB-MGRSBY Beneficiary Family Unit per annum in the State of Rajasthan;
 - b. Premium quoted shall be inclusive of all costs including expenses, overheads, profits and Goods service charges, but exclusive of all taxes, cess, and Goods & Service tax (if any) in the format specified at **Form Fin-1**; and
 - c. All Premium quoted shall be only in Indian Rupees and up to two decimal places.

7.7 Formats for Bid Submission

Bid submission shall be a single stage exercise with 2 steps, the two being: **Qualification Bid** and **Financial Bid**.

7.7.1 Formats for **Qualification Bid**

- a. Bid Application Cover Letter: **Qual-1**
- b. Applicant Details: **Qual-2**
- c. Power of Attorney for Signing of Bids: **Qual-3**
- d. Bidder's Undertaking: The undertaking by the bidder regarding unconditional acceptance to all the terms and conditions of the Scheme as provided in this Tender Document: **Qual-4**
- e. Undertaking Regarding outsourced agency, Other Providers, Intermediaries (if applicable): The undertaking by the Bidder to use the services of only those outsourced agencies and similar agencies that fulfil the criteria specified in the Tender Documents and/ or following relevant IRDA guidelines for this purpose, in the format set out in **Qual-5**
- f. Supporting documents to be submitted: Annexures **Qual-6-1 to 6-4**
 - (i) True certified copies of the existing registration granted by the IRDAI for carrying on general insurance (including health insurance) or standalone health insurance business in India and last two years' renewal certificates: marked as Annexure **Qual-6-1**
 - (ii) Last three (3) years' audited Balance Sheet and Profit and Loss Statement with Auditors' Report: marked as Annexure **Qual-6-2**
 - (iii) True certified copies which provides proof that the Insurance Company has done group health insurance policy Insurance (excluding personal accident or travel cover) covering at least 1,00,000 families for two of the last three completed financial years: marked as Annexure **Qual-6-3**
 - (iv) True certified copies from chartered accountant which provides proof that the Insurance Company has Gross Direct Premium Income from health of at least Rs. 200 crores in India in each of the last three completed financial years: marked as Annexure **Qual-6-4**
- g. Documents pertaining to **Bid Security, RISL Processing Fees, Document charges/fees.**
- h. Checklist for submission of Qualification Bid: **Qual-7**

7.7.2 Formats for **Financial Bid**

- a. The Bidder shall submit its Financial Bid through online mode only, in the format provided on BOQ (.xls) on the **eproc portal**. Financial bid submitted in any other form shall make the bid non-responsive and be liable to rejection by the RSHAA.
- b. The certificate from the Bidder's appointed actuary stating that the Premium quoted by the Bidder for the Scheme has been actuarially calculated, in the

format set out in **Form Fin-2** should be uploaded on the portal.

8. Content of Bids

The Bidder shall provide all the information sought under this RFP. The Authority will evaluate only those Proposals that are received in the required formats and complete in all respects. The Proposal shall be duly signed by the authorised signatory of the Bidder who shall also initial each page. In case of printed and published documents, only the cover shall be initialled. All the alterations, omissions, additions or any other amendments made to the Proposal shall be initialled by the person(s) signing the Proposal.

8.1 Submission of proposals through e-portal

The bid proposal including the documents accompanying the Proposal shall be uploaded on the e-portal. The documents shall include documents specified in clause 7.7.1 (these shall be scanned and uploaded)

- 8.1.1 Bidders shall only submit the Qualification Bid in the format set out in Forms Qual-1 to Qual-5, Qual-6-1 to Qual-6-4, Qual-7 as specified in Clause 7.7.1 above.
- 8.1.2 Original documents pertaining to **Bid Security, RISL Processing Fees, Document charges/fees** should be submitted in an envelope apart from uploading the scanned copies on the e-portal.
- 8.1.3 The proposal and the required documents as mentioned above in 8.1.1 shall be submitted on or before Proposal Due date and time.
- 8.1.4 The envelope containing documents as specified in 8.1.2 should be submitted not later than 2 pm on the next day after the proposal due date.
- 8.1.5 Bidders shall not include any other documents as part of the Qualification Bid except the documents specified in Clause 8.1.1 and 8.1.2.
- 8.1.6 The proposal shall be marked and addressed to as under:

“Physical Documents for Tender for the selection of Insurance Company for Ayushman Bharat – Mahatma Gandhi Rajasthan Swasthaya Bima Yojana”

ATTN. OF:	Mr.Naresh Kr. Thakaal
DESIGNATION	Chief Executive Officer, State Health Assurance Agency

ADDRESS:	Swasthya Bhawan, Tilak Marg, Jaipur - 3002005
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8.1.7 Proposals submitted by fax, telex, telegram or e-mail shall not be entertained and shall be rejected.

8.2 Financial Bid Submission

8.2.1 Bidders shall only submit the Financial Bid online only, through “eproc portal” in the format set out at **Form Fin-1 and Form Fin-2** as specified in Clause 7.7.2 above and not include any other documents as part of the Financial Bid. The Bidder shall submit the Financial Proposal in the format specified in the BOQ (.xls) on e-portal. The lowest total premium for the eligible family, including all taxes as given in column D of format Fin-1, will be the basis of selection of the successful bidder. The certificate of Actuary in Fin-2 will be scanned and uploaded on the portal in PDF format.

8.1.1 Each Bidder is required to quote the Premium in Format Fin 1:

- a. For providing the (i) Risk Cover, as set out in **Form Fin-1**.
- b. for each AB-MGRSBY Beneficiary Family Unit eligible and covered under the Scheme the premium quoted shall be per annum and shall be inclusive of all costs including costs, expenses, service charges, taxes, cess, overheads and profits payable in respect of such Premium; and
- c. all amounts quoted shall be only in Indian Rupees and up to two decimal places.

8.2 Signing of the Bid

Each Bid including all its pages must be signed by the authorized signatory of the Bidder.

8.3 Submission of the Bid

8.3.1 Each Bidder shall submit their bid on the e-tender portal specified by the State Government <http://eproc.rajasthan.gov.in>, as per the guidelines specified in this Tender Document and the instructions available on the said e-tender portal.

8.3.2 The Bid shall contain no alterations, omissions or additions. Any interlineations, erasures, or overwriting will be valid only if they are signed by the authorized signatory of the Bidder.

8.3.3 As a legal requirement, Class3 certificate (preferably with token) is required to access the e-tender portal. Interested bidders shall need to procure both Signing and Encryption certificates. Signing certificate will be used for Logging in and Encryption certificate will be used for Bid submission. Bidders may approach a Certifying Authority in India for obtaining Digital Signature Certificates, details of which can be accessed from the Controller of Certifying Authorities of the Ministry of Electronics and Information Technology, Government of India at www.cca.gov.in

8.4 Bid Submission Due Date

8.4.1 The Bid shall be submitted on or before 12:01pm on the last date of bid submission. After the specified time on the last date of bid submission, the e-tender portal shall not be able to accept any bid submissions and all such provisions on the said portal shall be disabled.

8.4.2 If there are delays by the State Government in deactivating the bid submission provision on the e-tender portal, and a bidder is able to upload the documents, the same shall be summarily rejected if the upload time in the software and the system is later than the submission time and date specified in **Clause 8.5.1** above.

8.4.3 The RSHAA may, at its discretion, extend the last date of bid submission for all Bidders by issuing an Addendum in accordance with **Clause 6.1**.

8.5 Withdrawal / Modification of Bids

8.5.1 A Bidder may substitute or withdraw its Bid after submission but prior to the specified time on the last date of bid submission, provided that a written notice of the substitution or withdrawal is submitted to the RSHAA.

8.5.2 If the RSHAA receives a substitution notice from a Bidder before the specified time on the last date of bid submission, then the Bidder will be allowed to substitute its original Bid through the e-tender portal.

8.5.3 No Bid may be substituted or withdrawn after the specified time on the last date of bid submission.

9 Bid Security

1. The RFP has been drawn up in accordance with and in compliance of the RTPP Act 2012 and Rules 2013.

2. The bidder is required to submit the Bid Security of an amount of Rs. 40 Crores in

form of banker's cheque or demand draft or RTGS or bank guarantee, in specified format, of a scheduled bank or deposit through eGRAS in favor of CEO, RSHAA payable at Jaipur.

3. It may be noted that the bidders who are exempted from Bid Security will submit relevant documents. Tenders of the bidders who do not have exemption of Bid Security shall be rejected if BID SECURITY is not submitted. Bidders are suggested with form of bid securing declaration as per rule 42 (3) of RTPP rules 2013 and performance security declaration as per rule 75 (1) of RTPP rules 2013 which they will provide on their letter head with necessary documents as mentioned at **clause 7.7**

4. The BID SECURITY of unsuccessful bidder will be returned to them without any interest, after conclusion of the resultant contract. The BID SECURITY of the successful bidder will be adjusted in performance security as per the terms of contract.

5. BID SECURITY of a bidder may be forfeited without prejudice to other rights of the procuring entity, if the bidder withdraws or amends its tender or impairs or derogates from the tender in any respect within the period of validity of its tender or if it comes to notice that the information/documents furnished in its tender is incorrect, false, misleading or forged. In addition to the aforesaid grounds, the successful bidders' BID SECURITY will also be forfeited without prejudice to other rights of Procuring entity, if it fails to furnish the required performance security within the specified period.

6. In case of the successful bidder, the amount of bid security may be adjusted in arriving at the amount of the Performance Security, or refunded if the successful bidder furnishes the full amount of performance security.

7. All matters or queries related to bidding process shall be resolved as per RTPP Act.

10 Opening of Bids

10.1 The RSHAA shall open the bids at the date and time indicated in the Data Sheet as per the time that is displayed from the server clock at the top of the e-tender Portal.

10.2 Only authorized representative (s) of the bidder (s) can attend the bid opening.

- 10.3 After opening of the Bids by the RSHAA, all Bidders whose Bids have been successfully received on the e-tender portal shall receive a mail notification informing the details such as the Bid has been opened by the official, department and date and time of opening.
- 10.4 Once all the Qualification Bids have been opened online through e-Tendering procedure, they will be evaluated for responsiveness and to determine whether the Bidders will qualify for the opening of the Financial Bids. The procedure for evaluation of the responsiveness of the Qualification Bid and the eligibility of Bidders is set out at **Clause 11.1**.
- 10.5 A comparative statement of prequalification assessment shall be sent to all Bidders whose Bids have been successfully received on the e-tender portal.
- 10.6 The Financial Bids of only those Bidders who have passed the Qualification Criteria will be considered for evaluation on the intimated date. The Financial Bids will be opened in the presence of the representatives of such Bidders that choose to be present. The procedure for evaluation of the Financial Bids is set out at **Clause 11.2 and 11.4**.
- 10.7 The Bidders may remain present in the Office of the RSHAA at the time of opening of Financial Bids. However, the results of the Financial Bids of all Bidders shall be available on the e-Tender Portal immediately after the completion of opening process.
- 10.8 Any information contained in a Bid will not in any manner be construed as binding on the RSHAA, its agents, successors or assigns; but will be binding on the Bidder, in the event that the Insurance Contract is subsequently awarded to it on the basis of such information.

11 Evaluation of Bids and Selection of Successful Bidder (s)

11.1 Stage 1: Evaluation of the Qualification Bid

- 11.1.1 The Qualification Bids will first be evaluated for responsiveness to the Tender Documents and evidences for fulfilment of the qualification criteria based on the following parameters:
- The Bid is complete in all respects and in the prescribed formats.
 - It contains no material alterations, conditions, deviations or omissions.
 - All documents required as specified in the Tender Documents and submitted by the Bidder are appropriate and valid.
 - All undertakings required under this Tender Document are in the prescribed format and unconditional.
 - Based on the review of documents the RSHAA comes to the conclusion, beyond any reasonable doubt, that the Bidder fulfils the minimum qualification criteria.

f. The application is unconditional in all respects.

11.1.2 Qualification Bids not meeting any of the criteria mentioned in **Clause 11.1.1** above shall be liable to be rejected.

11.1.3 In order to determine whether the Bidder is eligible and meets the qualification criteria, the RSHAA will examine the documentary evidence of the Bidder's qualifications submitted by the Bidder and any additional information which the RSHAA receives from the Bidder upon request by the RSHAA.

11.1.4 After completion of the evaluation of the Qualification Bids, the RSHAA will notify the Eligible Bidders of the date, time and place of opening of the Financial Bids. Such notification may be issued upon the completion of the evaluation Qualification Bids, in which case the Financial Bids may be opened as per the RTPP Act 2012 and Rules 2013. The Financial Bids of those Bidders who are not declared as Eligible Bidders will not be opened.

11.1.5 All the qualified bidders, who choose to be present, shall have the right to attend the final meeting in which financial bids shall be evaluated.

11.2 Stage 2: Evaluation of Financial Bids

11.2.1 **Opening of Financial Proposal:** -Financial Proposal of only those bidders will be opened, whose qualification bids are found eligible by the evaluation committee of RSHAA, Jaipur.

11.2.2 A quote will be submitted by the bidder on the BOQ on the eproc -portal.

NO.	Cover	Number of AB-MGRSBY Beneficiary Family Units	Annual Premium (inRs.) excluding GST/other taxes	GST/other taxes (if applicable as per law)	Total Premium Including all applicable taxes (B+C)
		(A)	(B)	(C)	(D)
1	Rs.5.00 lakhs per family per year. This cover shall be segmented into Rs. 50, 000 for secondary illnesses and Rs. 4,50,000 for tertiary illness per family per annum on family floater basis per AB-MGRSBY Beneficiary Family Unit eligible for RISK COVER to meet hospitalization expenses	XXXX	Rs..... (Rupees only)	Rs..... (Rupees only)	Rs..... (Rupees only)

	as per the Scheme.				
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11.2.3 Total Premium Including all applicable taxes (B+C) as reflected in column D will be the criteria for selection.

11.2.4 Upon opening of the Financial Bids of the Eligible Bidders, they will first be evaluated for responsiveness to the Tender Documents. If: (i) any Financial Bid is not complete in all respects; or (ii) any Financial Bid is not duly signed by the authorized representative of the Bidder; or (iii) any Financial Bid is not in the prescribed formats; and (iv) any Financial Bid contains material alterations, conditions, deviations or omissions, then such Financial Bid shall be deemed to be substantially non-responsive. Such Financial Bid that is deemed to be substantially non-responsive shall be rejected.

11.3 Stage 3: Clarifications during Bid Evaluation

11.3.1 In evaluating the Financial Bids, the RSHAA may seek clarifications from the Bidders regarding the information in the Bid by making a request to the Bidder. The request for clarification and the response shall be in writing. Such response(s) shall be provided by the Bidder to the RSHAA within the time specified by the RSHAA for this purpose.

11.3.2 If a Bidder does not provide clarifications sought by the RSHAA within the prescribed manner and time, the RSHAA may elect to reject its Bid. In the event that the RSHAA elects not to reject the Bid, the RSHAA may proceed to evaluate the Bid by construing the particulars requiring clarification to the best of its understanding, and the Bidder shall not be allowed to subsequently question such interpretation by the RSHAA.

11.3.3 No change in the Premium quoted or any change to substance of any Bid shall be sought, offered or permitted.

11.4 Stage 4: Selection of the Successful Bidder (s)

11.4.1 Once the Financial Bids of the Eligible Bidders have been opened and evaluated:

- a. The RSHAA shall notify an Eligible Bidder whose Financial Bid is found to be complete in all respect, of the date, time and place for the ranking of the Financial Bids and selection of the Successful Bidder (s) (the Selection Meeting) and invite such Eligible Bidder to be present at the Selection Meeting.

- b. The RSHAA shall notify an Eligible Bidder whose Financial Bid is found to be substantially non-responsive, that such Eligible Bidder's Financial Bid shall not be evaluated further.

11.4.2 In selecting the Successful Bidder (s), the objectives of the RSHAA is to select Bidder that:

- a. is an Eligible Bidder;
- b. has submitted a Financial Bid complete in all respects; and has quoted the:
 - a) Lowest Total Insurance Premium (L-1)

In case two or more bidders have the same lowest gross premium (rounded off to two decimal points), the Successful Bidder will be selected through following process:-

- (i) In case one bidder is private sector and another is a public sector company, preference shall be given to public sector company.
- (ii) If both are same (both private or both public), then the bidder with higher **Average turnover** in the last three financial years will be selected.

In case the L-1 rate is more than the ceiling of premium as defined by the Government of India, process will be followed as per **RTPP Act 2012 & Rules 2013**.

12 Performance Security

- (i) Performance guarantee shall be solicited from successful bidder. The amount of performance guarantee shall 5% of the project cost based on the quote of selected bidder.
- (ii) Performance guarantee shall be furnished in any one of the following forms:-
 - i. Deposit through RTGS;
 - ii. Bank Draft or Banker's Cheque of a scheduled bank;
 - iii. National Savings Certificates and any other script/instrument under National Saving schemes for promotion of small savings issued by a Post Office in Rajasthan, if the same can be pledged under the relevant rules. There shall be accepted at their surrender value at the time of bid and formally transferred in the name of procuring entity with the approval of Head Post Master;
 - iv. Bank guarantee's of a scheduled bank. It shall be got verified from the issuing bank. Other condition regarding bank guarantee shall be as mentioned in rule-42 of bid security of RTPP Rule 2013
 - v. Fixed deposit receipt (FDR) of a scheduled bank. It shall be in the name of procuring entity on account of bidder and discharge by the bidder in advance.

The procuring entity shall ensure before, accepting the fixed deposit Receipt that the bidder furnishes an undertaking from the bank to make payment /premature payment of the fixed Deposit Receipt on demand to the procuring entity without requirement of consent of the bidder concerned. In the event of forfeiture of the performance security, the Fixed Deposit shall be forfeited along with interest earned on such Fixed Deposit.

Performance Guarantee furnished in the form specified in clause (ii) to (v) of sub-rule (2) shall remain valid for a period of 180 days beyond date of completion of all contractual obligations of the bidder, including warranty obligations and maintenance and defect liability period.

2. If the service provider violates any of the terms and conditions of the contract, the performance security shall be liable to be forfeited, wholly or partly, as decided by the procuring entity.
3. In case of the successful bidder, the amount of bid security may be adjusted in arriving at the amount of the Performance Security, or refunded if the successful bidder furnishes the full amount of performance security.

(iii) All matters or queries related shall be resolved as per RTPP Act 2012 & Rules 2013

13 Execution of Insurance Contract

13.1 Notification of Award

13.1.1 Upon selecting the Successful Bidder (s) in accordance with **Clause 11.4** above, the RSHAA shall intimate via Email to MoHFW/ NHA approval for information. RSHAA shall issue two original copies of the Notification of Award(**NOA**) to the Successful Bidder (s):

- declaring it as the Successful Bidder (s);
- accepting its Financial Bid (as corrected by the RSHAA if required);
- requesting it to fulfil the conditions specified in **Clause 13.1.2**; and

Subject to fulfilment of the conditions specified in **Clause 13.1.2**, requesting it to execute the Insurance Contract and to fulfil the conditions precedent to execution in accordance with **Clause 13.2**.

13.1.2 The Bidder (s) declared as the Successful Bidder shall:

- a. Within three days of receiving the NOA, sign and return one original copy of the NOA to the RSHAA as acceptance thereof and in acceptance of the terms of the revised draft Insurance Contract issued by the RSHAA in accordance with **Clause 13.2** and it will be required to notify its acceptance of the terms of such further revised draft Insurance Contract; and

- b. Within three days of receiving the NOA, provide to the RSHAA information regarding the Plan of the outsourcing of non-core business to any agency. It shall be the obligation of the Insurer to satisfy itself of the qualifications of such agency and other providers including reinsurance companies as per IRDAI regulations. The Insurer may be asked to submit documents establishing the qualification of such outsourced agency and its arrangements with such agency. No such submission is required if the Insurer does not propose to hire a outsource agency or any other intermediary for any non-core task related to the AB-MGRSBY and/ or for reinsurance.

13.1.3 If the Bidder(s) that is issued the NOA does not comply with either or all of the conditions set out in **Clause 13.1.2**, the RSHAA may elect to grant such Bidder (s) an extension of time for the completion of such condition(s) or to disqualify the Bidder selected as the Successful Bidder (s) including debarring the Bidder (s) from participating in any future AB-MGRSBY Tenders in the State of Rajasthan for a period of three consecutive years from such date.

13.1.4 If the RSHAA elects to disqualify such Bidder (s), then the RSHAA may evaluate the Financial Bids of the Eligible Bidders received in accordance with the procedure at **Clause 11.4**. The RSHAA may exercise this option only during the validity period of the Bids, as extended from time to time, and not thereafter.

13.2 Execution of the Insurance Contract

The RSHAA and the Selected Bidder (s) shall execute the Insurance Contract after the acceptance of the NOA by the Selected Bidder (s) within the time line intimated by RSHAA. The Insurance Contract shall be executed in the form of the final drafts provided by the RSHAA.

13.2.1 The Selected Bidder (s) shall execute the Insurance Contract in the revised draft form published by the RSHAA or in the further revised draft form issued by the RSHAA, with minimal changes or amendments being made to reflect facts or to correct minor errors. The RSHAA shall, before the date specified in the Bid Schedule for the execution of the Insurance Contract, provide the Selected Bidder(s) with the final execution draft of the Insurance Contract.

13.2.2 The RSHAA shall not entertain any request from the Selected Bidder (s) for negotiation of deviation to the final execution draft of the Insurance Contract provided by the RSHAA.

13.2.3 If the Selected Bidder (s) seeks to materially negotiate or seeks any material deviation from the final execution draft of the Insurance Contract, the RSHAA may elect to disqualify the Selected Bidder(s) and revoke the NOA issued to the Selected Bidder(s). If the RSHAA elects to disqualify such Bidder(s) and revoke the NOA, then the consequences set out in **Clause 13.1.3 and Clause 13.1.4** shall follow.

- 13.2.4 Subject to the Selected Bidder (s) complying with **Clause13.1.2**, the RSHAA and the Selected Bidder (s) shall execute the Insurance Contract on the date specified in the Bid Schedule or such other date notified by the SHA. The Insurance Contract shall be executed in the form of the final execution draft provided by the RSHAA under **Clause13.2.1**.
- 13.2.5 The Selected Bidder (s) agrees that as conditions precedent to the execution of the Insurance Contract in accordance with **Clause 13.2.4**, it shall submit executed copies of the services agreements signed by the outsourced agency and other Service Providers nominated by it in accordance with **Clause 13.1.2(b)**. Such services agreement (s) shall be in compliance with the provisions of the Insurance Contract.
- 13.2.6 If the RSHAA is ready and willing to execute the Insurance Contract, but the Selected Bidder (s) does not agree to execute the Insurance Contract within the time period specified in **Clause13.2.4** or to fulfil the conditions precedent to the execution of the Insurance Contract that are specified in **Clause 13.2.4**, the RSHAA may elect to grant the Selected Bidder (s) an extension of time for the execution of the Insurance Contract or to disqualify the Selected Bidder and revoke the NOA. If the RSHAA elects to disqualify such Bidder (s) and revoke the NOA, then the consequences set out in **Clause13.1.3 and Clause13.1.4** shall follow.

14 Rights of the Rajasthan State Health Assurance Agency

The RSHAA reserves the right, in its sole discretion and without any liability to the Bidders, to:

- a. accept or reject any Bid or annul the Bidding Process or reject all Bids at any time prior to the award of the Insurance Contract, without thereby incurring any liability to the affected Bidder(s);
- b. accept the lowest Bid;
- c. suspend and/or cancel the Bidding Process and/or amend and/or supplement the Bidding Process or modify the dates or other terms and conditions relating thereto;
- d. consult with any Bidder in order to receive clarification or further information in relation to its Bid; and
- e. independently verify, disqualify, reject and/or accept any and all submissions or other information and/or evidence submitted by or on behalf of any Bidder.

15 General

15.1 Confidentiality and Propriety Data

- 15.1.1 The Tender Documents, and all other documents and information that are provided by the RSHAA are and shall remain the property of the RSHAA and are provided to the Bidders solely for the purpose of preparation and the submission of their Bids in accordance with the Tender Documents. The Bidders are to treat all information as strictly confidential and are not to use such information for any purpose other than for preparation and submission of their Bids.
- 15.1.2 The RSHAA shall not be required to return any Bid or part thereof or any information provided along with the Bid to the Bidders, other than in accordance with provisions set out in these Tender Documents.
- 15.1.3 The Bidder shall not divulge any information relating to examination, clarification, evaluation and selection of the Successful Bidder to any person who is not officially concerned with the Bidding Process or is not a retained professional advisor advising the RSHAA or such Bidder on or matters arising out of or concerning the Bidding Process.
- 15.1.4 Except as stated in these Tender Documents, the RSHAA will treat all information, submitted as part of a Bid, in confidence and will require all those who have access to such material to treat it in confidence. The RSHAA may not divulge any such information unless as contemplated under these Tender Documents or it is directed to do so by any statutory authority that has the power under law to require its disclosure or is to enforce or assert any right or privilege of the statutory authority and/or the RSHAA or as may be required by law (including under the Right to Information Act, 2005) or in connection with any legal process.

15.2 Governing Laws and Dispute Resolution

The Bidding Process, the Tender Documents and the Bids shall be governed by, and construed in accordance with, the laws of India and the competent courts at Jaipur shall have exclusive jurisdiction over all disputes arising under, pursuant to and/or in connection with the Bidding Process.

16 Bid Security

- 16.1 Bid security shall be 2% of the estimated project cost, as per RTPP Act, 2012 and Rules, 2013.
- 16.2 Concessional bid security may be taken from registered bidders as specified by the State Government. Every bidder, if not exempted, participating in the procurement process shall be required to furnish the bid security as specified in the notice inviting bids.

- 16.3 In lieu of bid security, a bid security declaration shall be submitted by Departments of the State Government and Undertakings, Corporations, Autonomous bodies, Registered Societies, Cooperative Societies which are owned or controlled or managed by the State Government and Government Undertakings of the Central Government.
- 16.4 Bid security instrument or receipt of bid security or a bid securing declaration shall necessarily accompany bid.
- 16.5 Bid security of a bidder will not be adjusted towards bid security for the fresh bids. The bid security originally deposited may, however, be taken into consideration in case bids are re-invited.
- 16.6 The bid security may be given in the form of a banker's cheque or demand draft or bank guarantee, in specified format, of a scheduled bank or deposit through RTGS. The bid security must remain valid thirty days beyond the original or extended validity period of the bid.
- 16.7 The bid security of unsuccessful bidders shall be refunded soon after final acceptance of successful bid and signing of Agreement and submitting performance security.
- 16.8 The Bid security taken from a bidder shall be forfeited in the following cases :-
- (a) when the bidder withdraws or modifies its bid after opening of bids;
 - (b) when the bidder does not execute the agreement, if any, after placement of supply / work order within the specified period;
 - (c) when the bidder fails to execute work as per work order within the time specified;
 - (d) when the bidder does not deposit the performance security within specified period after the work order is placed; and
 - (e) if the bidder breaches any provision of code of integrity prescribed for bidders specified in RTPP Act, 2012 and Rules, 2013.
- 16.9 In case of the successful bidder, the amount of bid security may be adjusted in arriving at the amount of the Performance Security, or refunded if the successful bidder furnishes the full amount of performance security.
- 16.10 All matters or queries related to bidding process shall be resolved as per RTPP Act.

Format: Qual-1: Bid Application Cover Letter

[On the letterhead of the Bidder]

Date:

From:

[insert name of Bidder]

[insert address of Bidder]

To:

CEO, Rajasthan State Health Assurance Agency

SwasthyaBhawan, TilakMarg

C-Scheme, Jaipur

Pin code: 302005

Dear Madam/Sir,

Sub: Qualification Bid for Implementation of the Ayushman Bharat – Mahatma Gandhi Rajasthan SwasthayaBimaYojana in the State of Rajasthan

With reference to your Tender Documents dated _____, we, [insert name of Bidder], wish to submit our Qualification Bid for the award of the Insurance Contract(s) for the implementation of the Ayushman Bharat – Mahatma Gandhi Rajasthan SwasthayaBimaYojana (AB-MGRSBY) in the State of Rajasthan. Our details have been set out as per Qual 2 of Volume I of Tender Document.

We hereby submit our Qualification Bid, which is unconditional and unqualified. We have examined the Tender Documents issued by the State Health Agency.

1. We acknowledge that the Department of Medical, Health & Family Welfare/RSHAA, Government of Rajasthan will be relying on the information provided in our Qualification Bid and the documents accompanying such Qualification Bid for selection of the Eligible Bidders for the evaluation of Financial Bids, and we certify that all information provided in the Qualification Bid is true and correct. Nothing has been omitted which renders such information misleading and all documents accompanying such Qualification Bid are true copies of their respective originals.
2. We shall make available to the Rajasthan State Health Assurance Agency any clarification that it may find necessary or require to supplement or authenticate our Qualification Bid.
3. We acknowledge the right of the Rajasthan State Health Assurance Agency to reject our Qualification Bid or not to declare us as the Eligible Bidder, without assigning any reason or otherwise and we hereby waive, to the fullest extent permitted by applicable laws, our right to challenge the same on any account whatsoever.

4. We undertake that:

- a. We satisfy the Qualification Criteria and meet all the requirements as specified in the Tender Documents.
- b. We agree and release the Rajasthan State Health Assurance Agency and their employees, agents and advisors, irrevocably, unconditionally, fully and finally from any and all liability for claims, losses, damages, costs, expenses or liabilities in any way related to or arising from the Tender Documents and/or in connection with the Bidding Process, to the fullest extent permitted by applicable laws and waive any and all rights and/or claims I/we may have in this respect, whether actual or contingent, whether present or in future.

5. We represent and warrant that:

- a. We have examined the Tender Documents and have no reservations to the same, including all Addenda issued by the Rajasthan State Health Assurance Agency.
- b. We accept the terms of the Insurance Contract that forms Volume III of the Tender Document and shall seek no material deviation from or otherwise seek to materially negotiate the terms of the draft main Insurance Contract or the draft Supplementary Insurance Contract, if declared as the Successful Bidder.
- c. [We are registered with the IRDAI] to undertake the general insurance (including health insurance) business or standalone health insurance business in India and we hold a valid registration for the same as on the date of submission of this Bid.
- d. We have not and will not undertake any canvassing in any manner to influence or to try to influence the process of selection of the Successful Bidder.
- e. The Tender Documents and all other documents and information that are provided by the Rajasthan State Health Assurance Agency to us are and shall remain the property of the Rajasthan State Health Assurance Agency and are provided to us solely for the purpose of preparation and the submission of this Bid in accordance with the Tender Documents. We undertake that we shall treat all information received from or on behalf of the Rajasthan State Health Assurance Agency as strictly confidential and we shall not use such information for any purpose other than for preparation and submission of this Bid.
- f. The Rajasthan State Health Assurance Agency is not obliged to return the Qualification Bid or any part thereof or any information provided along with the Qualification Bid, other than in accordance with provisions set out in the Tender Documents.
- g. We have made a complete and careful examination of the Tender Documents and

all other information made available by or on behalf of the State Health Agency.

- h. We have satisfied ourselves about all things, matters and information, necessary and required for submitting an informed Bid and performance of our obligations under the Insurance Contract.
 - i. Any inadequacy, lack of completeness or incorrectness of information provided in the Tender Documents or by or on behalf of the Rajasthan State Health Assurance Agency or ignorance of any matter related thereto shall not be a basis for any claim for compensation, damages, relief for non-performance of its obligations or loss of profits or revenue from the Rajasthan State Health Assurance Agency or a ground for termination of the Insurance Contract.
 - j. Our Bid shall be valid for a period of 180 days from the last date of bid submission, i.e., until _____.
6. We undertake that if there is any change in facts or circumstances during the Bidding Process, or if we become subject to disqualification in accordance with the terms of the Tender Documents, we shall inform the Rajasthan State Health Assurance Agency of the same immediately.
7. We are submitting with this Letter, the documents that are listed in the checklist set out in Qual7 of Volume I of tender document.
8. We undertake that if we are selected as the Successful Bidder we shall:
- a. Sign and return an original copy of the Notice of Award (NOA) to the Rajasthan State Health Assurance Agency (RSHAA) within three days of receipt of the NOA, as confirmation of our acceptance of the NOA.
 - b. Not seek to materially negotiate or seek any material deviations from the final drafts of the Insurance Contract provided to us by the Rajasthan State Health Assurance Agency.

Execute the Insurance Contract with **QUAL 2 - DETAILS OF THE BIDDER**

9. Details of the Company

- a. Name:
- b. Address of the corporate headquarters and its branch office head in the State, if any:
- c. Date of incorporation and/or commencement of business:

10. Details of individual(s) who will serve as the point of contact/communication for the State Nodal Agency:

- c. Name:
- d. Designation:
- e. Company:
- f. Address:
- g. TheState Health Agency.

11. We hereby irrevocably waive any right or remedy which we may have at any stage at law or howsoever arising to challenge the criteria for evaluation of the Qualification Bid or question any decision taken by the Rajasthan State Health Assurance Agency in connection with the evaluation of the Qualification Bid, declaration of the Eligible Bidders, or in connection with the Bidding Process itself, or in respect of the Insurance Contract(s) for the implementation of the AB-MGRSBY in the State of Rajasthan.
12. We agree and undertake to abide by all the terms and conditions of the Tender Documents, including all Addenda, Annexures and Appendices.
13. This Bidding Process, the Tender Documents and the Bid shall be governed by and construed in all respects according to the laws for the time being in force in India.

We submit this Letter accompanying the Qualification Bid under and in accordance with the terms of the Tender Documents.

Dated this *[insert date]* day of *[insert month]*, 201...

(Signature)
.....(insert name of the authorized signatory)
In the capacity of ____[position]
Duly authorized to sign this Bid for and on behalf of _____[name of Bidder]

Format: Qual-2: Applicant Details

1. Details of the Company
 - a. Name:
 - b. Address of the corporate headquarters:
 - c. Corporate Identification Number:
 - d. PAN
 - e. Date of incorporation:
 - f. Date of commencement of business:
 - g. Address and contact numbers of its branch office in the State/UT, if any:
 - h. Name and contact details of Branch Head in the State/UT:

2. Details of the individual who will serve as the point of contact / communication for the Rajasthan State Health Assurance Agency for the purposes of this tender:
 - a. Name:
 - b. Designation:
 - c. Company:
 - d. Address:
 - e. Telephone Number:
 - f. Mobile number:
 - g. E-mail Address:
 - h. Fax Number:

3. Particulars of the Authorised Signatory of the Bidder:
 - a. Name:
 - b. Designation:
 - c. Company:
 - d. Address:
 - e. Telephone Number:
 - f. Mobile number:
 - g. E-mail Address:
 - h. Fax Number:

Dated this ____ day of , 201X

____ (Signature)
..... (insert name of the authorized signatory)

In the capacity of ____ [position]

Duly authorized to sign this Bid for and on behalf of _____ [name of Bidder]

Format: Qual-3: Power of Attorney for Signing of Bids

(On Rs. 100 Stamp paper duly attested by Notary Public)

POWER OF ATTORNEY

Know all men by these presents that we _____
_____ (name and address of the registered office) having CIN
(insert registration number / CIN of the Insurance Company) do hereby constitute, appoint and
authorize Mr./Ms. _____ (name and residential address) who is
presently employed with us and holding the position of _____ as our
attorney, to do in our name and on our behalf, all such acts, deeds and things necessary in
connection with or incidental to submission of a bid pursuant to Tender Document No.....
dated (insert Tender Document No. and date of issue) issued by Government of,
acting through the Rajasthan State Health Assurance Agency, for **the Ayushman Bharat –
Mahatma Gandhi Rajasthan Swasthaya Bima Yojana**, including signing and submission of all
documents and providing information/responses to Rajasthan State Health Assurance
Agency in all matters in connection with our Bid.

We hereby declare that all acts, deeds and things done by our said attorney pursuant to this
Power of Attorney shall always be deemed to have been ratified by us and done by us.

Dated this the _____ Day of _____ 201X
For _____
(Name, Designation and Address)

Accepted

(Name, Title and Address of the Attorney)

Date: _____

Format: Qual-4: Bidder's Undertaking

[On letterhead of the Bidder]

From

[Name of Bidder]

[Address of Bidder]

Date: [insert date], 201X

To

CEO, Rajasthan State Health Assurance Agency

SwasthyaBhawan, TilakMarg

C-Scheme, Jaipur

Pin code: 302005

Dear Madam/Sir,

Subject: Undertaking Regarding Compliance with Terms of the Ayushman Bharat – Mahatma Gandhi Rajasthan SwasthayaBimaYojana

I, [insert name] designated as [insert title] at [insert location] of [insert name of Bidder] and being the authorized signatory for and on behalf of the Bidder, do hereby declare and undertake that we have read the Tender Documents for award of Insurance Contract for the implementation of the Ayushman Bharat Mahatma Gandhi Rajasthan SwasthayaBimaYojana (AB-MGRSBY).

We hereby undertake and explicitly agree that if we are selected as the Successful Bidder, we shall adhere to and unconditionally comply with the terms of the AB-MGRSBY as set out in the Tender Documents and the Insurance Contract.

Dated this ____ day of , 201X

(Signature)

.....(insert name of the authorized signatory)

In the capacity of ____ [position]

Duly authorized to sign this Bid for and on behalf of _____ [name of Bidder]

Format: Qual-5: Undertaking Regarding Outsource agency, Other Providers (if applicable)

[On letterhead of the Bidder]

From

[Name of Bidder]

[Address of Bidder]

Date: [insert date], 201X

To

CEO, Rajasthan State Health Assurance Agency

SwasthyaBhawan, TilakMarg

C-Scheme, Jaipur (Raj), Pin code: 302005

Dear Madam / Sir,

Subject: Undertaking Regarding Appointment of Outsourced, and Similar Agencies / Intermediaries

I, [insert name] designated as [insert title] at [insert location] of [insert name of Bidder] and being the authorized signatory for and on behalf of the Bidder, do hereby declare and undertake that we have read the Tender Documents for award of Insurance Contract for the implementation of the Ayushman Bharat – Mahatma Gandhi Rajasthan SwasthayaBimaYojana.

We hereby undertake and explicitly agree that if we are selected as the Successful Bidder, we shall for the purpose of any non-core business related to AB-MGRSBY, appoint only those third parties/appoint those Outsource agencies and similar agencies / intermediaries that meet the criteria specified, if any, in the Tender Documents.

We hereby undertake and explicitly agree that if we are selected as the Successful Bidder, we shall for the purpose of this tender will hire reinsurance companies as per IRDA 2016 regulations (including order of preference) and will inform the RSHAA details of arrangement with reinsurance company at the time of signing of the contract.

Dated this ____ day of , 201X

(Signature)

.....(insert name of the authorized signatory)

In the capacity of ____ [position]

Duly authorized to sign this Bid for and on behalf of _____ [name of Bidder]

Format: Qual-6: List of Supporting Documents

- a. True certified copies of the registration granted by the IRDAI for carrying on general insurance (including health insurance) or standalone health insurance business in India and last two years' renewal certificates: marked as Annexure **Qual-6-1**.
- b. Last three years' audited Balance Sheet and Profit and Loss Statement with Auditors' Report: marked as Annexure **Qual-6-2**.
- c. True certified copies which provides proof that the Insurance Company has a group health insurance policy (excluding personal accident or travel cover) covering at least 1,00,000 families for two of the last three completed financial years: marked as Annexure **Qual-6-3**.
- d. True certified copies from chartered accountant which provides proof that the Insurance Company has Gross Direct Premium Income from Health Insurance (excluding personal accident or travel cover) of at least Rs. 200 crores in India in each of the last three completed financial years: marked as Annexure **Qual-6-4**.
- e. Documents pertaining to bid security, document fees, RISL processing fees

Format: Qual-7: Checklist for Qualification Bid

[On letterhead of the Bidder]

We, (insert name of the Bidder), hereby confirm that we are submitting the following documents as a part of our Qualification Bid in response to this Tender Document under the AB-MGRSBY:

No.	Document	Tender Clause Reference	Document No. (Reference no. to be provided in the Qualification Bid)	Submitted (Yes / No)	Document Available at Page No.
1	Bid Application Cover Letter	7.7.1a	Qual-1		
2	Applicant Details	7.7.1b	Qual-2		
3	Power of Attorney	7.7.1c	Qual-3		
4	Undertaking by the bidder regarding unconditional acceptance to all the terms and conditions of the Scheme	7.7.1d	Qual-4		
5	Undertaking by the Bidder to use the services of only those outsourced agency and similar agencies that fulfil the criteria specified in the Tender Documents and/ or meet provisions as per regulations of IRDAI	7.7.1e	Qual-5		
6	True certified copies of the registration granted by the IRDAI & and last two years' renewal certificates	7.7.1f (i)	Qual-6-1		
7	Last 3 Years" audited Balance Sheet and Profit and Loss Statement with Auditors Report"	7.7.1f (ii)	Qual-6-2a Qual-6-2b Qual-6-2c		
8	True certified copies which provides proof that the Insurance Company has group health insurance policy (excluding personal accident or travel cover) covering at least 1,00,000 families for two of the last three completed financial years	7.7.1f (iii)	Qual-6-3		
9	True certified copies from chartered accountant which provides proof that the Insurance Company has Gross Direct Premium Income from Health Insurance of at least Rs. 200 crores in India in each of the last three completed financial years	7.7.1f(iv)	Qual-6-4		
10	Bid Security				
11	RISL Processing Fees				
12	Document Charges				
13	Checklist for Qualification Bid	7.7.1h	Qual-7		

Dated this ____ day of , 201X

_____(Signature)
.....(insert name of the authorized signatory)

In the capacity of ____[position]

Duly authorized to sign this Bid for and on behalf of _____[name of Bidder]

Format: Fin-1: Financial Bid

[On letterhead of the Bidder]

From

[insert name of Bidder]

[insert address of Bidder]

Date: [insert date], 201X

To

CEO, Rajasthan State Health Assurance Agency

SwasthyaBhawan, TilakMarg

C-Scheme, Jaipur (Raj), Pin code: 302005

Dear Madam / Sir,

Subject: Financial Bid for Implementation of the Ayushman Bharat – Mahatma Gandhi Rajasthan SwasthayaBimaYojana in the Stateof Rajasthan.

With reference to your Tender Documents dated (Insert Date) we, [insert name of Bidder], wish to submit our Financial Bid for the award of the Insurance Contract(s) for the implementation of the Ayushman Bharat Mahatma Gandhi Rajasthan SwasthayaBimaYojana (AB-MGRSBY) in the Stateof Rajasthan Our details have been set out in our Qualification Bid.

1. We hereby submit our Financial Bid, which is unconditional and unqualified. We have examined the Tender Documents, including all the Addenda.
2. We acknowledge that the Rajasthan State Health Assurance Agency will be relying on the information provided by us in the Financial Bid for evaluation and comparison of Financial Bids received from the Eligible Bidders and for the selection of the Successful Bidder for the award of the Insurance Contract for the implementation of the AB-MGRSBY in the Stateof Rajasthan . We certify that all information provided in the Financial Bid is true and correct. Nothing has been omitted which renders such information misleading and all documents accompanying our Financial Bid are true copies of their respective originals.
3. We shall make available to the Rajasthan State Health Assurance Agency any clarification it may find necessary or require to supplement or authenticate the Financial Bid.
4. We acknowledge the right of the Rajasthan State Health Assurance Agency to reject our Financial Bid or not to select us as the Successful Bidder, without assigning any reason or otherwise and we hereby waive, to the fullest extent permitted by applicable laws, our

right to challenge the same on any account whatsoever.

5. We hereby acknowledge and confirm that all the undertakings and declarations made by us in our Qualification Bid are true, correct and accurate as on the date of opening of our Financial Bid
6. We acknowledge and declare that the Rajasthan State Health Assurance Agency is not obliged to return the Financial Bid or any part thereof or any information provided along with the Financial Bid, other than in accordance with the provisions set out in the Tender Document.
7. We undertake that if there is any change in facts or circumstances during the Bidding Process which may render us liable to disqualification in accordance with the terms of the Tender Documents, we shall advise the Rajasthan State Health Assurance Agency of the same immediately.
8. We are quoting the following Premium: **(to be submitted through online mode only, in the format provided on BOQ (.xls) on the eproc portal)**

NO.	Cover	Number of AB-MGRSBY Beneficiary Family Units	Annual Premium (inRs.) excluding GST/other taxes	GST/other taxes (if applicable as per law)	Total Premium Including all applicable taxes (B+C)
		(A)	(B)	(C)	(D)
1	Rs.5.00 lakhs per family per year. This cover shall be segmented into Rs. 50, 000 for secondary illnesses and Rs. 4,50,000 for tertiary illness per family per annum on family floater basis per AB-MGRSBY Beneficiary Family Unit eligible for RISK COVER to meet hospitalization expenses as per the Scheme.	XXXX	Rs..... (Rupees only)	Rs..... (Rupees only)	Rs..... (Rupees only)

[Note to Bidders: The Bidders are required to quote the Premium under column B, C, and D up to two decimal points.]

9. We acknowledge, confirm and undertake that:
 - a. The terms and conditions of the Tender Documents and the Premium being quoted by us for the implementation of the Scheme are determined on a technically sound basis, are financially adequate, viable and sustainable on the

basis of information and claims experience available in our records.

10. We hereby irrevocably waive any right or remedy, which we may have at any stage at law or howsoever arising, to challenge the criteria for evaluation of the Financial Bid or question any decision taken by the Rajasthan State Health Assurance Agency in connection with the evaluation of the Financial Bid, declaration of the Selected Bidder, or in connection with the Bidding Process itself, in respect of the Insurance Contract and the terms and implementation thereof.
11. We agree and undertake to abide by all the terms and conditions of the Tender Documents, including all Addenda, Annexures and Appendices.
12. We have studied the Tender Documents (including all the Addenda, Annexures and Appendices) and all the information made available by or on behalf of the Rajasthan State Health Assurance Agency carefully. We understand that except to the extent as expressly set forth in the Insurance Contract, we shall have no claim, right or title arising out of any documents or information provided to us by the Rajasthan State Health Assurance Agency or in respect of any matter arising out of or concerning or relating to the Bidding Process.
13. We agree and understand that the Bid is subject to the provisions of the Tender Documents. In no case, shall we have any claim or right against the Rajasthan State Health Assurance Agency if the Insurance Contract is not awarded to us or our Financial Bid is not opened or found to be substantially non-responsive.
14. This Bid shall be governed by and construed in all respects according to the laws for the time being in force in India. The competent courts at Jaipur, Rajasthan will have exclusive jurisdiction in the matter.
15. Capitalized terms which are not defined herein will have the same meaning ascribed to them in the Tender Documents.

We hereby confirm that we are submitting this Financial Bid under and in accordance with the terms of the Tender Documents.

Dated this ____ day of , 201X

_____(signature)

.....(insert name of the authorized signatory)

In the capacity of ____ [position]

Duly authorized to sign this Bid for and on behalf of _____ [name of Bidder]

Format: Fin-2: Certificate from Bidder's Appointed Actuary

[On letterhead of the Bidder's Appointed Actuary]

From

[Name of Actuary]

[Address of Actuary]

Date: [insert date], 201X

To

CEO, Rajasthan State Health Assurance Agency

SwasthyaBhawan, TilakMarg

C-Scheme, Jaipur (Raj), Pin code: 302005

Dear Madam / Sir,

Subject: Actuarial Certificate in respect of Premium quoted by [insert name of Bidder] in its Financial Bid dated [insert date] for the AB-MGRSBY in the State of Rajasthan.

I/ We, [insert name of actuary], am/are a registered actuary under the laws of India and am / are licensed to provide actuarial services.

[insert name of Bidder] (the Bidder) is an insurance company engaged in the business of providing general insurance (including health insurance) services in India and we have been appointed by the Bidder as its actuary.

I/ We understand that the Bidder will submit its Bid for the implementation of the Ayushman Bharat – Mahatma Gandhi Rajasthan SwasthayaBimaYojana (the Scheme) in the State of Rajasthan.

I, [insert name] designated as [insert title] at [] of [insert name of actuary] do hereby certify that:

- a. We have read the Tender Documents for award of Insurance Contract for the implementation of the Scheme.
- b. The rates, terms and conditions of the Tender Documents and the Premium being quoted by the Bidder for the Scheme are determined on a technically sound basis, are financially adequate, viable and sustainable on the basis of information and claims experience available in the records of the Bidder.
- c. Following assumptions have been taken into account while calculating the price for the **Benefit Risk Cover** under the AB-MGRSBY:

- i. Projected Claim Ratio – ____ %
- ii. Administrative Cost – ____%
- iii. Profit – ____ %

Dated this ____ day of , 201X

At [insert place]

[Signature]

In the capacity of ____
[position]

**Tender Document for Selection of Insurance Company for the
implementation of
Ayushman Bharat –Mahatma Gandhi Rajasthan Swasthaya Bima
Yojna
In the State of Rajasthan**

October, 2019

Volume II:
About AB-MGRSBY

Schedule of Requirements, Specifications and Allied Technical Details

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Abbreviations

AB- MGRSBY	Ayushman Bharat- Mahatma Gandhi Rajasthan Swasthya Bima Yojna
AB-PMJAY	Ayushman Bharat- Pradhanmantri Jan Arogya Yojna
AL	Authorisation Letter (from the Insurer)
BFU	Beneficiary Family Unit
BPL	Below Poverty Line
BRC	Basic Risk Cover
CCGMS	Central Complaints Grievance Management System
CHC	Community Health Centre
CRC	Claims Review Committee
DAL	Denial of Authorisation Letter
DGRC	District Grievance Redressal Committee
DGNO	District Grievance Nodal Officer
EHCP	Empanelled Health Care Provider
HPGRC	High Powered Grievance Redressal Committee
GoR	Government of Rajasthan
GoI	Government of India
GRC	Grievance Redressal Committee
IC	Insurance Company
IRDAI	Insurance Regulatory Development Authority of India
MoHFW	Ministry of Health & Family Welfare, Government of India
NFSA	National Food Security Act
NGRC	National Grievance Redressal Committee
NHA	National Health Agency
NOA	Notice of Award
RAL	Request for Authorisation Letter (from the EHCP)
RTPP Act	Rajasthan Transparency in Public Procurement Act
SECC	Socio Economic Caste Census,2011
SHA	State Health Agency
SGRC	State Grievance Redressal Committee
SGNO	State Grievance Nodal Officer
RSHAA	Rajasthan State Health Assurance Agency
UCN	Unique Complaint Number

Definitions and Interpretations

Appellate Authority shall mean the authority designated by the Rajasthan State Health Assurance 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 Rajasthan State Health Assurance Agency and the Insurer.

Basic Sum Insured shall mean the sum Insured in respect of the Risk Cover for each AB- MGRSBY Beneficiary Family Unit shall be 5.00 lakhs per family per year. This cover shall be segmented into **Rs. 50, 000 for secondary illnesses listed at Ann.2.3 (a) and Rs. 4,50,000 for tertiary illness listed at Ann.2.3 (b)** per family per annum on family floater basis.

Beneficiary means a member of the AB-MGRSBY Beneficiary Family Units who is eligible to avail benefits under the Ayushman Bharat –Mahatma Gandhi Rajasthan Swasthya Bima Yojana.

- a. **Beneficiary Family Unit** refers a family who is covered under National Food Security Act 2013 and/or eligible family of AYUSHMAN BHARAT- PRADHAN MANTRI JAN AROGYA YOJNA from the eligible categories of Socio-Economic Caste Census (SECC) which are resident of Rajasthan and have linked their eligibility with the identity card as decided by GoR shall be considered as eligible for benefits under the Scheme and be automatically covered under the Scheme. In addition to this, additional categories which gets covered under the scheme in connection to **clause 2.2 of vol I** shall also be considered as beneficiary family units from the date of their coverage under the scheme. Date of coverage shall be decided as per directions of RSHAA. Unit of coverage under the Scheme shall be a family and each family for this Scheme shall be called a AB- MGRSBY Beneficiary Family Unit, which will comprise all members in that family whose names are mentioned in the ID Card as decided by GOR. In addition to this, children of that family up to the age of one year will also be considered the member of that family even without having name in the ID Card.

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

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 RSHAA 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 State Government.

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 State.

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.

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

DoHFW mean Department of Medical, Health & Family Welfare, Government of Rajasthan.

Empanelled Health Care Provider shall mean and refer to those public or private health care providers who are empanelled by the RSHAA for providing services to the Beneficiaries under the Ayushman Bharat – Mahatma Gandhi Rajasthan Swasthya Bima Yojna.

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.

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 Rajasthan State Health Assurance 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-MGRSBY.

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 State Government.

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

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.

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-NHPM. It will also foster co-ordination and convergence with other similar schemes being implemented by the Government of India and State Governments.

AB-MGRSBY shall refer to Ayushman Bharat - Mahatma Gandhi Rajasthan Swasthya Bima Yojana managed and administered by the Department of Medical, Health and Family Welfare, Government of Rajasthan 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.

AB-MGRSBY Beneficiary Database refers to those families including all its members figuring in the National Food Security Act 2013 and/ or Socio-Economic Caste Census (SECC) database under the deprivation criteria of D1, D2, D3, D4, D5 & D7, Automatically Included category (viz as Households without shelter, Destitute-living on alms, Manual Scavenger Families, Primitive Tribal Groups and Legally released Bonded Labour) and 11 broadly defined occupational un-organised workers (in Urban Sector) of the Socio-Economic Caste Census (SECC) 2011 database of the State under the AB-MGRSBY and have linked their eligibility with the ID card as decided by Government of Rajasthan.

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 RSHAA from time to time.

Risk Cover shall mean an annual Risk Cover for each AB- MGRSBY Beneficiary Family Unit shall be 5.00 lakhs per family per year. This cover shall be segmented into **Rs. 50,000 for secondary illnesses listed and Rs. 4,50,000 for tertiary illness** 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- MGRSBY Beneficiary Family Units.

RSHAA mean Rajasthan State Health Assurance Agency refers to the society registered under Societies Act 1958 by the department of Medical Health & Family Welfare, Government of Rajasthan for the purpose of coordinating and implementing the health insurance scheme/s in the state of Rajasthan.

Service Area refers to the entire State of Rajasthan covered and included under this Tender Document for the implementation of AB-MGRSBY.

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 State Government intends to select and sign the Insurance Contract for this Scheme.

Scheme shall mean the Ayushman Bharat –Mahatma Gandhi Rajasthan Swasthya Bima Yojana managed and administered by the Department of Medical, Health and Family Welfare, Government of Rajasthan.

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 State Government.

Insurance Contract shall mean the contract signed by the Rajasthan State Health Assurance Agency with the Selected Bidder.

State Government refers to the duly elected Government in the State in which the tender is issued.

Secondary and Tertiary illness: Secondary and Tertiary illness means the condition covered in annexure 2.3.

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

Disclaimer

The information contained in this Tender Document or subsequently provided to the Bidders, whether verbally or in documentary or any other form, by or on behalf of the Department of Health & Family Welfare, Government of Rajasthan, hereinafter referred to as the State Government, acting through the Rajasthan State Health Assurance Agency (SHA), or any of its employees or advisors, is provided to the Bidders on the terms and conditions set out in this Tender Document along with all its Volumes and such other terms and conditions subject to which such information is provided.

The purpose of this Tender Document is to provide the Bidder(s) with information to assist the formulation of their Tender. This Tender Document does not purport to contain all the information each Bidder may require. This Tender Document may not be appropriate for all persons and it is not possible for the State Government or the RSHAA or its representatives, to consider the objectives, financial situation and particular needs of each Bidder who reads or uses this Tender Document. Each Bidder should conduct its own investigations and analysis and should check the accuracy, reliability and completeness of the information in this Tender Document, and where necessary obtain independent advice from appropriate sources. Neither the State Government nor the RSHAA nor their employees or their consultants make any representation or warranty as to the accuracy, reliability or completeness of the information in this Tender Document. The State Government shall incur no liability under any law including the law of contract, tort, the principles of restitution, or unjust enrichment, statute, rules or regulations as to the accuracy, reliability or completeness of the Tender Document. The statements and explanations contained in this Tender Document are intended to provide an understanding to the Bidders about the subject matter of this Tender and should not be construed or interpreted as limiting in any way or manner the scope of services and obligations of the Bidders that will be set forth in the Insurer's Agreement or the State Government's rights to amend, alter, change, supplement or clarify the scope of work, or the agreement to be signed pursuant to this Tender or the terms thereof or herein contained. Consequently, any omissions, conflicts or contradictions in the Bidding Documents, including this Tender Document, are to be noted, interpreted and applied appropriately to give effect to this intent, and no claims on that account shall be entertained by the State Government.

This Tender Document does not constitute an agreement and does not constitute either an offer or invitation by the State Government or the RSHAA to the Bidders or any other person.

Information provided in the Tender Document to the Bidders is on a wider range of matters, some of which may depend upon interpretation of law. The information given is not intended to be an exhaustive account of statutory requirements and should not be regarded as complete or authoritative statement of law. The State Government or the RSHAA accepts no responsibility for the accuracy, or otherwise, of any interpretation or opinion on law expressed in this Tender Document.

The State Government may, in its absolute discretion but without being under any obligation to do so, update, amend or supplement the information, assessment or assumptions contained in this Tender Document.

The issue of this Tender Document does not imply that the State Government is bound to appoint the Successful Bidder as the Insurer, as the case may be, and the State Government reserves the right to reject all or any of the Bidders or Bids or not to enter into a Contract for the implementation of the Ayushman Bharat - Mahatma Gandhi Rajasthan Swasthya Bima Yojana Mahatma Gandhi Rajasthan Swasthya Bima Yojana in the State of Rajasthan, without assigning any reason whatsoever.

Each Bidder shall bear all its costs associated with or relating to the preparation and submission of its Bid including but not limited to preparation, copying, postage, delivery fees, expenses affiliated with any demonstration or presentation which may be required by the State Government or any other costs incurred in connection with or relating to its Bid. All such costs and expenses will be borne by the Bidders and the State Government and its employees and advisors shall not be liable, in any manner whatsoever, for the same or for any other costs or other expenses incurred by any Bidder in preparation or submission of its Bid, regardless of the conduct or outcome of the Bidding Process.

The entire Tender Document is in three volumes: *Volume I – Instruction to Bidders*, *Volume II – About AB- MGRSBY* and *Volume III – Insurance Contract to be signed by the Insurance Company*.

This document is *Volume II* of the Tender Document ‘About AB- MGRSBY: *Schedule of Requirements, Specifications and Allied Technical Details*’.

**Tender Document for
Selection of Insurance Company for the Implementation of
Ayushman Bharat –Mahatma Gandhi Rajasthan Swasthaya Bima
Yojana
In the State of Rajasthan**

**Volume II
About AB-MGRSBY
Schedule of Requirements, Specifications and Allied Details**

Volume II: About AB-MGRSBY

1. Name of the Scheme

The name of the Scheme shall be 'AYUSHMAN BHARAT –MAHATMA GANDHI RAJASTHAN SWASTHAYA BIMA YOJANA ', hereinafter referred to as the “**AB-MGRSBY**” or the “**Scheme**”.

2. Objectives of the Scheme

The objective of AB- MGRSBY 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 National Food Security Act 2013 and/or eligible families of Ayushman Bharat-Pradhan Mantri Jan Arogya Yojna on the basis of the Socio-Economic Caste Census (SECC), 2011 database of the State and any other category added by Government of Rajasthan/ GOI after mutual consent with the insurer. These eligible AB-MGRSBY 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).

3. AB-MGRSBY Beneficiaries and Beneficiary Family Unit

- b. All AB- MGRSBY Beneficiary Family Units means a family who is covered under National Food Security Act, 2013 and/or eligible family of AYUSHMAN BHARAT-PRADHAN MANTRI JAN AROGYA YOJNA (AB-PMJAY) from the eligible categories of Socio-Economic Caste Census (SECC) which are resident of Rajasthan and have linked their eligibility with the identity card as decided by GoR shall be considered as eligible for benefits under the Scheme and be automatically covered under the Scheme.
- c. In addition to this, additional categories which gets covered under the scheme in connection to **clause 2.2 of vol I** shall also be considered as beneficiary family units from the date of their coverage under the scheme. Date of coverage shall be decided as per directions of RSHAA.
- d. Unit of coverage under the Scheme shall be a family and each family for this Scheme shall be called a AB- MGRSBY Beneficiary Family Unit, which will comprise all members in that family whose names are mentioned in the ID Card as decided by GOR. In addition to this, children of that family up to the age of one will also be considered the member of that family even without having name in the ID Card.

4. Risk Covers and Sum Insured

4.1 Risk Cover and Sum Insured

- a. **Risk Cover (RC)** will include hospitalization/
- b.
- c. 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.

- d. As on the date of commencement of the Policy Cover Period, the AB- MGRSBY Sum Insured in respect of the Risk Cover for each AB- MGRSBY Beneficiary Family Unit shall be 5.00 lakhs per family per year. This cover shall be segmented into **Rs. 50, 000 for secondary illnesses listed at Ann.2.3 (a) and Rs. 4,50,000 for tertiary illness listed at Ann.2.3 (b)** 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- MGRSBY Beneficiary Family Unit, subject to **Section 4.2**.

4.2 AB-MGRSBY Sum Insured on a Family Floater Basis

- a. The Insurer shall ensure that the Scheme's Risk Cover shall be provided to each AB- MGRSBY Beneficiary Family Unit on a **family floater basis** covering all the members of the AB- MGRSBY Beneficiary Family Unit 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.
- b. The maximum liability of the Insurer on a family floater basis for one or more Claims under the RC during any Policy Cover Period shall not exceed the RC amount in respect of a AB- MGRSBY Beneficiary Family Unit.

5. Benefit Package: AB- MGRSBY Cover

5.1 Benefits under AB- MGRSBY Risk Cover

- a. The benefits within this Scheme under the Basic Risk Cover are to be provided on a cashless basis to the AB- MGRSBY 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 **Annex 2.2: 'Exclusions to the Policy' and Annex 2.3 'Packages and Rates'**.
- c. For availing select treatment in any empanelled hospitals, preauthorisation is required to be taken for defined cases.

5.2 Exclusions under AB- MGRSBY Insurance Cover

- a. Each of the benefits specified above in **Sections 5.1** shall be **available for irrespective of any pre-existing conditions, diseases, illnesses or injuries** affecting the AB- MGRSBY Beneficiaries on the date of commencement of each Policy Cover Period, subject only to the exclusions as provided in **Annex 2.2**.

5.3 Benefits Available only through Empanelled Health Care Providers

- a. The benefits under the AB- MGRSBY Risk Cover shall only be available to a AB- MGRSBY Beneficiary through an EHCP after identification of eligible family as per **Annex 2.4**

6. Package Rates

- a. The Insurer shall reimburse claims of public and private health care providers under the AB- MGRSBY 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 **Annex 2.3**, then the Package Rate so fixed shall apply for the Policy Cover Period.
 - (ii) The flat daily package rates for medical packages specified in **Annex 2.3** 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- MGRSBY Beneficiary family, if beneficiary gives consent in written for payment of surplus amount. Hospital shall be required to submit the consent with the claim at the time of claim submission.
 - (iv) The follow up care prescription for identified packages are set out in **Annex 2.3**.
 - (v) In case of AB- MGRSBY 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 & subsequent 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 **Annex 2.3** will only be reserved for Public EHCPs as decided by the RSHAA.
 - (viii) Certain packages as indicated in **Annex 2.3** have differential pricing
- b. These package rates (in case of surgical procedures or interventions or day care procedures, as applicable) or flat per day rate (in case of medical treatments) will include:
 - (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) Pre and Post Hospitalisation expenses: Expenses incurred for consultation, diagnostic tests and medicines before the admission of the patient in the same

hospital upto 5 days and up to 15 days of the discharge from the hospital for the same ailment/ surgery. After expiry of 15 days period patient will have to bear the cost of follow up related to that package. However if due to negligence of hospital any complications or failure occurs even after expiry of 15 days post discharge and patient is treated in the same hospital then hospital shall bear the expenses related to treatment.

- c. During the first Two years of Policy Cover Period, the Insurer or RSHAA shall not seek or permit any change to the Package Rates.
- d. The RSHAA and Insurer shall publish the Package Rates on its website in advance of each Policy Cover Period.
- e. Package list included in **Annex 2.3** can be revised and updated by NHA/Gol which shall come into effect from the date of notification issued by NHA.
- f. Once revised by NHA/Gol, packages and rates shall remain same for 2 years of the execution of insurance contract.
- g. However, package rates for some medical treatment or surgical procedures may exceed the Sum Insured limit, which in turn would enable AB- MGRSBY beneficiaries to avail treatment of such medical conditions or surgical procedures on their own cost / expenses at the negotiated rate rather than on an open-ended or fee for service basis.

7. Identification of AB- MGRSBY Beneficiary Family Units

- a. Identification of AB- MGRSBY Beneficiary Family Units will be done as per **Annex 2.4**

8. Empanelment of Health Care Providers

- a. All public hospitals with inpatient facilities (Community Health Centre and above) shall be 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-MGRSBY, 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 **Annex 2.5** of this document.
- c. At the time of empanelment, those Hospitals that have the capacity and which fulfil the minimum criteria for offering tertiary treatment services as prescribed by the RSHAA would be specifically designated for providing such tertiary care packages.
- d. The RSHAA shall be responsible for empanelment and periodic renewal of empanelment of health care providers for offering services under the AB-MGRSBY. The RSHAA may undertake this function either directly or through the selected

Insurance Company. However, the final decision regarding empanelment of hospital will rest with RSHAA.

- e. Under circumstances of any dispute, final decision related to empanelment of health care providers shall vest exclusively with the RSHAA.
- f. Detailed guidelines regarding empanelment of health care providers are provided at **Annex 2.5**.

9. Agreement with Empanelled Health Care Providers

- a. Once a health care provider is found to be eligible for empanelment, the RSHAA 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.
- c. The Agreement of an EHCP shall continue for a **period of 2 years or the agreement period of Insurance agreement, whichever is earlier which may be renewed in accordance with clause 8 (d)** unless the EHCP is de-empanelled in accordance with the **AB- MGRSBY guidelines** and its agreement terminated in accordance with its terms. In any case the agreement shall not be increased beyond the date of completion/termination of insurance agreement between RSHAA and Insurance Company from the date of execution of provider service agreement.
- 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 RSHAA and the Insurer or tripartite Provider Service Agreement with the EHCP.
- e. If the Insurer or its outsource agency or any of its representatives violates the provisions of **Section 9.d.** above, it shall be deemed as a material breach and the RSHAA 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-MGRSBY guidelines. All Private EHCPs shall be responsible for all costs related to hardware and maintenance of the IT infrastructure.

10. De-empanelment of Health Care Providers

- a. The RSHAA, reserves the right to suspend or de-empanel an EHCP from the AB-MGRSBY, as per the guidelines mentioned in **Annex 2.5**
- 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.
- c. Healthcare personnel (Treating doctors, Radiologist, Pathologist) and diagnostic center found associated with fraud in a particular hospital may be debarred from working in other EHCPs under the scheme by RSHAA and appropriate legal action may also be taken.

11. Insurance Contract Period

11.1 Term of the Insurance Contract with the Insurer

- a. The Insurance Contract that will be signed between the Insurer and the RSHAA pursuant to this Tender Document shall be for a period of two years. The contract may be extended with mutual agreement for another one year or even a lesser period as decided by RSHAA.

11.2 Issuance of Policy

- a. For the purpose of issuance of a policy, all eligible beneficiary family units in the entire State of Rajasthan shall be covered under one policy. This policy shall be issued by the insurer before the commencement of the policy start date.
- b. Notwithstanding any delay by the Insurer in issuing or failure to issue a Policy for a State, the Insurer agrees that the Policy Cover Period for such State shall commence on the date determined in accordance with **Section 11.4** and **Section 11.5** and that it shall provide the AB- MGRSBY Beneficiaries in that State with the AB- MGRSBY Cover from that date onwards.
- c. 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 by the Insurer, the terms of the Insurance Contract shall prevail for the purpose of determining the Insurer's obligations and liabilities to the RSHAA and the AB- MGRSBY Beneficiaries.

11.3 Commencement of Policy Cover Period in State or State Cluster

- a. The first Policy Cover Period under the Policy for the State of Rajasthan shall commence from the date decided and announced by the RSHAA.
- b. The Insurer shall use its best efforts to issue Policies for the State covering all AB-MGRSBY beneficiaries as per the AB-MGRSBY Beneficiary Database.

- c. Upon renewal of the Policy for a State in accordance with **Section 11.5**, the renewal Policy Cover Period for such State or State cluster shall commence from 0000 hours of the day, following the day on which the immediately preceding Policy Cover Period expires.

11.4 Policy Cover Period

In respect of each policy, the PolicyCover Period shall be for a period of 12 months from the date of commencement of such Policy Cover Period, i.e., until 2359 hours on the date of expiration of the twelfth month from the date of commencement determined in accordance with **Section 11.5.1** Provided that upon early termination of this Insurance Contract, the Policy Cover Period for the State 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.

11.5 Renewal of Policy Cover Period

- a. In respect of renewal policy, the RSHAA shall renew the Insurance Contract of the Insurer after two years for a maximum of one more policy period or for a lesser period as decided by RSHAA. Further, in case of emergent situations, the policy shall be extended as per the time frame decided by RSHAA and the decision of RSHAA shall be final and binding upon the Insurance Company.
- b. The Insurer shall renew the Policies for entire State subject to the following conditions being fulfilled:
 - (i) Achievement against KPIs threshold levels as mentioned in **Annex 2.10**.
 - (ii) The Insurer demonstrating to the reasonable satisfaction of the RSHAA that the Insurer is not suffering from any Insurer Event of Default or if it has occurred, such Insurer Event of Default is not continuing.
 - (iii) The Insurer receives the renewal Premium in respect of the eligible AB- MGRSBY Beneficiary Family Units identified / targeted in the field prior to the commencement of the renewal Policy Cover Period.
 - (iv) If any of the conditions for renewal in **points (i), (ii) and (iii)** of this **Section 11.5** are not fulfilled, then the RSHAA may refuse renewal of the Policy for a State or State cluster.
 - (v) Provided that in each case that the Party refusing or denying renewal gives written reasons for such refusal or denial, as the case may be.
- c. Upon renewal of each Policy for State, the RSHAA and Insurer shall inform along with the commencement and expiry dates of the renewal Policy Cover Period and the Policy Cover Period for all the AB- MGRSBY Beneficiary Family Units in that State or State cluster EHCP in the state. Such information shall be widely publicised.

11.5.1 Policy Cover Period for the AB- MGRSBY Beneficiary Family Unit in the First Policy Cover Period

- a. During the first Policy Cover Period for a State, the policy cover shall commence **from 0000 hours on the date indicated by the RSHAA.**
- b. The end date of the policy cover for State of Rajasthan is 12 months from the date of start of the Policy Cover.

11.6 Policy Cover Period in the Renewal Policy

- a. During each renewal Policy Cover Period following the first Policy Cover Period :
 - (i) The Policy Cover Period for each existing AB- MGRSBY Beneficiary Family Unit shall commence from 0000 hours of the day following the day on which the immediately preceding Policy Cover Period has expired;
 - (ii) The Insurer shall ensure that each AB- MGRSBY Beneficiary Family Unit shall have a minimum of 12 months of policy cover in respect of the AB- MGRSBY Cover in each renewal Policy Cover Period, unless, the AB- MGRSBY Beneficiary Family Unit has been validated by the RSHAA after the commencement of the renewal Policy Cover Period.

11.7 Termination of Insurance contract

Upon early termination of the Insurance Contract between the RSHAA 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 **Section 30.**

If any point of time, Insurance Company fails to fulfill its contractual obligations, RSHAA reserves the right to takeover the scheme and run on trust mode using same TPA and its associated infrastructure on same rates. Insurer shall include this clause in its contract with TPA and shall also share a copy with RSHAA at the time of execution of Insurance Contract with RSHAA.

12. Registration and Premium

12.1 Payment of Premium

- a. The RSHAA shall ensure payment of the premium as per the following schedule:
 - i. The premium would be paid every year in four quarterly instalments on or before the first day of the quarter every year. The policy year being reckoned from the date of commencement of the policy. Amount for

the premium of first quarter shall be arrived on number of beneficiary families showing on portal 7 days prior to the commencement of first quarter.

- ii. The premium amount for the first quarter shall be one fourth of the annual premium and for the later quarters, it will be in proportion to the number of beneficiary families showing on portal 7 days prior to the commencement of that quarter.
- iii. For the beneficiary families that may be included during intermediate period between two quarters, premium amount will be paid with the premium installment of next quarter. Calculation of this premium amount will be done monthly on Pro-rata basis, based on addition of families in every month of the quarter.
- iv. An amount of 1 % of the premium to be paid shall be deducted from the premium paid as per the schedule for purposes of carrying out IEC, monitoring and evaluation activities by RSHAA. This amount shall be included in the administrative cost mentioned in **Clause 10.2.b** of Vol III

c. Detailed premium payment guidelines are provided at **Annex 2.6**

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

- a. The RSHAA shall issue a letter to the Insurer stating the Insurer's average Claim Ratio for all 12 months of Policy Cover Period (depending on renewal for third year) for the State/UT. In the letter, the RSHAA 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 **Section 12.2.b**.
- 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 RSHAA 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 12% if claim ratio between 60-70%.
 - iii. Administrative cost allowed 15% if claim ratio between 70-85%.
- c. All the surplus as determined through formula mentioned above should be refunded by the insurer to the RSHAA 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 RSHAA 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 RSHAA shall be entitled to recover such amount as a debt due from the Insurer through means available within law.

13. Cashless Access of Services

- a. The AB- MGRSBY 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 EHCP shall be reimbursed as per the package cost specified in the Tender Document agreed for specified packages. In case cost of package exceeds the amount available in beneficiary Risk Cover as specified in **clause 6. (g)**, EHCP shall be reimbursed upto the ceiling amount of Risk Cover. Surplus amount shall be borne by the beneficiary after following the procedure as mentioned in **clause 6 a (iii)**.
- c. The Insurer shall ensure that each EHCP shall at a minimum possess the Hospital IT Infrastructure required to access the AB- MGRSBY Beneficiary Database and undertake verification based on the Beneficiary Identification process laid out, using unique AB- MGRSBY Family ID on the ID Card and also ascertain the balance available under the AB- MGRSBY 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.
- e. The Insurer shall train Swasthya Margdarshaks (SM) that will be deputed by each EHCP that will be responsible for the administration of the AB- MGRSBY 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-MGRSBY Beneficiary Family Unit as per Annex 2.4 and ensure:
 - (i) That the patient is admitted for a covered procedure and package for such an intervention is available.
 - (ii) AB-MGRSBY Beneficiary has balance in her/ his AB- MGRSBY Cover amount.

14.Pre-authorisation of Procedures

- a. All procedures in **Annex 2.3** 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 **Annex 2.3**.
- b. No EHCP shall, under any circumstances whatsoever, 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-MGRSBY
- c. Request for hospitalization shall be forwarded by the EHCP after obtaining due details from the treating doctor and documents laid down under Minimum Document Protocol (MDP), 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 **Section 14.d**, the EHCP shall forward the clarification for delay with the request for authorisation.
- f. **Pre-auth. to be processed in consultation with specialist.No claim could be rejected without having been examined by a specialist doctor of that particular speciality.**
- g. 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 **6 hour** for emergencies. If there is no response from the Insurer **within 12 hours** of an EHCP filing the pre-authorisation request, **except for listed packages specified in guidelines to be issued later.**
- h. The request of the EHCP shall be deemed to be automatically authorised.However in case of auto approval of pre authorization request, penalty as mentioned in penalty clause shall be imposed on insurer. Later, if the claim becomes liable for rejection due to inadequacy for document at pre-authorization stage insurer shall be charged for claim amount for such cases.

The Insurer shall not be liable to honour any claims from the EHCP for procedures featuring in **Annex 2.3**, for which the EHCP does not have a pre-authorisation, if prescribed

- i. Reimbursement of all claims for procedures listed under **Annex 2.3** shall be as per the limits prescribed for each such procedure.
- j. 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.
- k. The Insurer guarantees payment only after receipt of RAL and the necessary medical details. This shall be completed within 24 hours of receiving the RAL.
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 daily report to the RSHAA explaining reasons for denial of every such pre-authorisation request.

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

- m. Authorisation letter (AL) will mention the authorisation number. The EHCP must see that these rules are strictly followed.
- n. The authorisation is given only for the ailment covered and mentioned in the RAL for hospitalization.
- o. The entry on the AB- MGRSBY portal for claim amount blocking as well at discharge would record the authorisation number as well as package amount.
- p. In case the balance sum available is less than the specified amount for the Package, the EHCP shall only charge the balance amount against the package from the AB- MGRSBY beneficiary after receiving consent as mentioned in **clause 6 (a) (iv)**.
- q. 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.
- r. In cases where the AB- MGRSBY 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- MGRSBY beneficiary was admitted.

15. Portability of Benefits

- a. The benefits of AB- MGRSBY 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 undertakes that it will 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, State Governments shall enter into arrangement with ALL other States 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 **Annex 2.7**

16. Claims Management

- a. All EHCPs shall be obliged to submit their claims within **24 hours** of discharge in the format prescribed by the Insurer. However, in case of Public EHCPs this time may be relaxed as defined by RSHAA.
- b. The Insurer shall be responsible for settling all claims **within 15 days after submission of claim by EHCP**. If a claim is not rejected, the Insurer shall either make the payment (based on the applicable package rate) or shall conduct further investigation into the claim received from EHCP.
- c. Guidelines for submission of claims, claims processing, handling of claim queries, dealing with fraudulent claims and all other related details are furnished in **Annex 2.7**.

17. Project Offices of the Insurer

17.1 Project Office at the State Level

The Insurer shall establish a Project Office at a convenient place at JAIPUR for coordination with the RSHAA on a regular basis.

17.2 District Offices

- a. The Insurer shall set up an office in each of the districts of the State of Rajasthan at the district headquarters of such district (each a District Office).
- b. Each District Office shall be responsible for coordinating the Insurer's activities at the district level with the SHA's district level administration.

17.3 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- MGRSBY and for the performance of its obligations and discharge of its liabilities under the Insurance Contract:
- (i) One State Coordinator who shall be responsible for implementation of the Scheme and performance of the Insurance Contract in the State/UT.
 - (ii) One full time District Coordinator/grievance officer 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.

The State 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 RSHAA 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 RSHAA and running of the website at the State level and updating data at regular intervals on the website. The website shall have information on AB- MGRSBY in the local language and English with functionality for claims settlement and account information access for the AB- MGRSBY 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 State level obligations with the State level administration of the SHA.
- 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 district level, exclusively for the purpose of the implementation of the AB-MGRSBY:
- (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 RSHAA from time to time or as specified in the Scheme Guidelines, at monthly intervals.
 - (iii) To undertake the Pre-authorisation functions under AB-MGRSBY.
 - (iv) 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.
 - (v) To undertake internal monitoring and control functions.
 - (vi) To undertake feedback functions which include designing feedback formats, collecting data based on those formats from different stakeholders like AB-MGRSBY beneficiaries, the EHCPs etc., analysing the feedback data and recommending appropriate actions.
 - (vii) To coordinate the Insurer's district level obligations with the district level administration of the RSHAA.
- 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 Section 20.
- 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-MGRSBY 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 RSHAA within 30 days of all such appointments and replacements. The Insurer shall ensure that its employees coordinate and consult with the RSHAA's corresponding personnel for the successful implementation of AB- MGRSBY 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.

18.Capacity Building Interventions

The Insurer shall, at a minimum, conduct the following training:

Empanelled Health Care Provider Training

- a. The Insurer shall provide training to the Swasthya Margdarshak for all EHCPs in a State or State cluster at least once every 6 months, that is, at least twice during each Policy Cover Period. 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 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 insurer shall organise training workshops at any other time as directed by RSHAA.

19. Outsourcing of Non- core Business by Insurer to an Agency

- a. The Insurer shall notify the RSHAA of the agencies or service providers that it wishes to appoint within three days of NOA as per details in the clause 11.1.2 b of Volume 1 of this tender document.
- 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 RSHAA.
- 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.

20. Management Information System

- a. All Management Information System (MIS) shall be on a centralised web-based architecture designed by the RSHAA/NHA/ 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 RSHAA and any number of authorized representatives of the RSHAA or its advisors/ consultants with access to the various modules on the MIS dashboard. The RSHAA shall have the right to download, print or store the data available on the MIS dashboard. RSHAA may share this data to GOI as per data sharing agreement.

- d. In addition, the Insurer shall submit reports to the RSHAA regarding health-service usage patterns, Claims data and such other information regarding the delivery of benefits as may be required by the RSHAA 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 RSHAA and/ or to the MoHFW, GoI and to submit such reports in formats as required by and specified by the RSHAA from time to time.
- f. All data generated 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 RSHAA and data shall be shared to NHA for details analysis. The Insurer undertakes to handover all such information and data to the RSHAA within 10 days of the expiration or cancellation of the Policy for that State or State cluster and on the expiration or early termination of the Insurance Contract.

21. Commitments of the Insurer

The Insurer shall undertake the following tasks which are necessary for successful implementation of the Scheme. These are indicative but not exhaustive.

- a. Set up a fully operational Project and District office within 30 days of signing the Insurance Contract with the RSHAA.
- b. Oversee IT infrastructure in EHCPs including training of EHCP staff on the same.
- c. It will be the responsibility of the incoming Insurer to ascertain the details about the existing hardware and software and to undertake necessary modifications (if necessary) at EHCP's cost if the hardware is not working because of compatibility issues.
- d. Settle legitimate and due claims of the EHCPs within the allocated timeframe of 15 days.

Participate in and coordinate timely redressal of grievances in close coordination with the concerned Grievance Redressal Committee.

- e. Comply with the orders of the concerned Grievance Redressal Committee should an order be issued against the Insurer itself.
- f. Abide by the terms and conditions of the Insurance Contract throughout the tenure of the Contract.

- g. If required, enter into a service agreement with the outsource agency within a period of 14 days from signing of the Insurance Contract with the RSHAA.
- h. Ensuring that the contact details of the State Coordinator of the Insurer and the nodal officer of the EHCP (as the case may be) are updated on the AB- MGRSBY website.
- i. Ensure provision of services in absence of internet connectivity as provided in **Section 22**.

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 (As per approval from RSHAA) to ensure continued provision of Cashless Access Services to the AB-MGRSBY Beneficiaries in accordance with the methodology prescribed in the AB-MGRSBY Guidelines;
- 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 RSHAA; 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 RSHAA in the format prescribed by the RSHAA at that point in time.

23. Monitoring and Verification

23.1 Scope of Monitoring

- a. Monitoring under AB-MGRSBY shall include supervision and monitoring of all the activities under the AB-MGRSBY undertaken by the Insurer and ensuring that the Insurer complies with all the provisions of the Insurance Contract signed with the Rajasthan State Health Assurance Agency (RSHAA) and all contracts and sub-contracts/ agreements issued by the Insurer pursuant to the Insurance Contract with the RSHAA 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.

23.2 Monitoring Activities to be undertaken by the Insurer

23.2.1 General Monitoring Obligations

Under the AB-MGRSBY, 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 RSHAA. 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- MGRSBY 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.

23.2.2 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 RSHAA 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 RSHAA 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 **Annex 2.8**.

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.

23.2.3 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 **Section 23.2.2** above.
- b. Hospital audit shall be conducted as per the format prescribed in **Annex 2.9**.
- 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 in **Annex 2.9**.

23.3 Monitoring Activities to be undertaken by the State Health Agency

23.3.1 Audits by the State Health Agency

- a. Audit of the audits undertaken by the Insurer: The RSHAA 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 **Section 23.3.1.a**, the RSHAA 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 RSHAA shall constitute a **Claims Review Committee (CRC)** that shall look into minimum 10% of claims rejected or partially settled by the Insurer to assure itself of the legitimacy of the Insurer's decisions.
 - (ii) Claims for which EHCP, feels are wrongly rejected, then it may file review with IC and IC will decide such claims within 15 days.

- (iii) If EHCP is still aggrieved with the review by IC, then the matter may be filed in GRC/CRC. GRC may forward cases to CRC for examination.
- (iv) GRC/CRC shall examine the case within as soon as possible 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 GRC/CRC 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.
- (v) Concurrent Audits: The RSHAA 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.

23.3.2 Spot Checks by the State Health Agency

- a. The RSHAA 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 RSHAA.

23.3.3 Performance Review and Monitoring Meetings

- a. The RSHAA shall organize fortnightly meetings for the first three months and monthly review meetings thereafter with the Insurer. The RSHAA shall have the right to call for additional review meetings as required to ensure smooth functioning of the Scheme.
- b. Whereas the RSHAA 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 RSHAA shall have the right to call for interim review meetings as and when required on specific issues.

23.4 Key Performance Indicators for the Insurer

- 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 **Annex 2.10**.
- b. At the end of every 12 months, the RSHAA 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.

23.5 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 RSHAA on the Insurer shall have to be paid by the Insurer within 60 days of such demand.
- d. Based on the review the RSHAA shall have the right to issue rectification orders demanding the performance to be brought up to the levels desired as per the AB-MGRSBY 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 RSHAA.
- g. If the RSHAA 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 RSHAA and the Insurer.

24. Fraud Control and Management

- a. The Scheme shall use an integrated centralized IT platform prepared by NHA and/or RSHAA for detecting outlier behaviour and predictive modelling to identify fraud.
- b. The MIS software will be designed to generate automatic reports and present trends including outlier behaviours against the list of trigger alerts.

- c. For an indicative (not exhaustive) list of fraud triggers that may be automatically and on a real-time basis be tracked by the centralised AB-PMJAY IT platform, refer to **Annex 2.11**. The Insurer shall have capacities and track the indicative (not exhaustive) triggers and it can add more triggers to the list.
- d. Seamless integration of the centralised AB- PMJAY IT platform with State level servers shall ensure real time alerts to the RSHAAs for immediate intimation to the Insurer and for detailed investigations.
- e. 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 RSHAA.
- f. Investigations pursuant to any such alert shall be concluded within 15 days as far as possible and all final decision related to outcome of the Investigation and consequent penal action, if the fraud is proven, shall vest solely with the RSHAA.
- g. The RSHAA shall take all such decision within the provisions of the Insurance Contract and be founded on the Principles of Natural Justice.
- h. The RSHAA 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 **Annex 2.12**.

25.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 10 th day of the month following the end of the quarter
(iii)	Claims/ Utilization Summary Reports	Monthly	Within 5 th day of the month following the end of the month
(iv)	Overall Scheme Progress Reports	Monthly	Within 10 th day of the month following the end of the quarter

- b. All reports shall be uploaded by the Insurer online on the RSHAA web portal.
- c. The Insurer shall receive auto-acknowledgement immediately on submission of the report.
- d. The RSHAA shall review all progress reports and provide feedback, if any, to the Insurer.

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

26.Events of Default of the Insurer and Penalties

26.1 Events of Default

- a. Following instances would constitute Events of Default for the Insurer which may lead to termination of the Insurance Contract with the RSHAA:
 - (i) Performance against KPI is below the threshold specified in **Annex 2.10** for two consecutive quarters.
 - (ii) Intentional or unintentional act of undisputedly proven fraud committed by the Insurer.
- b. Further each of the following events or circumstances, to the extent not caused by a default of the RSHAA or Force Majeure, shall be considered for the purposes of the Insurance Contract as Events of Default of the Insurer which, if not rectified within the time period permitted, may lead to Termination of the Insurance Contract:
 - (i) The Insurer has **failed to perform or discharge any of its obligations** in accordance with the provisions of the Insurance Contract with RSHAA unless such event has occurred because of a Force Majeure Event, or due to reasons solely attributable to the RSHAA without any contributory factor of the Insurer.
 - (ii) 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.
 - (iii) If at any time **any payment**, assessment, charge, lien, penalty or damage herein specified to be paid by the Insurer to the RSHAA, or any part thereof, **shall be in arrears and unpaid**;
 - (iv) **Any representation** made or warranties given by the Insurer under the Insurance Contract is found to be **false or misleading**;
 - (v) 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;
 - (vi) The Insurer has been adjudged as bankrupt or become insolvent;
 - (vii) 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 RSHAA, 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;

- (viii) The Insurer has abandoned the Project Office(s) of the AB- MGRSBY and is non-contactable.

26.2 Penalties

- a. KPI performance related penalties are provided in the KPI table in **Annex 2.10**.
- b. Apart from the KPI related penalties, the RSHAA shall impose the following penalties on the Insurer which have been referred to in the other sections of this Tender Document:

No.	Additional Defaults	Penalty
(i)	If premium refund is not made by the Insurer to the RSHAA within 30 days of the communication for refund sent by the RSHAA 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 claim payment to the hospital is delayed beyond defined period of 15days.	An interest of 1% for every seven day of delay after 15days
(iii)	For claims outside State, 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

27.Coordination Committee

27.1 Constitution and Membership

- a. The RSHAA shall, within 15 days of the date of execution of this Insurance Contract, establish a coordination committee which shall meet quarterly to perform its functions.
- b. The Coordination Committee shall be constituted as follows:
 - (i) Principal Secretary (Health and Family Welfare) or any other representative designated by her/ him (Chairperson).
 - (ii) CEO, RSHAA
 - (iii) Joint, CEO,RSHAA (Member Secretary)
 - (iv) Director Health Services.
 - (v) The State Nodal Officers/Project director and one other member nominated by the RSHAA.
 - (vi) The State Coordinator (s) of the Insurance Company (ies) and one other member from the Corporate/ regional office of the Insurer.

State may add additional members, if required.

27.2 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 RSHAA 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 agree upon.

28. Grievance Redressal

A robust and strong grievance redressal mechanism has been designed for AB-MGRSBY. The District authorities shall act as a frontline for the redressal of Beneficiaries / Providers / other Stakeholder's grievances. The District authorities shall also attempt to solve the grievance at their end. The grievances so recorded shall be numbered consecutively and the Beneficiaries / Providers or any other aggrieved party shall be provided with the number assigned to the grievance. The District authorities shall provide the Beneficiaries / Provider or any other aggrieved party with details of the follow-up action taken as regards the grievance as per the process laid down. The District authorities shall also record the information in pre-agreed format of any complaint / grievance received by oral, written or any other form of communication.

Under the Grievance Redressal Mechanism of AB-MGRSBY, 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 **Annex 2.14**.

29. Renewal of the Insurance Contract

- a. This Insurance Contract is subject to renewal after two years for one more year.
- b. All decisions related to renewal shall vest with the RSHAA.
- c. The RSHAA shall take the decision regarding the Insurance Contract renewal based on the parameters specified in **Section 11.5** of this Volume II of the Tender Document.
- d. The Insurer hereby acknowledges and accepts that the decision related to renewal is at the discretion of the RSHAA and this shall not be deemed as a right of the Insurer under this Insurance Contract.

30. Termination of the Insurance Contract and Consequences

30.1 Grounds for Termination

- a. If the RSHAA does not renew the Insurance Contract of the Insurer as per **Section 29** above, it shall be terminated prematurely.
- b. The Insurance Contract may be terminated also on the occurrence of one or more of the following events:
 - (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 RSHAA in time to the Insurer; or
 - (iii) the Insurer has failed to pay any of the Liquidated Damages/ penalties within 60 days of receipt of a written notice from the RSHAA requesting payment thereof; or
 - (iv) the Insurer's liability for Liquidated Damages for any Policy Cover Period would exceed the Aggregate Liquidated Damages Liability Cap of five percent; or
 - (v) the Insurer amends or modifies or seeks to amend or modify the Premium or the terms and conditions of the AB- MGRSBY Cover for any renewal Policy Cover Period; or
 - (vi) the Insurer is otherwise in material breach of this Insurance Contract that remains uncured despite receipt of a 60-day cure notice from the RSHAA; or
 - (vii) any representation, warranty or undertaking given by the Insurer proved to be incorrect in a material respect or is breached; or
 - (viii) Non-performance on KPIs.
 - (ix) Fraudulent practices
- c. Termination shall take place following the legal protocols specified in the Insurance Contract (refer to Volume III of this Tender Document).
- d. Premature termination of Insurance Contract shall give the following rights to the RSHAA:
 - (i) Quantify pending dues of the Insurer to the RSHAA and pending claims of the EHCP.
 - (ii) Quantify premium to be refunded on account of premature termination in lieu of the remaining Policy Cover Period.
 - (iii) Demand that the Insurer unconditionally migrates the Policies of all the AB- MGRSBY beneficiaries to another Insurance Company at a time and as per the guidelines issued.
 - (iv) At any point of time, if Insurance Company fails to fulfill its contractual obligations, RSHAA reserves the right to take over the scheme and run on trust mode using same TPA and infrastructure created by Insurance Company on same rates and on risk and cost of Insurance Company.
 - (v) If the Insurance Company fails to comply with the provisions of agreement or breaches any substantial part then RSHAA reserve the right to take up the matter with IRDA or may also initiate proceedings for blacklisting of Insurance Company.

30.2 Migration of Policies Post Termination

- a. At least 120 days prior to the expiration of this Insurance Contract or the Termination Date, the RSHAA 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 RSHAA has issued such a Migration Request:
 - (i) The RSHAA 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 RSHAA 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 RSHAA chooses to withdraw the Migration Request, then the remaining provisions of this **Section 30.2** 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 RSHAA in the format prescribed by the RSHAA 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 RSHAA, 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**).

Annexes: Volume II

Annex 2.1 AB-MGRSBY Beneficiaries

AB-MGRSBY Beneficiaries and Beneficiary Family Unit

- a. All AB- MGRSBY Beneficiary Family Units means a family who is covered under National Food Security Act 2013 and/or eligible family of AYUSHMAN BHARAT- PRADHAN MANTRI JAN AROGYA YOJNA from the eligible categories of Socio-Economic Caste Census (SECC),2011 which are resident of Rajasthan and have linked their eligibility with the identity card as decided by GoR shall be considered as eligible for benefits under the Scheme and be automatically covered under the Scheme.
- b. In addition to this, additional categories which gets covered under the scheme in connection to **clause 2.2 of volume I** shall also be considered as beneficiary family units from the date of their coverage under the scheme. Date of coverage shall be decided as per directions of RSHAA.
- c. Unit of coverage under the Scheme shall be a family and each family for this Scheme shall be called a AB- MGRSBY Beneficiary Family Unit, which will comprise all members in that family whose names are mentioned in the ID Card as decided by GOR. In addition to this, children of that family up to the age of one year will also be considered the member of that family even without having name in the ID Card.

Annex 2.2 Exclusions to the Policy

The Insurance Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

1. **Conditions that do not require hospitalization:** Condition that do not require hospitalization and can be treated under Out Patient Care. Out patient Diagnostic, Medical and Surgical procedures or treatments unless necessary for treatment of a disease covered under day care procedures(as applicable) will not be covered.
2. Except those expenses covered under pre and post hospitalisation expenses, further expenses incurred at Hospital or Nursing Home primarily for evaluation / diagnostic purposes only during the hospitalized period and expenses on vitamins and tonics etc unless forming part of treatment for injury or disease as certified by the attending physician.
3. Any dental treatment or surgery which is corrective, cosmetic or of aesthetic procedure, filling of cavity, root canal including wear and tear etc. unless arising from disease or injury and which requires hospitalisation for treatment.
4. **Congenital external diseases:** Congenital external diseases or defects or anomalies, Convalescence, general debility, “run down” condition or rest cure.
5. **Fertility related procedures:** Hormone replacement therapy for Sex change or treatment which results from or is in any way related to sex change.
6. **Vaccination:** Vaccination, inoculation or change of life or cosmetic or of aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness. Circumcision (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident),
7. **Suicide:** Intentional self-injury/suicide
8. **Persistent Vegetative State**

Annex 2.3 Packages and Rates

- Package list included in **Annex 2.3** can be revised and updated by NHA/Gol which shall come into effect from the date of notification issued by NHA.
- Once revised by NHA/Gol, packages and rates shall remain same for 2 years of the execution of insurance contract.
- Secondary illnesses include those packages as defined in the secondary packages list given below for which the risk cover is Rs.50,000 per eligible family per annum.
- Tertiary illnesses include those packages as defined in the tertiary packages list given below for which the risk cover is Rs.4,50,000 per eligible family per annum.
- Packages reserved for government EHCPs is given in the list below.

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S.No	Specialty	No. of packages	No. of packages mandated for pre-authorization
1	Cardiology		
2	Cardio-thoracic surgery		
3	Cardio-vascular surgery		
4	Ophthalmology		
5	ENT		
6	Orthopaedics		
7	Polytrauma		
8	Urology		
9	Obstetrics & Gynaecology		
10	General Surgery		
11	Neurosurgery		
12	Interventional Neuroradiology		
13	Plastic & reconstructive		
14	Burns management		
15	Oral and Maxillofacial Surgery		
16	Paediatric medical management		
17	Neo-natal		
18	Paediatric cancer		
19	Paediatric surgery		
20	Medical packages		
21	Oncology		
22	Emergency Room Packages (Care requiring less than 12 hrs stay)		
23	Mental Disorders Packages		
	Total		

ALL PACKAGES WILL INCLUDE DRUGS, DIAGNOSTICS, CONSULTATIONS, PROCEDURE, STAY.

Performance-linked Incentive:

A performance-linked payment system has been designed to incentivize hospitals to promote equity in access, hospitals providing services in backward districts where number of private hospitals are less than 10 in existing scheme (Baran, Banswara, Bundi, Chittorgarh, Dholpur, Dungarpur, Jaisalmer, Pratapgarh and Rajasamand) including three aspirational districts (i.e. Baran, Dholpur and Jaisalmer) will receive an additional 10%.

Remaining details includeing package list to be provided later.

Annex 2.4 Guidelines for Identification of AB- MGRSBY Beneficiary Family Units

- A. Beneficiary identification will include the following broad steps:
Swasthya Margdarshak ensures eligibility of the family and beneficiary in the scheme through software by either of the followings:
1. Family Identification:
 - a. By entering of the ID Card number as prescribed by GoR or its acknowledgement slip number
 - b. By entering of the Aadhar Card Number of beneficiary which is/are linked with the unique family identity card
 - c. By entering of the HHID no. of eligible SECC family linked with unique family identity card.
 2. Beneficiary Identification:
 - a) After identification of family unit, beneficiary will be identified using biometric method of identification as far as possible.
 - b) in case of failure of biometric identification or if Aadhaar card is not issued for a patient, any specified photo ID issued by Government or semi Government produced by the beneficiary at the point of contact shall be admissible. Photo ID shall be duly verified by the EHCP.
 - c) For the children upto age of 5 years, biometric identification and photo ID is not mandatory. Their identification may be done based on the biometric identification and/or photo ID of any other person from beneficiary family unit

Annex 2.5 Guidelines for Empanelment of Health Care Providers and Other Related Issues

1. Basic Principles

For providing the benefits envisaged under the Scheme, the Rajasthan State Health Assurance Agency (RSHAA) through State Empanelment Committee (SEC) will empanel private and public health care service providers.

At the district level, District Empanelment Committee (DEC) will be formed which will be responsible for hospital empanelment related activities at the district level and to assist the State Empanelment Committee (SEC) in empanelment and disciplinary proceedings with regards to network providers in their districts. The detailed guidelines/circular on empanelment will be issued by RSHAA.

2. Institutional Set-Up for Empanelment

A. State Empanelment Committee (SEC) will constitute of following members:

1. CEO, Rajasthan State Health Assurance Agency– Chairperson or any other officer designated by CEO;
2. Medical Officer, Rajasthan State Health Assurance Agency – Member;
3. Sr.AO, Rajasthan State Health Assurance Agency – Member;
4. Two State government officials nominated by the Department – Members
5. In case of Insurance Model, Insurance company to nominate a representative not below Additional General Manager or equivalent;

The RSHAA through State Empanelment Committee (SEC) shall ensure:

- Ensuring empanelment within the stipulated timeline for quick implementation of the programme;
- The empanelled provider meets the minimum criteria as defined by the guidelines for general or specialty care facilities;
- Empanelment and de-empanelment process transparency;
- Time-bound processing of all applications; and
- Time-bound escalation of appeals.

It is prescribed that at the district level, District Empanelment Committee (DEC) will be formed which will be responsible for hospital empanelment related activities at the district level and to assist the SEC in empanelment and disciplinary proceedings with regards to network providers in their districts.

B. District Empanelment Committee (DEC) will constitute of the following members

- | | |
|---|--------------------|
| ➤ Chief Medical Officer of the district | -Chair Person |
| ➤ DGNO | - Member |
| ➤ District Program Manager, NHM | - Member |
| ➤ District Consultant, NUHM | - Member Secretary |
| ➤ Insurance company representative | - Member* |

For Divisional HQ and State capital, DEC may include additional members, if required.

It is requiring that the Insurance Company to mandatorily provide a medical representative to assist the DEC in its activities.

- In case of empanelment starts before the finalization of Insurance Company then member of insurance company is not required. Insurance company will be free to inspect each hospital at there on own level within three months of finalisation of BIDs. If any discrepancy observed by the Insurance company then they should be intimated to RSHAA. RSHAA will again inspect those cases. Decision of RSHAA is final in all cases.

The DEC will be responsible for:

- Getting the field verification done along with the submission of the verification reports to the SEC through the online empanelment portal.

- The DEC will also be responsible for recommending, if applicable, any relaxation in empanelment criteria that may be required to ensure that sufficient numbers of empanelled facilities are available in the district.
- Final approval of relaxation will lie with SEC.

The SEC will consider, among other things, the reports submitted by the DEC and recommendation approve or deny or return to the hospital the empanelment request.

3. Process of Empanelment

A. Empanelment requirements

- i) RSHAA will empanel hospitals only in the state of Rajasthan.
- ii) All public facilities with capability of providing inpatient services (Community Health Centre level and above) are deemed empanelled under AB-MGRSBY. The State Health Department shall ensure that the enabling infrastructure and guidelines are put in place to enable all public health facilities to provide services under AB-MGRSBY.
- iii) Employee State Insurance Corporation (ESIC) hospitals will also be eligible for empanelment in AB-MGRSBY, based on the approvals.
- iv) For private providers and not for profit hospitals, a tiered approach to empanelment will be followed. Empanelment criteria are prepared for various types of hospitals / specialties catered by the hospitals and attached in Annex 1.
- v) Private hospitals will be encouraged to provide ROHINI provided by Insurance Information Bureau (IIB). Similarly public hospitals will be encouraged to have NIN provided by MoHFW.
- vi) A performance-linked payment system has been designed to incentivize hospitals to promote equity in access, hospitals providing services in backward districts where number of private hospitals are less than 10 in existing scheme (Baran, Banswara, Bundi, Chittorgarh, Dholpur, Dungarpur, Jaisalmer, Pratapgarh and Rajasamand) including three aspirational districts (i.e. Baran, Dholpur and Jaisalmer) will receive an additional 10%.

Criteria for empanelment has been divided into two broad categories as given below.

Category 1: General Criteria	Category 2: Specialty Criteria
All the hospitals empanelled under AB-MGRSBY for providing general care have to meet the minimum criteria established under the scheme detailed in Annex 1. No exceptions will be made for any hospital at any cost.	Hospitals would need to be empanelled separately for certain tertiary care packages authorized for one or more specialties (like Cardiology, Oncology, Neurosurgery etc.). This would only be applicable for those hospitals who meet the general criteria for the AB-MGRSBY.

Detailed empanelment criteria have been provided as [Annex 1](#).

State Governments will have the flexibility to **revise/relax** the empanelment criteria based, barring minimum requirements of Quality as highlighted in Annex 1, as per local context, availability of providers, and the need to balance quality and access; with prior approval from National Health Agency. The same will have to be incorporated in the web-portal for online empanelment of hospitals.

Hospitals will undergo a renewal process for empanelment once every **2years or till the expiry of validity of Insurance Contract whichever is earlier** to determine compliance to minimum standards.

National Health Agency may revise the empanelment criteria at any point during the programme, if required and the states will also undertake any required re-assessments for the same.

4. Awareness Generation and Facilitation

The state government shall ensure that maximum number of eligible hospitals participate in the AB-MGRSBY, and this need to be achieved through IEC campaigns, collaboration with and district, sub-district and block level workshops.

For the purpose of IEC, monitoring and evaluation, 1 % of the premium payable every quarter shall be deducted.

The state and district administration should strive to encourage all eligible hospitals in their respective jurisdictions to apply for empanelment under AB-MGRSBY. The RSHAA shall organise a district workshop to discuss the details of the scheme till the time insurer is finalized. After finalization of insurer, organization of workshop will be liability of the insurer.

Representatives of both public and private hospitals (both managerial and operational persons) including officials from Insurance Company will be invited to participate in this workshop.

5. Online Empanelment

- A. A web-based platform is being provided for empanelment of hospitals for AB-MGRSBY.

- B. The hospitals can apply through this portal only, as a first step for getting empanelled in the programme.
- C. This web-based platform will be the interface for application for empanelment of hospitals under AB-MGRSBY.
- D. Following the workshop, the hospitals will be encouraged to initiate the process of empanelment through the web portal. Every hospital willing to get empanelled will need to visit the web portal, www.abnhpm.gov.in and create an account for themselves.
- E. Availability of PAN CARD number (not for public hospitals) and functional mobile number of the hospital will be mandatory for creation of this account / Login ID on the portal for the hospital.
- F. Once the login ID is created, hospital shall apply for empanelment through an online application on the web portal - www.abnhpm.gov.in.
- G. Each hospital will have to create a primary and a secondary user ID at the time of registration. This will ensure that the application can be accessed from the secondary user ID, in case the primary user is not available for some reason.
- H. All the required information and documents will need to be uploaded and submitted by the hospital through the web portal.
- I. Hospital will be mandated to apply for all specialties for which requisite infrastructure and facilities are available with it. Hospitals will not be permitted to choose specific specialties it wants to apply for unless it is a single specialty hospital. For the specialties selected for empanelment, the EHCP can not deny any package/procedure/services (as per Annex 2.3) to the eligible beneficiary if it is providing the same to others.
- J. After registering on the web-portal, the hospital user will be able to check the status of their application. At any point, the application shall fall into one of the following categories:
 - i) Hospital registered but application submission pending
 - ii) Application submitted but document verification pending
 - iii) Application submitted with documents verified and under scrutiny by DEC/SEC
 - iv) Application sent back to hospital for correction
 - v) Application sent for field inspection
 - vi) Inspection report submitted by DEC and decision pending at SEC level
 - vii) Application approved and contract pending
 - viii) Hospital empanelled
 - ix) Application rejected
 - x) Hospital de-empanelled

xi) Hospital blacklisted (2 years)

6. Role of DEC

- A. After the empanelment request by a hospital is filed, the application should be scrutinized by the DEC and processed completely within 15 days of receipt of application.
- B. A login account for a nodal officer from DEC will be created by SEC. This login ID will be used to download the application of hospitals and upload the inspection report.
- C. As a first step, the documents uploaded have to be correlated with physical - verification of original documents produced by the hospital. In case any documents are found wanting, the DEC may return the application to the hospital for rectifying any errors in the documents.
- D. After the verification of documents, the DEC will physically inspect the premises of the hospital and verify the physical presence of the details entered in the empanelment application, including but not limited to equipment, human resources, service standards and quality and submit a report in a said format through the portal along with supporting pictures/videos/document scans.
- E. DEC will ensure the visits are conducted for the physical verification of the hospital. The verification team will have at least one qualified medical doctor (minimum MBBS).
- F. The team will verify the information provided by the hospitals on the web-portal and will also verify that hospitals have applied for empanelment for all specialties as available in the hospital.
- G. In case during inspection, it is found that hospital has not applied for one or more specialties but the same facilities are available, then the hospital will be instructed to apply for the missing specialties within a stipulated timeline (i.e. 7 days from the inspection date).
 - i) In this case, the hospital will need to fill the application form again on the web portal. However, all the previously filled information by the hospital will be pre-populated and hospital will be expected to enter the new information.
 - ii) If the hospital does not apply for the other specialties in the stipulated time, it will be disqualified from the empanelment process.
- H. In case during inspection, it is found that hospital has applied for multiple specialties, but all do not conform to minimum requirements under AB- MGRSBY then the hospital will only be empanelled for specialties that conform to AB-MGRSBY norms.

- I. The team will recommend whether hospital should be empanelled or not based on their field-based inspection/verification report.
- J. DEC team will submit its final inspection report to the state. The district nodal officer has to upload the reports through the portal login assigned to him/her.
- K. The DEC will then forward the application along with its recommendation to the SEC.

7. Role of SEC

- A. The SEC will consider, among other things, the reports submitted by the DEC and recommendation approve or deny or return back to the hospital the empanelment request.
- B. In case of refusal, the SEC will record in writing the reasons for refusal and either direct the hospital to remedy the deficiencies, or in case of egregious emissions from the empanelment request, either based on documentary or physical verification, direct the hospital to submit a fresh request for empanelment on the online portal.
- C. The SEC will also consider recommendations for relaxation of criteria of empanelment received from DEC or from the RSHAA and approve them to ensure that sufficient number and specialties of empanelled facilities are available in the states.
- D. Hospital will be intimated as soon as a decision is taken regarding its empanelment and the same will be updated on the web portal. The hospital will also be notified through SMS/email of the final decision. If the application is approved, the hospital will be assigned a unique national hospital registration number under AB-MGRSBY.
- E. If the application is rejected, the hospital will be intimated of the reasons on the basis of which the application was not accepted and comments supporting the decision will be provided on the AB- MGRSBY web portal. Such hospitals shall have the right to file a review against the rejection with the Rajasthan State Health Assurance Agency within 15 days of rejection through the portal. In case the request for empanelment is rejected by the RSHAA in review, the hospitals can approach the State Grievance Redressal Mechanism for remedy.
- F. In case the hospital chooses to withdraw from AB-MGRSBY, it will only be permitted to re-enter/ get re-empanelled under AB- MGRSBY after a period of 6 months.
- G. If a hospital is blacklisted for a defined period due to fraud/abuse, after following due process by the State Empanelment Committee, it can be permitted to re-apply after cessation of the blacklisting period or revocation of the blacklisting order, whichever is earlier.
- H. There shall be no restriction on the number of hospitals that can be empanelled

under AB- MGRSBY in a district.

- I. *Final decision on request of a Hospital for empanelment under AB-MGRSBY, shall be completed within 30 days of receiving such an application.*
- J. *The constitution and role of the DEC and SEC may be changed by the government at any time, if required.*

8. Signing of Contract

- A. Within 7 days of approval of empanelment request by SEC, the State Government will sign a contract with the empanelled hospitals as per the template defined in the tender document.
- B. Tripartite agreement will be made between the Insurance Company, RSHAA and the hospital.
- C. Each empanelled hospital will need to provide a name of a nodal officers who will be the focal point for the AB- MGRSBY for administrative and medical purposes.
- D. Once the hospital is empanelled, a separate admin user for the hospital will be created to carry out transactions for providing treatment to the beneficiaries.

9. Process for Disciplinary Proceedings and De-Empanelment

- A. Institutional Mechanism
 - i) De-empanelment process can be initiated by RSHAA after conducting proper disciplinary proceedings against empanelled hospitals on misrepresentation of claims, fraudulent billing, wrongful beneficiary identification, overcharging, charging money from patients unnecessarily, unnecessary procedures, false/misdiagnosis, referral misuse and other frauds that impact delivery of care to eligible beneficiaries. If any point of time Insurance Company finds any such misconduct on the part of the hospital, they can submit recommendation regarding the same to RSHAA. RSHAA reserves the right to investigate and validate the facts behind such recommendation and after that may take necessary action.
 - ii) Hospital can contest the action of de-empanelment with SEC. If hospital is aggrieved with actions of SEC/RSHAA, the former can approach the RSHAA to review its decision, following which it can request for redressal through the Grievance Redressal Mechanism as per guidelines.
 - iii) In case of implementation through the insurance mode, the SEC and DEC will mandatorily include a representative of the Insurance Company when deliberating and deciding on disciplinary proceedings under the scheme.
 - iv) The SEC may also initiate disciplinary proceedings based on field audit

reports/survey reports/feedback reports/ complaints filed with them/ complaints.

- v) For disciplinary proceedings, the DEC may consider submissions made by the beneficiaries (through call centre/ mera hospital or any other application/ written submissions/Emails etc.) or directions from SEC or information from other sources to investigate a claim of fraud by a hospital.
- vi) On taking up such a case for fraud, after following the procedure defined, the DEC will forward its report to the SEC along with its recommendation for action to be taken based on the investigation.
- vii) The SEC will consider all such reports from the DEC's and pass an order detailing the case and the penalty provisions levied on the hospital.
- viii) Any disciplinary proceeding so initiated shall have to be completed within 30 days.

B. Steps for Disciplinary Proceedings

Step 1 - Putting the provider on "Watch-list"

Based on the claims, data analysis and/or the provider visits, if there is any doubt on the performance of a Provider, the SEC on the request of the IC or the RSHAA or on its own findings or on the findings of the DEC, can put that hospital on the watch list. The data of such hospital shall be analysed very closely on a daily basis by the RSHAA/SEC for patterns, trends and anomalies and flagged events/patterns will be brought to the scrutiny of the DEC and the SEC as the case may be. The IC shall notify such service provider that it has been put on the watch-list and the reasons for the same.

Step 2 – Issuing show-cause notice to the hospital

Based on the activities of the hospital if the insurer believes that there are clear grounds of hospital indulging in wrong practices, a showcause notice shall be issued to the hospital. Hospital will need to respond to the notice within 7 days of receiving it.

Step 3 - Suspension of the hospital

A Provider can be temporarily suspended in the following cases:

- i) For the Providers which are on the "Watch-list" or have been issued showcause notice if the SEC observes continuous patterns or strong evidence of irregularity based on either claims data or field visit of the hospital or in case of unsatisfactory reply of the hospital to the showcause notice, the hospital may be suspended from providing services to beneficiaries under the scheme and a formal investigation shall be instituted.
- ii) If a Provider is not in the "Watch-list", but the SEC observes at any stage that it has data/ evidence that suggests that the Provider is involved in any

unethical Practice/ is not adhering to the major clauses of the contract with the Insurance Company / Involved in financial fraud related to health insurance patients, it may immediately suspend the Provider from providing services to policyholders/insured patients and a formal investigation shall be instituted.

A formal letter shall be send to the concerned hospital regarding its suspension with mentioning the time frame within which the formal investigation will be completed.

Step 4 - Detailed Investigation

The detailed investigation shall be undertaken for verification of issues raised in disciplinary proceedings and may include field visits to the providers (with qualified allopathic doctor as part of the team), examination of case papers, talking with the beneficiary/ policyholders/insured (if needed), examination of provider records etc. If the investigation reveals that the report/ complaint/ allegation against the provider is not substantiated, RSHAA would immediately revoke the suspension (in case of suspension) on the direction of the SEC. A letter regarding revocation of suspension shall be sent to the provider within 24 hours of that decision.

Step 5 – Presentation of Evidence to the SEC

The detailed investigation report should be presented to the SEC and the detailed investigation should be carried out in stipulated time period of not more than 7 days. If the investigation reveals that the complaint/allegation against the provider is correct, then the following procedure shall be followed:

- i) The hospital must be issued a “show-cause” notice seeking an explanation for the aberration.
- ii) In case the proceedings are under the SEC, after receipt of the explanation and its examination, the charges may be dropped or modified or an action can be taken as per the guidelines depending on the severity of the malafide/error. In cases of de-empanelment, a second show cause shall be issued to the hospital to make a representation against the order and after considering the reply to the second showcause, the SEC can pass a final order on de-empanelment. If the hospital is aggrieved with actions of SEC/RSHAA, the former can approach the RSHAA to review its decision, following which it can request for redressal through the Grievance Redressal Mechanism as per guidelines.
- iii) In case the preliminary proceedings are under the DEC, the DEC will have to forward the report to the SEC along with its findings and recommendations for a final decision. The SEC may ask for any additional material/investigation to be brought on record and to consider all the material at hand before issuing a final order for the same.

The entire process should be completed within 30 days as far as possible from the date of suspension. The disciplinary proceedings shall also be undertaken through the online portal only.

Step 6 - Actions to be taken after De- empanelment

Once the hospital has been de-empanelled, following steps shall be taken:

- i) A letter shall be sent to the hospital regarding this decision.
- ii) A decision may be taken by the SEC to ask the RSHAA to lodge an FIR in case there is suspicion of criminal activity.
- iii) This information shall be sent to all the other Insurance Companies as well as other regulatory bodies and the MoHFW/ NHA.
- iv) The RSHAA may be advised to notify the same in the local media, informing all policyholders/insured about the de-empanelment ensuring that the beneficiaries are aware that the said hospital will not be providing services under AB-MGRSBY.
- v) A de-empanelled hospital cannot re-apply for empanelment for at least 2 years after de-empanelment. However, if the order for de-empanelment mentions a longer period, such a period shall apply for such a hospital.

This process is only indicative and subject to change as per directions of RSHAA.

vi) Health care personnel (Treating doctors ,radiologist, Pathologist) and diagnostic center found associated with fraud in a particular hospital may be debarred from working in other EHCPs under the scheme by RSHAA and appropriate legal action may also be taken

C. Gradation of Offences

On the basis of the investigation report/field audits, the following charges may be found to be reasonably proved and a gradation of penalties may be levied by the SEC. However, this tabulation is intended to be as guidelines rather than mandatory rules and the SEC may take a final call on the severity and quantum of punishment on a case to case basis.

Penalties for Offences by the Hospital			
Case Issue	First Offence	Second Offence	Third Offence
Illegal cash payments by beneficiary	Full Refund to the beneficiary on production of original receipt and compensation 3 times of illegal payment to	In addition to actions as mentioned for first offence, Rejection of claim for the case	De-empanelment/ black-listing

	the RSHAA.		
Billing for services not provided	Rejection of claim and penalty of 3 times the amount claimed for services not provided to be paid to RSHAA	Rejection of claim and penalty of 8 times the amount claimed for services not provided to be paid to RSHAA.	De-empanelment
Up coding/ Unbundling/ Unnecessary Procedures	Rejection of claim and penalty of 8 times the excess amount claimed due to up coding /unbundling/Unnecessary Procedures, to be paid to RSHAA.	Rejection of claim and penalty of 16 times the excess amount claimed due to up coding/unbundling/Unnecessary Procedures, to be paid to RSHAA.	De-empanelment
Wrongful beneficiary Identification	Rejection of claim and penalty of 3 times the amount claimed for wrongful beneficiary identification to be paid to RSHAA	Rejection of claim and penalty of 8 times the amount claimed for wrongful beneficiary identification to be paid to RSHAA	De-empanelment
Non-adherence to AB- MGRSBY quality and service standard	In case of minor gaps, warning period of 2 weeks for rectification, for major gaps, Suspension of services until rectification of gaps and validation by SEC/ DEC	Suspension until rectification of gaps and validation by SEC/ DEC	De-empanelment

All these penalties are recommendatory and the SEC may inflict larger or smaller penalties depending on the severity/regularity/scale/intentionality on a case to case basis with reasons mentioned clearly in a speaking order.

Annex 1: Detailed Empanelment Criteria

On call Medical Practitioners/Doctors/Specialists who provide their services on call shall only be associated with Max. 3 EHCPs. This may, however be reviewed by RSHAA later on.

Category 1: Essential criteria:

A Hospital would be empanelled as a network private hospital with the approval of the Rajasthan State Health Assurance Agency if it adheres with the following minimum criteria:

1. Should have at least 10 inpatient beds with adequate spacing and supporting staff as per norms.
 - i. Exemption may be given for single-specialty hospitals like Eye and ENT.
 - ii. General ward - @80sq ft per bed, or more in a Room with Basic amenities- bed, mattress, linen, water, electricity, cleanliness, patient friendly common washroom etc. Non-AC but with fan/Cooler and heater in winter.
2. It should have adequate and qualified medical and nursing staff (doctors¹& nurses²), physically in charge round the clock; (necessary certificates to be produced during empanelment).
3. Fully equipped and engaged in providing Medical /Surgical services, commensurate to the scope of service/ available specialities and number of beds.
 - i. Round-the-clock availability (or on-call) of a Surgeon and Anaesthetist where surgical services/ day care treatments are offered.
 - ii. Round-the-clock availability (or on-call) of an Obstetrician, Paediatrician and Anaesthetist where maternity services are offered.
 - iii. Round-the-clock availability of specialists (or on-call) in the concerned specialties having sufficient experience where such services are offered (e.g. Orthopaedics, ENT, Ophthalmology, Dental, general surgery (including endoscopy) etc.)
4. Round-the-clock support systems required for the above services like Pharmacy, Blood Bank, Laboratory, Dialysis unit, Endoscopy investigation support, Post op ICU care with ventilator support, X-ray facility (mandatory) etc., either 'In-House' or with 'Outsourcing arrangements', preferably with NABL accredited laboratories, with appropriate agreements and in nearby vicinity.
5. Round-the-clock Ambulance facilities (own or tie-up).
6. 24 hours emergency services managed by technically qualified staff wherever emergency services are offered
 - i. Casualty should be equipped with Monitors, Defibrillator, Nebulizer with accessories, Crash Cart, Resuscitation equipment, Oxygen cylinders with flow meter/ tubing/catheter/face mask/nasal prongs, suction apparatus etc. and with attached toilet facility.
7. Mandatory for hospitals wherever surgical procedures are offered:

- i. Fully equipped Operation Theatre of its own with qualified nursing staff under its employment round the clock.
 - ii. Post-op ward with ventilator and other required facilities.
8. Wherever intensive care services are offered it is mandatory to be equipped with an Intensive Care Unit (For medical/surgical ICU/HDU/Neonatal ICU) with requisite staff
 - i. The unit is to be situated in close proximity of operation theatre, acute care medical, surgical ward units, labour room and maternity room as appropriate.
 - ii. Suction, piped oxygen supply and compressed air should be provided for each ICU bed.
 - iii. Further ICU- where such packages are mandated should have the following equipment:
 - 1) Piped gases
 - 2) Multi-sign Monitoring equipment
 - 3) Infusion of ionotropic support
 - 4) Equipment for maintenance of body temperature
 - 5) Weighing scale
 - 6) Manpower for 24x7 monitoring
 - 7) Emergency cash cart
 - 8) Defibrillator.
 - 9) Equipment for ventilation.
 - 10) In case there is common Paediatric ICU then Paediatric equipments, e.g.: paediatric ventilator, Paediatric probes, medicines and equipment for resuscitation to be available.
 - iv. HDU (high dependency unit) should also be equipped with all the equipment and manpower as per HDU norms.
9. Records Maintenance: Maintain complete records as required on day-to-day basis and is able to provide necessary records of hospital / patients to the Society/Insurer or his representative as and when required.
 - i. Wherever automated systems are used it should comply with MoHFW/ NHA EHR guidelines (as and when they are enforced)
 - ii. All AB- MGRSBY cases must have complete records maintained
 - iii. Share data with designated authorities for information as mandated.
10. Legal requirements as applicable by the local/state health authority.
11. Adherence to Standard treatment guidelines/ Clinical Pathways for procedures as mandated by NHA from time to time.
12. Registration with the Income Tax Department.
13. NEFT enabled bank account
14. Telephone/Fax
15. Safe drinking water facilities/Patient care waiting area
16. Uninterrupted (24 hour) supply of electricity and generator facility with required capacity suitable to the bed strength of the hospital.
17. Waste management support services (General and Bio Medical) – in compliance with the bio-medical waste management act and certificate from State Pollution Control Board.

18. Appropriate fire-safety measures.
19. Provide space for a separate kiosk for AB- MGRSBY beneficiary management (AB- MGRSBY non-medical³ coordinator) at the hospital reception.
20. Ensure a dedicated medical officer to work as a medical⁴ co-ordinator towards AB- MGRSBY beneficiary management (including records for follow-up care as prescribed)
21. Ensure appropriate promotion of AB- MGRSBY in and around the hospital (display banners, brochures etc.) towards effective publicity of the scheme in co-ordination with the RSHAA/ district level AB- MGRSBY team.
22. IT Hardware requirements (desktop/laptop with internet, printer, webcam, scanner/ fax, bio-metric device etc.) as mandated by the RSHAA.

Category 2: Advanced criteria:

Over and above the essential criteria required to provide basic services under AB- MGRSBY (as mentioned in Category 1) those facilities undertaking defined speciality packages (as indicated in the benefit package for specialities mandated to qualify for advanced criteria) should have the following:

1. These empanelled hospitals may provide specialized services such as Cardiology, Cardiothoracic surgery, Neurosurgery, Nephrology, Reconstructive surgery, Oncology, Paediatric Surgery, Neonatal intensive care etc.
2. A hospital could be empanelled for one or more specialities subject to it qualifying to the concerned speciality criteria for respective packages
3. Such hospitals should be fully equipped with ICCU/SICU/ NICU/ relevant Intensive Care Unit in addition to and in support of the OT facilities that they have.
4. Such facilities should be of adequate capacity and numbers so that they can handle all the patients operated in emergencies.
 - i. The Hospital should have sufficient experienced specialists in the specific identified fields for which the Hospital is empanelled as per the requirements of professional and regulatory bodies/ as specified in the clinical establishment act/ State regulations.
 - ii. The Hospital should have sufficient diagnostic equipment and support services in the specific identified fields for which the Hospital is empanelled as per the requirements specified in the clinical establishment act/ State regulations.
5. Indicative domain specific criteria are as under:
 - A. Specific criteria for Cardiology/ CTVS**
 1. CTVS theatre facility (Open Heart Tray, Gas pipelines Lung Machine with TCM, defibrillator, ABG Machine, ACT Machine, Hypothermia machine, IABP, cautery etc.)
 2. Post-op with ventilator support
 3. ICU Facility with cardiac monitoring and ventilator support
 4. Hospital should facilitate round the clock cardiologist services.
 5. Availability of support speciality of General Physician & Paediatrician
 6. Fully equipped Catheterization Laboratory Unit with qualified and trained Paramedics.

B. Specific criteria for Cancer Care

1. For empanelment of Cancer treatment, the facility should have a Tumour Board which decides a comprehensive plan towards multi-modal treatment of the patient or if not then appropriate linkage mechanisms need to be established to the nearest regional cancer centre (RCC). Tumor Board should consist of a qualified team of Surgical, Radiation and Medical /Paediatric Oncologist in order to ensure the most appropriate treatment for the patient.
2. Relapse/recurrence may sometimes occur during/ after treatment. Retreatment is often possible which may be undertaken after evaluation by a Medical/ Paediatric Oncologist/ Tumor Board with prior approval and pre-authorization of treatment.
3. For extending the treatment of chemotherapy and radiotherapy the hospital should have the requisite Pathology/ Haematology services/ infrastructure for radiotherapy treatment viz. for cobalt therapy, linear accelerator radiation treatment and brachytherapy available in-house. In case such facilities are not available in the empanelled hospital for radiotherapy treatment and even for chemotherapy, the hospital shall not perform the approved surgical procedure alone but refer the patients to other centres for follow-up treatments requiring chemotherapy and radiotherapy treatments. This should be indicated where appropriate in the treatment approval plan.
4. Further hospitals should have following infrastructure for providing certain specialized radiation treatment packages such as stereotactic radiosurgery/ therapy.
 - i. Treatment machines which are capable of delivering SRS/SRT
 - ii. Associated Treatment planning system
 - iii. Associated Dosimetry systems

C. Specific criteria for Neurosurgery

1. Well Equipped Theatre with qualified paramedical staff, C-Arm, Microscope, neurosurgery compatible OT table with head holding frame (horse shoe, may field / sugita or equivalent frame).
2. ICU facility
3. Post-op with ventilator support
4. Facilitation for round the clock MRI, CT and other support bio-chemical investigations.
5. Hospital should facilitate round the clock Neurosurgeon, Anesthetist services.

D. Specific criteria for Burns, Plastic & Reconstructive surgery

1. The Hospital should have full time / on - call services of qualified plastic surgeon and support staff with requisite infrastructure for corrective surgeries for post burn contractures.
2. Isolation wards having monitor, defibrillator, central oxygen line and all OT equipment.
3. Well Equipped Theatre
4. Intensive Care Unit.
5. Post-op with ventilator support
6. Trained Paramedics
7. Post-op rehab/ Physiotherapy support/ Psychology support.

E. Specific criteria for /Paediatric Surgery

1. The Hospital should have full time/on call services of paediatric surgeons
2. Well-equipped theatre
3. ICU support
4. Support services of paediatrician
5. Availability of mother rooms and feeding area.
6. Availability of radiological/ fluoroscopy services (including IITV), Laboratory services and Blood bank.

F. Specific criteria for specialized new born care.

1. The hospital should have well developed and equipped neonatal nurse/Neonatal ICU (NICU) appropriate for the packages for which empanelled, as per norms
2. Availability of radiant warmer/ incubator/ pulse oximeter/ photo therapy/ weighing scale/ infusion pump/ ventilators/ CPAP/ monitoring systems/ oxygen supply / suction / infusion pumps/ resuscitation equipment/ breast pumps/ bilimeter/ KMC (Kangaroo Mother Care) chairs and transport incubator - in enough numbers and in functional state; access to hematological, biochemistry tests, imaging and blood gases, using minimal sampling, as required for the service packages
3. For Advanced Care and Critical Care Packages, in addition to 2. above: parenteral nutrition, laminar flow bench, invasive monitoring, in-house USG. Ophthalmologist on call.
4. Trained nurses 24x7 as per norms
5. Trained Paediatrician(s) round the clock
6. Arrangement for 24x7 stay of the Mother – to enable her to provide supervised care, breastfeeding and KMC to the baby in the nursery/NICU and upon transfer therefrom; provision of bedside KMC chairs.
7. Provision for post-discharge follow up visits for counselling for feeding, growth / development assessment and early stimulation, ROP checks, hearing tests etc.

G. Specific criteria for Polytrauma

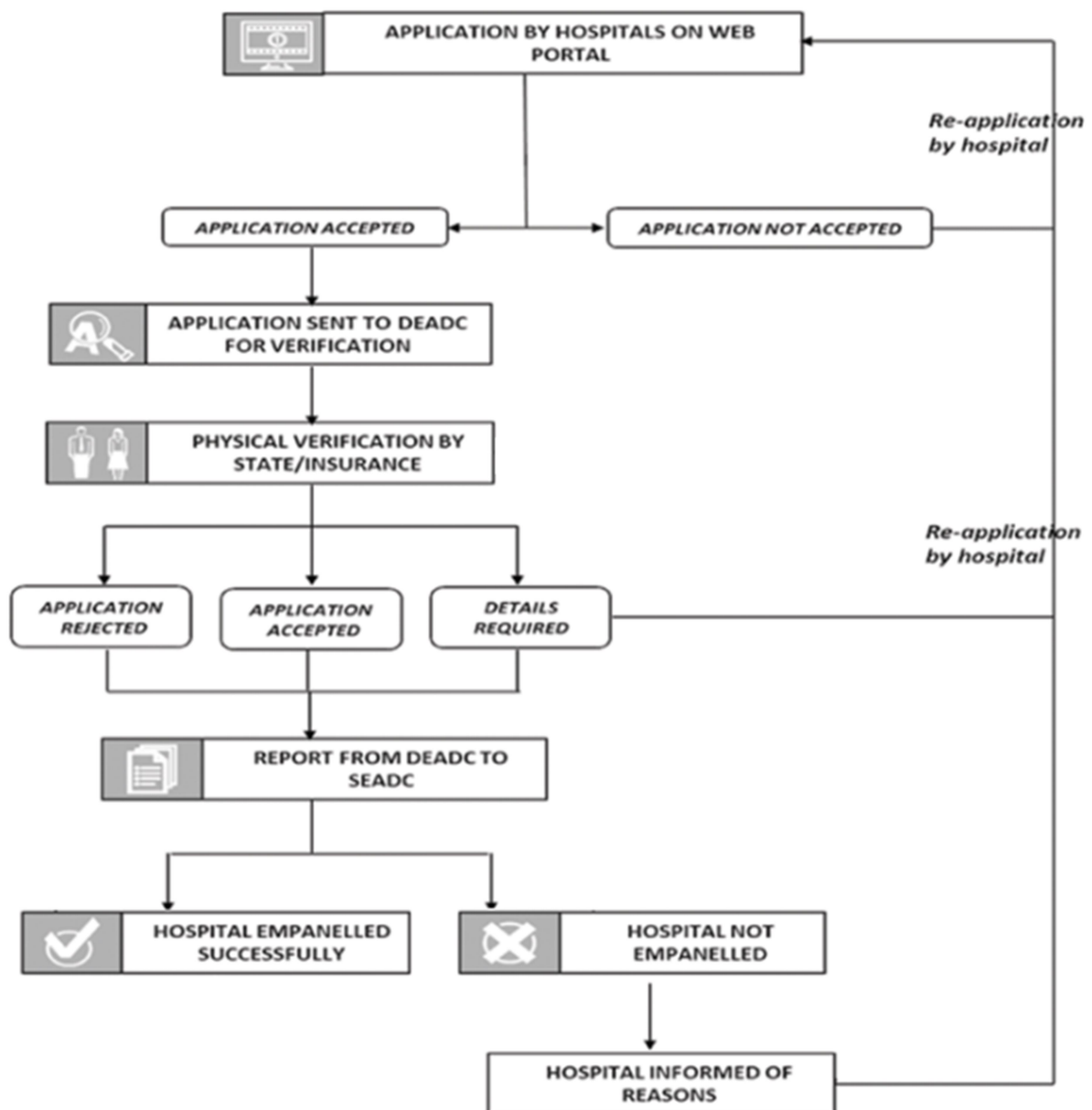
1. Shall have Emergency Room Setup with round the clock dedicated duty doctors.
2. Shall have the full-time service availability of Orthopaedic Surgeon, General Surgeon, and anaesthetist services.
3. The Hospital shall provide round the clock services of Neurosurgeon, Orthopaedic Surgeon, CT Surgeon, General Surgeon, Vascular Surgeon and other support specialists as and when required based on the need.
4. Shall have dedicated round the clock Emergency theatre with C-Arm facility, Surgical ICU, Post-Op Setup with qualified staff.
5. Shall be able to provide necessary diagnostic support round the clock including specialized investigations such as CT, MRI, emergency biochemical investigations.

H. Specific criteria for Nephrology and Urology Surgery

1. Dialysis unit
2. Well-equipped operation theatre with C-ARM
3. Endoscopy investigation support
4. Post op ICU care with ventilator support
5. Sew lithotripsy equipment

6. Hospital should facilitate round the clock Urologist, Nephrologist and Anesthetist's services.

Annex 2: Process Flow for the Empanelment



Annex 2.6 Premium Payment Guidelines

Release of Premium

- a. A flat premium per family, irrespective of the number of members under AB- MGRSBY in that family, will be determined through open tendering process.
- b. The modalities that will be adhered for release of premium for the implementation of AB- MGRSBY will be as under:

I – Number of Eligible Beneficiary Families

The premium for the targeted beneficiary families will be as per the eligibility criteria of AB- MGRSBY based on the NFSA and /or SECC Database/additional category through unique family identity card as decided by GoR.

II – Stage of Release of Premium:

Rajasthan State Health Assurance Agency(RSHAA) will, on behalf of the Beneficiary Family Units that are targeted / identified by the RSHAA and covered by the Insurer, pay the Premium for the benefit cover to the Insurer in accordance with the following schedule:

- a. The premium would be paid every year in four quarterly instalments on or before the first day of the quarter every year. The policy year being reckoned from the date of commencement of the policy. Amount for the premium of first quarter shall be arrived on number of beneficiary families showing on portal 7 days prior to the commencement of first quarter.
- b. The premium amount will be in proportion to the number of beneficiary families showing on portal 7 days prior to the commencement of that quarter.
- c. An amount of 1 % of the premium to be paid shall be deducted from the premium paid as per the schedule for the purposes of carrying out IEC ,monitoring & evaluation by RSHAA. This amount shall be included in the administrative cost mentioned in the **Clause 10.2.b of Volume 3**.
- d. For the beneficiary families that may be included during intermediate period between two quarters, premium amount will be paid with the premium installment of next

quarter. Calculation of this premium amount will be done monthly on Pro-rata basis, based on addition of families in every month of the quarter.

Refund of Premium

The Insurer will be required to refund premium as stipulated below if they fail to reach the claim ratio specified in comparison with the premium paid (excluding GST & Other taxes / Duties) below in the full period of insurance policy period. The premium refund shall be as per the formula below:

- f. The RSHAA shall issue a letter to the Insurer stating the Insurer's average Claim Ratio for all 12 months of Policy Cover Period. In the letter, the RSHAA shall indicate the amount of premium that the Insurer shall be obliged to refund. The amount of premium to be refunded shall be calculated based on the provisions as mentioned below.
- g. 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 RSHAA within 30 days. The percentage that will be need to be refunded will be as per the following:
 - i. Administrative cost *also allowed 10% if claim ratio less than 60%.
 - ii. Administrative cost allowed* 12% if claim ratio between 60-70%.
 - iii. Administrative cost allowed* 15% if claim ratio between 70-85%.

* Administrative costs includes amount of 1 % of the premium to be paid; shall be deducted from the premium paid as per the schedule for the purposes of carrying out IEC ,monitoring & evaluation by RSHAA.
- h. The entire surplus as determined through formula mentioned above should be refunded by the insurer to the RSHAA within 30 days.
- i. If the Insurer delays payment of or fails to pay the refund amount within 30 days from the date of communication by RSHAA, then the Insurer shall be liable to pay interest at the rate of one percent of the refund amount due and payable to the RSHAA for every 7 days of delay beyond such 30 day period.
- j. If the Insurer fails to refund the Premium within such 90-day period and/ or the default interest thereon, the RSHAA shall be entitled to recover such amount as a debt due from the Insurer through means available within law.

No Separate Fees, Charges or Premium

The Insurer shall not charge any Beneficiary Family Unit or any of the Beneficiaries any separate fees, charges, commission or premium, by whatever name called, for providing the benefits. However, the aforesaid provision shall not be applicable, if in case, the beneficiary is required to take treatment above the amount of Risk Cover.

Annex 2.7 Claims Management Guidelines including Portability

All Empanelled Health Care Providers (EHCP) will make use of IT system of AB- MGRSBY to manage the claims related transactions. IT system of AB- MGRSBY has been developed for online transactions and all stakeholders are advised to maintain online transactions preferably to ensure the claim reporting in real time. However, keeping in mind the connectivity constraints faced by some districts an offline arrangement has also been included in the IT system that has to be used only when absolute. The AB- MGRSBY strives to make the entire claim management paperless that is at any stage of claim registration, intimation, payment, investigation by EHCP or by the Insurer the need of submission of a physical paper shall not be required. This mean that this claim data will be sent electronically through IT system to the Central/ State server. The NHA, SHA, Insurer (if), and EHCP shall be able to access this data with respect to their respective transaction data only.

Once a claim has been raised (has hit the Central/State server), the following will need to be adhered to by the Insurance Company regarding claim settlement:

1. Claim Payments and Turn-around Time

The Insurer shall follow the following process regarding the processing of claims received from the EHCP:

- A. The Insurer or the agency (IRDAI compliant only) appointed by it shall decide on the acceptance or rejection of any claim received from an EHCP. Any rejection notice issued by the Insurer or the agency to EHCP shall clearly state that rejection is subject to the EHCP's right to appeal against rejection of the claim.
- B. If a claim is not rejected, the Insurer shall either make the payment (based on the applicable package rate) or shall conduct further investigation into the claim received from EHCP.
- C. The process specified in clause A and B above (rejection or payment/investigation) in relation to claim shall be carried out in such a manner that it is completed (Turn-around Time, TAT) shall be no longer than 15 calendar days (irrespective of the number of working days).
- D. The EHCP is expected to upload all claim related documents within 24 hours of discharge of the beneficiary.
- E. The counting of days for TAT shall start from the date of claim submission.

- F. The Insurer shall make claim payments to each EHCP against payable claims on a daily basis through electronic transfer to such EHCP's designated bank account. Insurer is then also required to provide the details of such payments against each paid claim on the online portal (IT System of AB-MGRSBY).
- G. All claims investigations shall be undertaken by a qualified and experienced medical staff/team, with at least one MBBS degree holder, appointed by the Insurer or its representative, to ascertain the nature of the disease, illness or accident and to verify the eligibility thereof for availing the benefits under this Agreement and relevant Cover Policy. The Insurer's medical staff shall not impart any advice on any treatment or medical procedures or provide any guidance related to cure or other care aspects. However, the Insurance Company can ensure that the treatment was in conformity to the Standard Treatment Guidelines, if implemented. **Pre-auth. to be processed in consultation with specialist. No claim could be rejected without having been examined by a specialist doctor of that particular speciality.**
- H. The Insurer will need to update the details on online portal (IT system of AB-MGRSBY) of:
- i) All claims that are under investigation on a fortnightly basis for review; and
 - ii) Every claim that is pending beyond 15 days, along with its reasons for delay in processing such Claim.
 - iii) The Insurer may collect at its own cost, complete Claim papers (including diagnostic reports) from the EHCP, if required for audit purposes for claims under investigation. This shall not have any bearing on the Claim Payments to the Empanelled Health Care Provider.

2. Penalty on Delay in Settlement of Claims

There will be a penalty for delay in settlement of claims by the Insurance Company beyond the turnaround time of 15 days. A penalty of 1% of claimed amount per week for delay beyond 15 days to be paid directly to the hospitals by the Insurance Company. This penalty will become due after 30 days in case of Inter-State claims or portability of benefits

3. Update of Claim Settlement

The Insurance Company will need to update the claim settlement data on the portal on a daily basis and this data will need to be updated within 24 hours of claims payment. Any claim payment which has not been updated shall be deemed to have been unpaid and the interest, as applicable, shall be charged thereon.

4. Right of Review, 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 Trust/Insurer, if the Empaneled Health Care Provider feels that the Claim is payable.
- A. Claims for which EHCP, are wrongly rejected, then it may file review with IC and IC will decide such claims within 15 days. A review may be made within thirty (30) days of the said rejection being intimated to the hospital
- B. If EHCP is still aggrieved with the review by IC, then the matter may be filed in GRC/CRC .
- C. GRC/CRC shall examine the case after review by IC; within 30 working days as far as possible and recommend its decision to the concerned GRC.
- D. An appeal may be made within thirty (30) days of the said rejection being intimated to the hospital to the District-level Grievance Committee (DGRC) which may decide the matter itself or can forward the matter to the claims review committee.
- A. RSHAA may prescribe token fees for hearing these appeals in order to avoid frivolous matters being forwarded to GRC/CRC. The details will be shared later.
- B. The Insurer and/or the DGRC can re-open the Claim, if the Empaneled Health Care Provider submits the proper and relevant Claim documents that are required by the Insurer.
- C. The DGRC may suo moto review any claim and direct either or both the Insurer and the health care provider to produce any records or make any deposition as it deems fit.
- D. The Insurer or the health care provider may refer an appeal with the State-level Grievance Committee (SGRC) on the decision of the DGRC within thirty days (30) failing which the decision shall be final and binding. The decision of the SGRC on such appeal is final and binding.
- E. The decisions of the DGRC and SGRC shall be a speaking order stating the reasons for the decision
- F. If the DGC (if there is no appeal) or SGRC directs the Insurer to pay a claim amount, the Insurer shall pay the amount within 15 days. Any failure to pay the amount shall attract an interest on the delayed payment @ 1% for every week or part thereof. If the Insurer does not pay the amount within 2 months they shall pay a fine of Rs. 25,000/- for each decision of DGC not carried out and Rs. 50,000 for each non-compliance of decision of SGRC. This amount shall be remitted to the State Health Agency.

G. Detailed timelines for claims re-opening:

These guidelines and processes are only indicative in nature and RSHAA reserves the right to modify, change, and amend the same as and when required.

5. Guidelines for Portability

An Empanelled Health Care Provider (EHCP) under AB- PMJAY in any state should provide services as per AB- PMJAY guidelines to beneficiaries from any other state also participating in AB-PMJAY. This means that a beneficiary will be able to get treatment outside the EHCP network of his/her Home State.

Any empanelled hospital under AB- PMJAY will not be allowed to deny services to any AB-MGRSBY beneficiary. All interoperability cases shall be mandatorily under pre-authorisation mode and pre-authorisation guidelines of the treatment delivery state in case of AB-PMJAY implementing States / UTs or indicative pre-authorisation guidelines as issued by NHA, shall be applicable.

Enabling Portability

To enable portability under the scheme, the stakeholders need to be prepared with the following:

- A. **States:** Each of the States participating in AB- PMJAY will sign MoU with Central Government which will allow all the empanelled hospitals by that state under AB-PMJAY to provide services to eligible beneficiaries of other States from across the country. Moreover, the state shall also be assured that its beneficiaries will be able to access services at all AB- PMJAY empanelled hospitals seamlessly in other states across India.
- B. **Empanelled hospitals:** The Empanelled Hospital shall have to sign a tripartite contract with its insurance company and Rajasthan State Health Assurance Agency which explicitly agrees to provide AB- PMJAY services to beneficiaries from both inside and outside the state and the Insurance Company agrees to pay to the EHCP through the inter-agency claim settlement process, the claims raised for AB-

PMJAYbeneficiaries that access care outside the state in AB- PMJAYempanelled healthcare provider network.

- C. **Insurance companies/Trusts:** The Insurance Company (IC) signs a contract with all other IC's and Trusts in the States / UTs under AB- PMJAYto settle down the interoperability related claims within 30 days settlement so that the final payment is made for a beneficiary by the Insurance Company or Trust of his/her home state.
- D. **IT systems:** The IT System will provide a central clearinghouse module where all inter-insurance, inter trust and trust-insurance claims shall be settled on a monthly/bi-monthly basis. The IT System will also maintain a Balance Check Module that will have data pushed on it in real time from all participating entities. The central database shall also be able to raise alerts/triggers based on suspicious activity with respect to the beneficiary medical claim history based on which the treatment state shall take necessary action without delay.
- E. **Grievance Redressal:** The Grievance Redressal Mechanism will operate as in normal cases except for disputes between Beneficiary of Home State and EHCP or IC of Treatment State and between Insurance Companies/Trusts of the Home State and Treatment State. In case of dispute between Beneficiary and EHCP or IC, the matter shall be placed before the RSHAA of the treatment state. In cases of disputes between IC/Trust of the two states, the mattershould be taken up by bilateral discussions between the SHAs and in case of non-resolution, brought to the NHA for mediation. The IC/Trusts of Home State should be able to raise real time flags for suspect activities with the Beneficiary State and the Beneficiary State shall be obligated to conduct a basic set of checks as requested by the Home State IC/Trust. These clauses have to be built in into the agreement between the ICs and the Trusts. The NHA shall hold monthly mediation meetings for sorting out intra-agency issues as well as sharing portability related data analytics.
- F. **Fraud Detection:** Portability related cases will be scrutinized separately by the NHA for suspicious transactions, fraud and misuse. Data for the same shall be shared with the respective agencies for necessary action. The SHAs, on their part, must have a dedicated team for conducting real time checks and audits on such flagged cases

with due diligence. The IC working in the State where benefits are delivered shall also be responsible for fraud prevention and investigation.

Implementation Arrangements of Portability

- A. Packages and Package Rates:** The Package list for portability will be the list of mandatory AB-PMJAY packages released by the NHA and package rates as applicable and modified by the Treatment State will be applicable. The Clause for honouring these rates by all ICs and Trusts shall have to be built into the agreement.
- Clauses for preauthorization requirements and transaction management system shall be as per the treatment state guidelines.
 - The beneficiary balance, reservation of procedures for public hospitals as well as segmentation (into secondary/tertiary care or low cost/high cost procedures) shall be as per the home state guidelines.
 - Therefore, for a patient from Rajasthan, taking treatment in Tamil Nadu for CTVS in an EHCP – balance check and reservation of procedure check will be as per Rajasthan rules, but TMS and preauthorization requirements shall be as per TN rules. The hospital claim shall be made as per TN rates for CTVS by the TN SHA (through IC or trust) and the same rate shall be settled at the end of every month by the Rajasthan SHA (through IC).
- B. Empanelment of Hospitals:** The SHA of every state in alliance with AB- PMJAY shall be responsible for empanelling hospitals in their territories. This responsibility shall include physical verification of facilities, specialty related empanelment, medical audits, post procedure audits etc.
- C. Beneficiary Identification:** In case of beneficiaries that have been verified by the home state, the treatment state EHCP shall only conduct identity verification and admit the patient as per the case.
- In case of beneficiaries that have not been so verified, the treatment EHCP shall conduct the Beneficiary Identification Search Process and the

documentation for family verification (ration card/family card of home state) to the Home State Agency for validation.

- The Home State Agency shall validate and send back a response in priority with a service turnaround time of 30 minutes. In case the home agency does not send a final response (IC/Trust check), deemed verification of the beneficiary shall be undertaken and the record shall be included in the registry. The home state software will create a balance for such a family entry.
- The empanelled hospital will determine beneficiary eligibility and send the linked beneficiary records for approval to the Insurance company/trust of Treatment State which in turn will send the records to the Insurance company/trust in the home State of beneficiary. The beneficiary approval team of the Insurance company/trust in the home State of beneficiary will accept/reject the case and convey the same to the Insurance company/trust in the State of hospital which will then inform the same to the hospital. In case the beneficiary has an E-Card (that is, he/she has already undergone identification earlier), after a KYC check, the beneficiary shall be accepted by the EHCP.
- If the NHA and the RSHAA agree to provide interoperability benefits to the entire Home State Beneficiary List, the identification module shall also include the Home State Beneficiary Database for validation and identification of eligible beneficiaries.

D. Balance Check: After identification and validation of the beneficiary, the balance check for the beneficiary will be done from the home state. The balance in the home state shall be blocked through the necessary API and updated once the claim is processed. The NHA may provide a centralised balance check facility.

E. Claim Settlement: A claim raised by the empanelled hospital will first be received by the Trust/Insurer of the Treatment State which shall decide based on its own internal processes. The approval of the claim shall be shared with the Home State Insurance Company/Trust which can raise an objection on any ground within 3 days.

In case the Home State raises no objection, the Treatment State IC/Trust shall settle the claim with the hospital. In case the Home State raises an objection, the Treatment State shall settle the claim as it deems fit. However, the objection of the Home State shall only be recommendatory in nature and the Home State shall have to honour the decision of the Treatment State during the time of interagency settlement.

- F. **Fraud Management:** In case the Trust/Insurer of the home State of beneficiary has identified fraudulent practices by the empanelled hospital, the Trust/Insurer should inform the RSHAA of the Treatment State of EHCP along with the supporting documents/information. The RSHAA of the Treatment State shall undertake the necessary action on such issues and resolution of such issues shall be mediated by the NHA during the monthly meetings.
- G. **Expansion of Beneficiary Set:** In case, there is an alliance between AB- PMJAY and any State Scheme or AB- PMJAY has been expanded in the Home State, the above process for portability may be followed for all beneficiaries of the Home State.
- H. **IT Platform:** The states using their own platform shall have to provide interoperability with the central transaction and beneficiary identification system to operationalize guidelines for portability for AB-PMJAY.
- I. **Modifications:** The above guidelines may be modified from time to time by the National Health Agency and shall apply on all the states participating in the AB-PMJAY.

These guidelines and processes are only indicative in nature and RSHAA reserves the right to modify, change, and amend the same as and when required.

Annex 2.8 Template for Medical Audit

Template for Medical Audit

AB-MGRSBY ID		Hospital ID	
Patient Name		Hospital Name	
Case No.		Hospital Contact No.	
Date of Admission		Date of Discharge	
Date of Audit		Time of Audit	
Name of the Auditor		Contact No. (Auditor)	

Audit Observations

No.	Criteria	Yes	No	Comments
1.	Does each medical record file contain:			
a.	Is discharge summary included?			
b.	Are significant findings recorded?			
c.	Are details of procedures performed recorded?			
d.	Is treatment given mentioned?			
e.	Is patient's condition on discharge mentioned?			
f.	Is final diagnosis recorded with main and other conditions?			
g.	Are instructions for follow up provided?			
2.	Patient history and evidence of physical examination is evident.			
a.	Is the chief complaint recorded?			
b.	Are details of present illness mentioned?			
c.	Are relevant medical history of family members present?			
d.	Body system review?			
e.	Is a report on physical examination available?			
f.	Are details of provisional diagnosis mentioned?			
3.	Is an operation report available? (only if surgical procedure done)			
a.	Does the report include pre-operative diagnosis?			
b.	Does the report include post-operative diagnosis?			
c.	Are the findings of the diagnosis specified?			
d.	Is the surgeon's signature available on records?			
e.	Is the date of procedure mentioned?			
4.	Progress notes from admission to discharge			
a.	Are progress reports recorded daily?			
b.	Are progress reports signed and dated?			
c.	Are progress reports reflective of patient's admission status?			
d.	Are reports of patient's progress filed chronologically?			
e.	Is a final discharge note available?			
5	Are pathology, laboratory, radiology reports available (if ordered)?			

6	Do all entries in medical records contain signatures?			
a.	Are all entries dated?			
b.	Are times of treatment noted?			
c.	Are signed consents for treatment available?			
7	Is patient identification recorded on all pages?			
8	Are all nursing notes signed and dated?			

Overall observations of the Auditor:

Significant findings:

Recommendations:

Date:

Signature of the Auditor

Annex 2.9 Template for Hospital Audit

Template for Hospital Audit

Hospital Name		Hospital ID	
Hospital Address			
Hospital Contact No.			
Date of Audit		Time of Audit	
Name of the Auditor		Contact No. (Auditor)	

Audit Observations

No.	Criteria	Yes	No	Comments
1.	Was there power cut during the audit?			
2.	If yes, what was the time taken for the power back to resume electric supply?			
3.	Was a AB- MGRSBY kiosk present in the reception area?			
4.	Was any staff present at the kiosk?			
5.	Did you see the AB- MGRSBY Empanelled Hospital Board displayed near the kiosk in the reception area?			
6.	Was the kiosk prominently visible?			
7.	Was the kiosk operational in local language?			
8.	Were AB- MGRSBY brochures available at the kiosk?			
9.	Were the toilets in the OPD area clean?			
10.	Was drinking water available in the OPD area for patients?			

Overall observations of the Auditor:

Significant findings:

Recommendations:

Signature of the Auditor

Date:

Annex 2.10 Key Performance Indicators

	KPIs	Time Frame	Penalty
1	Setting up of a State Project Office and Appointment of Project Head and other Staff (to be specified by SHA) for co-ordination and Scheme implementation	30 days after signing of Insurance Contract.	Rs. 25,000 per week and part thereof.
2	Establishment of District Offices	30 days after signing of Insurance Contract.	Rs. 5,000 per week (per district office) and part thereof.
3	Claims-related Activities:		
	a. Pre-authorisation	6 hours for emergency cases and 12 hours for all other cases;	Automatic approval post 6 and 12 hours for emergency and non-emergency cases respectively.
	b. Scrutiny and Claim approval from EHCP	Within 15 days of claim submission for the first time excluding the days when the claim is pending with the network hospital.	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 RSHAA in making payment of the Premium that is due and payable, then the Insurer shall be liable to pay a penal interest to the EHCP at the rate of 1% of the Claim amount for every 15 days of delay beyond the 30-day period.
4	Delays in compliance to orders of the Grievance Redressal Committee (GRC)	Beyond 30 days.	Rs. 25,000 for the first month of delay in implementing GRC order, Rs. 50,000 per month for every subsequent month thereafter.
5	Rejection of claim by a non specialist.		Penalty for the same amount of claim rejected, payable to RSHAA.
6	Pre-Auth Approval done without consultation with specialist.		Penalty of 5% of the claim amount, payable to RSHAA.
7	Pre-Auth Rejection without query.		Penalty of 5% of the claim amount, payable to RSHAA.

8	If a claim is held to be wrongfully rejected by the insurer, in CRC/GRC, then a penalty shall be levied against the insurer		This penalty shall be equal to the fee that is levied on the EHCP for registering their appeal with GRC/CRC; say 5% of the claim. This shall be paid to the EHCP.
9	Completing minimum audit targets - both claims and medical audits	Specified number of medical and claims audit reports to be submitted in the reporting quarter.	Rs. 10,000 for each audit report not submitted as per plan.
10	Timely submission of a specified minimum audit reports on a quarterly basis – both claims and medical audits <i>(To be implemented only when the IT Platform has developed the capability of allowing online filing of these reports)</i>	Specified number of medical & claims audit reports to be submitted within -7 days of completing the audit.	Rs. 10,000 for each audit report not submitted in time.

Annex 2.11 Indicative Fraud Triggers

Claim History Triggers

1. Impersonation.
2. Mismatch of in house document with submitted documents.
3. Claims without signature of the AB- MGRSBY Beneficiary on pre-authorisation form.
4. Second claim in the same year for an acute medical illness/surgical.
5. Claims from multiple hospitals with same owner.
6. Claims from a hospital located far away from AB- MGRSBY Beneficiary's residence, pharmacy bills away from hospital/residence.
7. Claims for hospitalization at a hospital already identified on a "watch" list or black listed hospital.
8. Claims from members with no claim free years, i.e. regular claim history.
9. Same AB- MGRSBY Beneficiary claimed in multiple places at the same time.
10. Excessive utilization by a specific member belonging to the AB- MGRSBY Beneficiary Family Unit.
11. Deliberate blocking of higher-priced Package Rates to claim higher amounts.
12. Claims with incomplete/ poor medical history: complaints/ presenting symptoms not mentioned, only line of treatment given, supporting documentation vague or insufficient.
13. Claims with missing information like post-operative histopathology reports, surgical / anaesthetist notes missing in surgical cases.
14. Multiple claims with repeated hospitalization (under a specific policy at different hospitals or at one hospital of one member of the AB- MGRSBY Beneficiary Family Unit and different hospitals for other members of the AB- MGRSBY Beneficiary Family Unit), multiple claims towards the end of Policy Cover Period, close proximity of claims.

Admissions Specific Triggers

15. Members of the same AB- MGRSBY Beneficiary Family Unit getting admitted and discharged together.
16. High number of admissions.
17. Repeated admissions.
18. Repeated admissions of members of the AB- MGRSBY Beneficiary Family Unit.
19. High number of admission in odd hours.
20. High number of admission in weekends/ holidays.
21. Admission beyond capacity of hospital.
22. Average admission is beyond bed capacity of the EHCP in a month.
23. Excessive ICU admission.
24. High number of admission at the end of the Policy Cover Period.
25. Claims for medical management admission for exactly 24 hours to cover OPD treatment, expensive investigations.
26. Claims with Length of Stay (LoS) which is in significant variance with the average LoS for a particular ailment.

Diagnosis Specific Triggers

27. Diagnosis and treatment contradict each other.
28. Diagnostic and treatment in different geographic locations.
29. Claims for acute medical illness which are uncommon e.g. encephalitis, cerebral malaria, monkey bite, snake bite etc.
30. Ailment and gender mismatch.
31. Ailment and age mismatch.
32. Multiple procedures for same AB- MGRSBY Beneficiary – blocking of multiple packages even though not required.
33. One-time procedure reported many times.
34. Treatment of diseases, illnesses or accidents for which an Empanelled Health Care Provider is not equipped or empanelled for.
35. Substitution of packages, for example, Hernia as Appendicitis, Conservative treatment as Surgical.
36. Part of the expenses collected from AB- MGRSBY Beneficiary for medicines and screening in addition to amounts received by the Insurer.
37. ICU/ Medical Treatment blocking done for more than 5 days of stay, other than in the case of Critical Illness.
38. Overall medical management exceeds more than 5 days, other than in the case of Critical Illness.
39. High number of cases treated on an OOP basis at a given provider, post consumption of financial limit.

Billing and Tariff based Triggers

40. Claims without supporting pre/ post hospitalisation papers/ bills.
41. Multiple specialty consultations in a single bill.
42. Claims where the cost of treatment is much higher than expected for underlying etiology.
43. High value claim from a small hospital/nursing home, particularly in class B or C cities not consistent with ailment and/or provider profile.
44. Irregular or inordinately delayed synchronization of transactions to avoid concurrent investigations.
45. Claims submitted that cause suspicion due to format or content that looks "too perfect" in order. Pharmacy bills in chronological/running serial number or claim documents with colour photocopies. Perfect claim file with all criteria fulfilled with no deficiencies.
46. Claims with visible tempering of documents, overwriting in diagnosis/ treatment papers, discharge summary, bills etc. Same handwriting and flow in all documents from first prescription to admission to discharge. X-ray plates without date and side printed. Bills generated on a "Word" document or documents without proper signature, name and stamp.

General

47. Qualification of practitioner doesn't match treatment.
48. Specialty not available in hospital.
49. Delayed information of claim details to the Insurer.
50. Conversion of OP to IP cases (compare with historical data).

51. Not dispensing post-hospitalization medication to AB- MGRSBY Beneficiaries.

Annex 2.12 Indicators to Measure Effectiveness of Anti-Fraud Measures

1. Monitoring the number of grievances per 1,00,000 AB- MGRSBY Beneficiaries.
2. Proportion of Emergency pre-authorisation requests.
3. Percent of conviction of detected fraud.
4. Share of pre-authorisation and claims audited.
5. Claim repudiation/ denial/ disallowance ratio.
6. Number of dis-empanelment/ number of investigations.
7. Share of AB- MGRSBY Beneficiary Family Units physically visited by Scheme functionaries.
8. Share of pre-authorisation rejected.
9. Reduction in utilization of high-end procedures.
10. AB-MGRSBY Beneficiary satisfaction.
11. Share of combined/ multiple-procedures investigated.
12. Share of combined/ multiple-procedures per 1,00,000 procedures.
13. Pre-authorisation pendency rate and Claim pendency rate per 100 cases decided OR percent of pre-authorisation decided after additional observation being attended + correlated with frauds detected as a consequence of this effort.
14. Instances of single disease dominating a geographical area/Service area are reduced.
15. Disease utilization rates correlate more with the community incidence.
16. Number of FIRs filed.
17. Number of enquiry reports against hospitals.
18. Number of enquiry reports against Insurer or RSHAA staff.
19. Number of charge sheets filed.
20. Number of judgments received.
21. Number of cases discussed in Empanelment and Disciplinary Committee.
22. Reduction in number of enhancements requested per 100 claims.
23. Impact on utilization.
24. Percent of pre-audit done for pre-authorisation and claims.
25. Percent of post-audit done for pre-authorisation and claims.
26. Number of staff removed or replaced due to confirmed fraud.
27. Number of actions taken against hospitals in a given time period.
28. Number of adverse press reports in a given time period.
29. Frequency of hospital inspection in a given time period in a defined geographical area.
30. Reduction in share of red flag cases per 100 claims.

Annex 2.13 Guidelines for Hospital Transaction Process including pre-authorisation

AB-MGRSBY would be cashless & paperless at any of the empanelled hospitals. The beneficiaries shall not be required to pay any charge for the hospitalization expenses. The benefit also includes pre- and post-hospitalisation expenses. The scheme is an entitlement based and entitlement of the beneficiary is decided on the basis of family being figured in SECC database.

The core principle for finalising the Balance Check and providing treatment at empanelled hospital guidelines for AB- MGRSBY is to construct a broad framework as guiding posts for simplifying the service delivery under the ambit of the policy and the technology.

1. IT platform to be used for AB-MGRSBY:

Responsibility of – State Government

IT platform for identification of beneficiaries and transactions at the Empanelled Health Care Provider (EHCP) will be provided by MoHFW/NHA/RSHAA.

The State will need to:

- A. Ensure that a Medical Officer as Nodal Officer at EHCP for AB- MGRSBY has been nominated.
- B. Ensure appointment of Swasthaya Margdarshak for the EHCP
- C. Ensure that a dedicated helpdesk for AB- MGRSBY at a prominent place at the EHCP
- D. Availability of printed booklets, in abundant quantities at the helpdesk, which will be given to beneficiaries along with the AB- MGRSBY e-cards, if beneficiary has not been issued the AB- MGRSBY e-card earlier.
- E. State/ Rajasthan State Health Assurance Agency (RSHAA) shall identify and set-up team(s) which shall have the capacities to handle hardware and basic software support, troubleshooting etc.
- F. Training of EHCP staff and Swasthaya Margdarshak by the Insurer.

The State shall ensure availability of above, in order to carry out all the activities laid down in this guideline.

2. Process for Beneficiary identification, issuance of identification document and transaction for service delivery

Responsibility of – Swasthaya Margdarshak or another authorised person at EHCP

Timeline – Ongoing

- A. Beneficiary Verification & Authentication
 - i) Member may bring the following to the AB- MGRSBY helpdesk:
 - Letter from MoHFW/NHA

- Any other defined document as prescribed by the State Government.
- ii) Swasthaya Margdarshak/Operator will check if AB- MGRSBY e-Card/ AB- MGRSBY ID/ Aadhaar Number is available with the beneficiary
- iii) *In case Internet connectivity is available at hospital*
 - Operator/Swasthaya Margdarshak identifies the beneficiary's eligibility and verification status from AB- MGRSBY Central Server
 - If beneficiary is eligible and verified under AB-MGRSBY, server will show the details of the members of the family with photo of each verified member
 - If found OK then beneficiary can be registered for getting the cashless treatment.
 - If patient is eligible but not verified then patient will be asked to produce Aadhaar Card/Number/ Ration Card for verification (in absence of Aadhaar)
 - Beneficiary mobile number will be captured.
 - If Aadhaar Card/Number is available and authenticated online then patient will be verified under scheme (as prescribed by the software) and will be issued a AB- MGRSBY e-Card for getting the cashless treatment.
 - Beneficiary gender and year of birth will be captured with Aadhaar eKYC or Ration Card
 - If Aadhaar Card/Number is not available then beneficiary will be advised to get the Aadhaar Card/number within stipulated time.
 - If Aadhaar card of the beneficiary is not made/Aadhaar based biometric verification is not possible, then an alternate mechanism may be adopted as decided by RSHAA.
- iv) *In case Internet connectivity is not available at hospital*
 - AB-MGRSBY Registration Desk at Hospital will call Central Helpline and using IVRS enters AB- MGRSBY ID or Aadhaar number of the patient. IVRS will speak out the details of all beneficiaries in the family and hospital will choose the beneficiary who has come for treatment. It will also inform the verification status of the beneficiary
 - If eligible and verified then beneficiary will be registered for getting treatment by sending an OTP on the mobile number of the beneficiary
 - In case beneficiary is eligible but not verified then she/he can be verified using Aadhaar OTP authentication and can get registered for getting cashless treatment
- v) *In case of emergency or in case person does not show AB- MGRSBY e-Card/ID or Aadhaar Card/Number and claims to be AB- MGRSBY beneficiary and show some photo ID proof issued by Government, then beneficiary may get the treatment after getting TPIN (Telephonic Patient Identification Number) from*

the call centre and same will be recorded. Government Photo ID proof need not be insisted in case of emergency. In all such cases, relevant AB- MGRSBY beneficiary proof will be supplied within specified time before discharge otherwise beneficiary will pay for the treatment to the Hospital.

- vi) If eligibility, verification and authentication are successful, beneficiary should be allowed for treatment

These details captured will be available at Insurance Company level for their approval. Once approved, the beneficiary will be considered as successfully identified and verified under AB-MGRSBY.

3. Package Selection

- A. The operator will check for the specialty for which the hospital is empanelled. Hospitals will only be allowed to view and apply treatment package for the specialty for which they are empanelled.
- B. Based on diagnosis sheet provided by doctor, operator should be able to block Surgical or Non-Surgical benefit package(s) using AB- MGRSBY IT system.
- C. Both surgical and non-surgical packages cannot be blocked together; either of the type can only be blocked.
- D. As per the package list, the mandatory diagnostics/documents will need to be uploaded along with blocking of packages.
- E. Some packages will be reserved for blocking only in public hospitals.
- F. The operator can block more than one package for the beneficiary. A logic will be built in for multiple package selection, such that reduced payment is made in case of multiple packages being blocked in the same hospitalization event.
- G. If a registered mobile number of beneficiary family is available, an SMS alert will be sent to the beneficiary notifying him of the packages blocked for him.
- H. At the same time, a printable registration slip needs to be generated and handed over to the patient or patient's attendant.
- I. If for any reason treatment is not availed for any package, the operator can unblock the package before discharge from hospital.

4. Pre-authorisation

- A. There would be defined packages which will require pre-authorization from the insurance company. The operator should be able to initiate a request to the insurance company for pre-authorization using the web application.
- B. The hospital operator will send all documents required for pre-authorization to the insurance company using the Centralized AB-MGRSBY/ States transaction management application.
- C. The documents exchanged will not be stored on the AB-MGRSBY server

permanently. Only the information about pre-authorization request and response received will be stored on the central server. It is the responsibility of the insurance company to maintain the documents at their end.

- D. The documents needed may vary from package to package and hence a master list of all documents required for all packages will be available on the server.
- E. The request as well as approval of the form will be done using the AB- MGRSBY IT system or using API exposed by AB-MGRSBY (Only one option can be adopted by the insurance Co.), or using State's own IT system (if adopted by the State).
- F. In case of no or limited connectivity, the filled form can also be sent to the insurance company either through fax/ email. However, once internet connectivity is established, the form should also be submitted using online system as described above.
- G. The insurance company will have to approve or reject the request latest by 6 hours. If the insurance company/ trust fails to do so, the request will be considered deemed to be approved after 6 hours by default.
- H. Pre-auth to be processed in consultation with a specialist. No claim could be rejected without having been examined by a specialist doctor of that particular speciality.
- I. In case of an emergency or delay in getting the response for pre-authorization request due to technical issues, provision will be there to get the pre-authorization code over the phone from Insurance Company or the call centre setup by Insurance Company. The documents required for the processing, may be sent using the transaction system within stipulated time.
- J. In case of emergency, insurance company will provide the pre-authorization code generated through the algorithm/ utility provided by MoHFW/NHA-NIC.
- K. Pre-authorization code provided by the Insurer will be entered by the operator and will be verified by the system.
- L. If pre-authorization request is rejected, Insurance Company will provide the reasons for rejection. Rejection details will be captured and stored in the transaction database.
- M. If the beneficiary or the hospital is not satisfied by the rejection reason, they can appeal through grievance system.

5. Balance Check, Treatment, Discharge and Claim Request

- A. Based on selection of package(s), the operator will check from the Central AB-MGRSBY Server if sufficient balance is available with the beneficiary to avail services.
- B. States using their own IT system for hospital transaction will be able to check and update balance from Central AB- MGRSBY server using API
- C. If balance amount under available covers is not enough for treatment, then remaining amount (treatment cost - available balance), will be paid by beneficiary

- (OOP expense will also be captured and stored)
- D. The hospital will only know if there is sufficient balance to provide the selected treatment in a yes or no response. The exact amount will not be visible to the hospital.
 - E. SMS will be sent to the beneficiary registered mobile about the transaction and available balance
 - F. List of diagnostic reports recommended for the blocked package will be made available and upload of all such reports will be mandatory before discharge of beneficiary.
 - G. Transaction System would have provision of implementation of Standard Treatment Guidelines for providing the treatment
 - H. After the treatment, details will be saved and beneficiary will be discharged with a summary sheet.
 - I. Treatment cost will be deducted from available amount and will be updated on the Central AB- MGRSBY Server.
 - J. The operator fills the online discharge summary form and the patient will be discharged. In case of mortality, a flag will be raised against the deceased member declaring him as dead or inactive.
 - K. At the same time, a printable receipt needs to be generated and handed over to the patient or patient's attendant.
 - L. After discharge, beneficiary gets a confirmation and feedback call from the AB- MGRSBY call centre; response from beneficiary will be stored in the database
 - M. Data (Transaction details) should be updated to Central Server and accessible to Insurance Company for Claim settlement. Claim will be presumed to be raised once the discharge information is available on the Central server and is accessible to the Insurance Company
 - N. SMS will be sent to beneficiary registered mobile about the transaction and available balance
 - O. After every discharge, claims would be deemed to be raised to the insurance company. An automated email alert will be sent to the insurance company specifying patient name, AB- MGRSBY ID, registration number & date and discharge date. Details like Registration ID, AB- MGRSBY ID, date and amount of claim raised will be accessible to the insurance company on AB- MGRSBY System/ State IT system. Also details like Registration-ID, AB-MGRSBY-ID, Date and amount of claim raised, date and amount of claim disbursement, reasons for different in claims raised and claims settled (if any), reasons for rejection of claims (if any) will be retrieved from the insurance company through APIs.
 - P. Once the claim is processed and the hospital gets the payment, the above-mentioned information along with payment transaction ID will be updated on central AB- MGRSBY system by the insurance company for each claim separately.

- Q. Hospital Transaction Management Module would be able to generate a basic MIS report of beneficiary admitted, treated and claim settled and in process and any other report needed by Hospitals on a regular basis
- R. Upon discharge, beneficiary will receive a feedback call from the Call centre where he can share his feedback about his/her hospitalisation experience.

6. Monitoring of Transaction Process at EHCP

Responsibility of – RSHAA and Insurance Company

Timeline – Continuous

RSHA and Insurance Company will need to have very close monitoring of the process in order to ascertain challenges, if any, being faced and resolution of the same. Some examples of the parameters on which monitoring may be based are as follows:

- A. Number of EHCP and Ayushman Mitras
- B. Time taken for verification and issuance of e-card of each member
- C. Time taken for approval of verification of beneficiaries
- D. Percentage of families with at least one member having issued e-card out of total eligible families in SECC
- E. Number of admissions per family
- F. Grievances received against Ayushman Mitras or EHCP
- G. Proportion of Emergency pre-authorisation requests
- H. Percent of conviction of detected fraud.
- I. Share of pre-authorisation and claims audited
- J. Claim repudiation/ denial/ disallowance ratio
- K. AB-MGRSBY Beneficiary satisfaction

The RSHAA can issue clarification if required.

Annex 2.14 Guideline for Greivance Redressal

Grievance Department has to be manned by dedicated resources to address the grievances from time to time as per the instructions of the NHA. The District authorities shall act as a frontline for the redressal of Beneficiaries’/ Providers/ other Stakeholder’s grievances. The District authorities shall also attempt to solve the grievance at their end. The grievances so recorded shall be numbered consecutively and the Beneficiaries / Providers shall be provided with the number assigned to the grievance. The District authorities shall provide the Beneficiaries / Provider with details of the follow-up action taken as regards the grievance as and when the Beneficiaries require it to do so. 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-MGRSBY, following set of three tier Grievance Redressal Committees at state level and NGRC at the national level, have been set up to attend to the grievances of various stakeholders at different levels.

These guidelines are indicative in nature and can be changed if required.

District Grievance Redressal Committee (DGRC)

The District Grievance Redressal Committee (DGRC) will be constituted by the Rajasthan State Health Assurance Agency(SHA) in each district within 15 days of signing of MoU with the Insurance Company.

- The District Magistrate or an officer of the rank of Addl. District Magistrate, who shall be the Chairperson of the DGRC.
- The CMO/ CMOH/ DM&HO/ DHO or equivalent rank officer shall be the Convenor of the DGRC.
- Representatives from the district level offices of the Departments of Rural Development.
- The District Coordinator of the Insurer.
- The District Grievance Nodal Officer (DGNO)
- The DGRC may invite other experts for their inputs for specific cases.

Note: DGNO shall try to resolve the complaint by forwarding the same to Action Taking Authority (ATA). If the complaint is not resolved or comments are not received over the same within 15 days of the complaint, then the matter may be referred to DGRC.

State Grievance Redressal Committee (SGRC)

The State Grievance Redressal Committee (SGRC) will be constituted by the Rajasthan State Health Assurance Agency within 15 days of signing of MoU with the Central Government.

- CEO of State Health Authority / State Nodal Agency shall be the Chairperson of the SGRC.
- Representatives of the Departments of Rural Development, Women & Child Development, Labour, Tribal Welfare.

- Director Health Services.
- Medical Superintendent of the leading state level government hospital.
- The State Grievance Nodal Officer (SGNO) of the RSHAA shall be the Convenor of SGRC.
- The SGRC may invite other experts for their inputs on specific cases.

Note:. If any party is not agreed with the decision of DGRC, then they may approach the SGRC against the decision of DGRC.

Appellate Authority.

The Appellate Authority will be constituted by the Rajasthan State Health Assurance Agency.

1. In case of any grievance between RSHAA and Insurance Company, Appellate Authority will be chaired by the Secretary of Department of Health & Family Welfare of the State
2. Appeal against the decision of SGRC shall lie to Appellate Authority
3. Decision of Appellate Authority will be final and binding upon both the parties.

National Grievance Redressal Committee (NGRC)

The NGRC shall be formed by the MoHFW, GoI at the National level. The constitution of the NGRC shall be determined by the MoHFW in accordance with the Scheme Guidelines from time to time. Proposed members for NGRC are:

1. CEO of National Health Agency (NHA) - **Chairperson**
2. JS , Ministry of Health & Family Welfare- Member
3. Additional CEO of National Health Agency (NHA)- Member Convenor
4. Executive Director, IEC, Capacity Building and Grievance Redressal
5. NGRC can also invite other experts/ officers for their inputs in specific cases.

CEO (NHA) may designate Addl. CEO (NHA) to chair the NGRC.

Investigation authority for investigation of the grievance may be assigned to Regional Director- CGHS/Director Health Services/ Mission director NHM of the State/UT concerned.

NGRC will consider:

- a. The petition of any stakeholder aggrieved with the action or the decision of the Rajasthan State Health Assurance Agency / State Government
- b. Review of State-wise performance based monthly report for monitoring, evaluation and make suggestions for improvement in the Scheme as well as evaluation methodology
- c. Any other reference on which report of NGRC is specifically sought by the Competent Authority.

The Meetings of the NGRC will be convened as per the cases received with it for consideration or as per the convenience of the Chairman, NGRC.

10. Grievance Settlement of Stakeholders

If any stakeholder has a grievance against another one during the subsistence of the policy period or thereafter, in connection with the validity, interpretation, implementation or alleged breach of any provision of the scheme, it will be settled in the following way by the Grievance Committee:

A. Grievance of a Beneficiary

i) Grievance against insurance company, hospital, their representatives or any functionary

If a beneficiary has a grievance on issues relating to entitlement, or any other AB-MGRSBY related issue against Insurance Company, hospital, their representatives or any functionary, the beneficiary can call the toll free call centre number 14555 (or any other defined number by the State) and register the complaint. Beneficiary can also approach DGRC. The complaint of the beneficiary will be forwarded to the relevant person by the call centre as per defined matrix. The DGRC shall take a decision within 30 days of receiving the complaint.

If either of the parties is not satisfied with the decision, they can appeal to the SGRC within 30 days of the decision of the DGRC. The SGRC shall take a decision on the appeal within 30 days of receiving the appeal. The decision of the SGRC on such issues will be final.

Note: In case of any grievance from beneficiary related to hospitalisation of beneficiary (service related issue of the beneficiary) the timelines for DGRC to take decision is within 24 hours from the receiving of the grievance.

ii) Grievance against district authorities

If the beneficiary has a grievance against the District Authorities or an agency of the State Government, it can approach the SGRC for resolution. The SGRC shall take a decision on the matter within 30 days of the receipt of the grievance. The decision of SGRC shall be final.

B. Grievance of a Health Care Provider

i) Grievance against beneficiary, insurance company, their representatives or any other functionary

If a Health Care Provider has any grievance with respect to beneficiary, Insurance Company, their representatives or any other functionary, the Health Care Provider will approach the DGRC. The DGRC should be able to reach a decision within 30 days of receiving the complaint.

Step I- If either of the parties is not satisfied with the decision, they can go to the SGRC within 30 days of the decision of the DGRC, which shall take a decision within 30 days of receipt of appeal.

Step II- If either of the parties is not satisfied with the decision, they can go to the NGRC within 30 days of the decision of the SGRC, which shall take a decision within 30 days of receipt of appeal. The decision of NGRC shall be final.

C. Grievance of insurance company

i) Grievance against district authorities/ health care provider

If Insurance Company has a grievance against District Authority / Health Care Provider or an agency of the State Government, it can approach the SGRC for resolution. The SGRC shall decide the matter within 30 days of the receipt of the grievance.

In case of dissatisfaction with the decision of the SGRC, the affected party can file an appeal before Appellate Authority within 30 days of the decision of the SGRC and Appellate Authority shall take a decision within 30 days of the receipt of appeal after seeking a report from the other party. The decision of Appellate Authority shall be final.

11. Functions of Grievance Redressal Committees

A. Functions of the DGRC:

The DGRC shall perform all functions related to handling and resolution of grievances within their respective Districts. The specific functions will include:

- i) Review grievance records.
- ii) Call for additional information as required either directly from the Complainant or from the concerned agencies which could be the Insurer or an EHCP or the RSHAA or any other agency/ individual directly or indirectly associated with the Scheme.
- iii) Conduct grievance redressal proceedings as required.
- iv) If required, call for hearings and representations from the parties concerned while determining the merits and demerits of a case.
- v) Adjudicate and issue final orders on grievances.
- vi) In case of grievances that need urgent redressal, develop internal mechanisms for redressing the grievances within the shortest possible time, which could include but not be limited to convening special meetings of the Committee.
- vii) Monitor the grievance database to ensure that all grievances are resolved within 30 days.

B. Functions of the SGRC:

The SGRC shall perform all functions related to handling and resolution of all grievances received either directly or escalated through the DGRC. The specific functions will include:

- i) Oversee grievance redressal functions of the DGRC including but not limited to monitoring the turnaround time for grievance redressal.

- ii) Act as an Appellate Authority for appealing against the orders of the DGRC.
- iii) Perform all tasks necessary to decide on all such appeals within 30 days of receiving such appeal.
- iv) Adjudicate and issue final orders on grievances.
- v) Nominate District Grievance Officer (DGO) at each District.
- vi) Direct the concerned Insurance Company to appoint District Nodal Officer of each district.

C. Functions of the NGRC:

The NGRC shall act as the final Appellate Authority at the National level for portability cases.

12. Lodging of Grievances/ Complaints

- A. If any stakeholder has a complaint (complainant) against any other stakeholder during the subsistence of the Policy Cover Period or thereafter, in connection with the validity, interpretation, implementation or alleged breach of the Insurance Contract between the Insurer and the RSHAA or a Policy or of the terms of their agreement (for example, the Services Agreement between the Insurer and an Empanelled Health Care Provider), then such complainant may lodge a complaint by online grievance redressal portal or letter or e-mail.
- B. For this purpose, a stakeholder includes: any AB- MGRSBY Beneficiary; an empanelled health care provider (EHCP); a De-empanelled Health Care Provider; the Insurer or its employees; the RSHAA or its employees or nominated functionaries for implementation of the Scheme (DNOs, State Nodal Officer, etc.); and any other person having an interest or participating in the implementation of the Scheme or entitled to benefits under the AB- MGRSBY Cover.
- C. A complainant may lodge a complaint in the following manner:
 - i) directly with the DGNO of the district where such stakeholder is located or where such complaint has arisen and if the stakeholder is located outside the Service Area, then with any DGNO located in the Service Area; or
 - ii) with the SHA: If a complaint has been lodged with the SHA, they shall forward such complaint to the concerned DGNO.
- D. Upon a complaint being received by the DGNO, the DGNO shall decide whether the substance of the complaint is a matter that can be addressed by the stakeholder against whom the complaint is lodged or whether such matter requires to be dealt with under the grievance redressal mechanism.
- E. If the DGNO decides that the complaint must be dealt with under the grievance redressal mechanism, the DGNO shall refer such complaint to the Convener of the relevant Grievance Redressal Committee.
- F. If the DGNO decides that the complaint need not be dealt with under the grievance redressal mechanism, then the procedures set out in various process/guidelines

shall apply.

13. Redressal of Complaints

- A. The DGNO shall enter the particulars of the complaint on the Web-based Central Complaints and Grievance Management System (CCGMS) established by the MoHFW.
- B. The CCGMS will automatically: (i) generate a Unique Complaint Number (UCN); (ii) categorize the nature of the complaint; and (iii) an e-mail or letter to be sent to the appropriate stakeholder to which such category of complaint is to be referred (including updating on phone).
- C. Once the UCN is generated, the DGNO shall send or cause to be sent an acknowledgement email/phone call to the complainant and provide the complainant with the UCN. Upon receipt of the UCN, the complainant will have the ability to track the progress of complaint resolution online through CCGMS and use the same at the time of calling the helpline for allowing easy retrieval of the specific complaint data.
- D. The stakeholder against whom a complaint has been lodged must send its comments/ response to the complainant and copy to the DGNO within 15 days. If the complaint is not addressed within such 15-day period, the DGNO shall send a reminder to such stakeholder for redressal within a time period specified by the DGNO.
- E. If the DGNO is satisfied that the comments/ response received from the stakeholder will addresses the complaint, then the DGNO shall communicate this to the complainant by e-mail and update the CCGMS.
- F. If the DGNO is not satisfied with the comments/ response received or if no comments/ response are received from the stakeholder despite a reminder, then the DGNO shall refer such complaint to the Convener of the relevant Grievance Redressal Committee depending on the nature of the complaint after which the procedures set out shall apply.

14. Grievance Redressal Mechanism

Upon escalation of a complaint for grievance redressal the following procedures shall apply:

- A. The DGNO/SGRC shall update the CCGMS to change the status of the complaint to a grievance, after which the CCGMS shall categorize the grievance and automatically refer it to the Convenor of the relevant Grievance Redressal Committee by way of e-mail.
- B. The Convenor of the relevant Grievance Redressal Committee shall place the grievance before the Grievance Redressal Committee for its decision at its next meeting.

- C. Each grievance shall be addressed by the relevant Grievance Redressal Committee within a period of 30 days of receipt of the grievance. For this purpose, each Grievance Redressal Committee shall be convened at least once every 30 days to ensure that all grievances are addressed within this time frame. Depending on the urgency of the case, the Grievance Redressal Committee may decide to meet earlier for a speedier resolution of the grievance.
- D. The relevant Grievance Redressal Committee shall arrive at a reasoned decision within 30 days of receipt of the grievance. The decision of the relevant Grievance Redressal Committee shall be taken by majority vote of its members present. Such decision shall be given after following the principles of natural justice, including giving the parties a reasonable opportunity to be heard.
- E. If any party to a grievance is not satisfied with the decision of the relevant Grievance Redressal Committee, it may appeal against the decision within 30 days to the relevant Grievance Redressal Committee or other authority having powers of appeal.
- F. If an appeal is not filed within such 30-day period, the decision of the original Grievance Redressal Committee shall be final and binding.
- G. A Grievance Redressal Committee or other authority having powers of appeal shall dispose of an appeal within 30 days of receipt of the appeal. The decision of the Grievance Redressal Committee or other authority with powers of appeal shall be taken by majority vote of its members. Such decision shall be given after following the principles of natural justice, including giving the parties a reasonable opportunity to be heard. The decision of the Grievance Redressal Committee or other authority having powers of appeal shall be final and binding.

15. Proceedings Initiated by the State Health Authority, State Grievance Redressal Committee, the National Health Authority

The RSHAA, SGRC and/ or the National Health Authority (NHA) shall have the standing to initiate *suo moto* proceedings and to file a complaint on behalf of itself and AB- MGRSBY Beneficiaries under the Scheme.

A. Compliance with the Orders of the Grievance Redressal Committees

- i) The Insurer shall ensure that all orders of the Grievance Redressal Committees by which it is bound are complied with within 30 days of the issuance of the order, unless such order has been stayed on appeal.
- ii) If the Insurer fails to comply with the order of any Grievance Redressal Committee within such 30-day period, the Insurer shall be liable to pay a penalty of Rs. 25,000 per month for the first month of such non-compliance and Rs. 50,000 per month thereafter until the order of such Grievance Redressal Committee is complied with. The Insurer shall be liable to pay such penalty to the RSHAA within 15 days of receiving a written notice.

- iii) On failure to pay such penalty, the Insurer shall incur an additional interest at the rate of one percent of the total outstanding penalty amount for every 15 days for which such penalty amount remains unpaid.

B. Complaints/ Suggestions received through Social Media/Call centre

As Social Media channels will be handled by NHA, hence, the complaints/ suggestions raised through Social Media channels like, Facebook, twitter handles, etc. will be routed to the respective SGNO by NGNO (National Grievance Nodal Officer). SGNO needs to register the same on the Grievance portal and publish a monthly report on the action taken to the NGNO.

Complaint may also be lodged through Call center by beneficiary. Call center need to register the details like complaint details in the defined format and forward the same to State Grievance Nodal Officer of the State concerned. SGNO needs to upload the details of the complaint on the grievance portal and allocate the same to the concerned District. The Complaint / grievance will be redressed as per guidelines.

Note: Matrix for grievance referral under the Scheme is presented in the table below:

Aggrieved Party	Indicative Nature of Grievance	Grievance Against	Referred To
AB-MGRSBY Beneficiary	- Denied treatment - Money sought for treatment, despite Sum Insured under AB- MGRSBY Cover being available - Demanding more than Package Rate/ Pre-Authorized Amount, if Sum Insured under AB- MGRSBY Cover is insufficient or exhausted - AB-MGRSBY Card retained by Empanelled Health Care Provider - Medicines not provided against OPD Benefits or follow-up care	Hospital	DGNO
Empanelled Health Care Provider	- Claims rejected by Insurer or full Claim amount not paid - Suspension or de-empanelment of Empanelled Health Care Provider - Hospital IT Infrastructure not functioning , insurer not accepting manual transaction	Insurer/ SHA	DGNO
Insurer	No space provided for District Office	DNO	SGNO

Aggrieved Party	Indicative Nature of Grievance	Grievance Against	Referred To
	- AB-MGRSBY Beneficiary Database not updated for renewal Policy Cover Period - Premium not received within time prescribed.	SHA	SGRC
Inter State/UT (Portability issues)			
AB-MGRSBY Beneficiary	- Denied treatment - Money sought for treatment, despite Sum Insured under AB- MGRSBY Cover being available - Demanding more than Package Rate/ Pre-Authorized Amount, if Sum Insured under AB- MGRSBY Cover is insufficient or exhausted - Medicines not provided against OPD Benefits or follow-up care	Hospital	DGNO of the State/UT where Beneficiary is applying/availing benefits of AB-MGRSBY (other than parent State/UT)
Empanelled Health Care Provider	Claims rejected by Insurer or full Claim amount not paid	Insurer/ SHA	SGRC of both parent State/UT and State/UT where the claim is raised State/UT

**Tender Document for Selection of Insurance Company for the
implementation of
Ayushman Bharat – Mahatma Gandhi Rajasthan Swasthya Bima Yojna
In the State of Rajasthan**

October, 2019

Volume III:
Insurance Contract
To be signed by the Insurance Company

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Abbreviations

AB-MGRSBY	Ayushman Bharat-Mahatma Gandhi Rajasthan SwasthyaBimaYojna
AB-PMJAY	Ashman Bharat-Pradhan Mantra Jan Argy Yohan
AL	Authorisation Letter (from the Insurer)
BFU	Beneficiary Family Unit
BPL	Below Poverty Line
RC	Risk Cover
CCGMS	Central Complaints Grievance Management System
CHC	Community Health Centre
CRC	Claims Review Committee
DAL	Denial of Authorisation Letter
DGRC	District Grievance Redressal Committee
DGNO	District Grievance Nodal Officer
EHCP	Empanelled Health Care Provider
HPGRC	High Powered Grievance Redressal Committee
GoR	Government of Rajasthan
GoI	Government of India
GRC	Grievance Redressal Committee
IC	Insurance Company
IRDAI	Insurance Regulatory Development Authority of India
MoHFW	Ministry of Health & Family Welfare, Government of India
NGRC	National Grievance Redressal Committee
NHA	National Health Agency
NOA	Notice of Award
PHC	Primary Health Centre
RAL	Request for Authorisation Letter (from the EHCP)
RTPP Act	Rajasthan Transparency in Public Procurement Act
SECC	Socio Economic Caste Census, 2011
SGRC	State Grievance Redressal Committee
SGNO	State Grievance Nodal Officer
SHA	State Health Agency
UCN	Unique Complaint Number

**Insurance Contract
for the implementation of
Ayushman Bharat – Mahatma Gandhi Rajasthan SwasthyaBimaYojna (AB-
MGRSBY)**

This Agreement for the implementation of AB-MGRSBY for providing the AB-MGRSBY Cover (the **Insurance Contract**) is made at _____ on _____:

BETWEEN

- (1) **THE GOVERNMENT OF THE STATE OF _____**, represented by the _____, having his principal office at _____ (hereinafter referred to as the **Rajasthan State Health Assurance Agency** 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 _____ an insurance company registered with the Insurance Regulatory & Development Authority having registration number _____ and having its registered office at _____ (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 Rajasthan State Health Assurance Agency and the Insurer shall collectively be referred to as the **Parties** and individually as the **Party**.

WHEREAS

A. The "Ayushman Bharat– Mahatma Gandhi Rajasthan Swarthya BimaYojna"(AB-MGRSBY), a government scheme, which aims to provide health insurance cover to the extent of ₹ 5,00,000 segmented as ₹ 50,000 for secondary illnesses and ₹ 4,50,000 for tertiary illnesses per annum on a family floater and cashless basis through an established network of health care providers to the AB-MGRSBY Beneficiary Family Units (*defined below*).

B. The Government of Rajasthan decided has to implement the AB-MGRSBY to provide health insurance to defined categories of families that are eligible for the scheme in the State of Rajasthan.

C. The objective of AB- MGRSBY is to reduce catastrophic health expenditure, improve access to quality health care, and reduce out of pocket healthcare expenditures of poor and vulnerable families falling under the National Food Security Act, 2013 and/or 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), 2011 database of the State. These eligible AB- MGRSBY 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 _____(date) the Rajasthan State Health Assurance 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-MGRSBY Pursuant to the Tender Documents, the bidders submitted their bids on _____ for the implementation of the AB-MGRSBY.

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

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-MGRSBY for the implementation of the AB-MGRSBY in all the districts in the State of Rajasthan.

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

1.1 Definitions

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

Addendum or Addenda means document issued in continuation or as modification or as clarification to certain points in the Tender Documents. The bidders would need to consider the main document as well as any addenda issued subsequently for responding to the bid.

AB-MGRSBY shall refer to Ayushman Bharat – Mahatma Gandhi Rajasthan SwasthyaBimaYojna (AB-MGRSBY) , a scheme managed and administered by the Department of Health and Family Welfare, Government of Rajasthan through Rajasthan State Health Assurance Agency with the objective of reducing out of pocket healthcare expenses and improving access of validated Beneficiary Family Unitsto quality inpatient care and day care surgeries for treatment of diseases and medical conditions through a network of Empanelled Health Care Providers.

AB-MGRSBY Beneficiary Database refers to those families including all its members figuring in the National Food Security Act 2013 and/ or Socio-Economic Caste Census (SECC) database under the deprivation criteria of D1, D2, D3, D4, D5 & D7, Automatically Included category (viz. as Households without shelter, Destitute-living on alms, Manual Scavenger Families, Primitive Tribal Groups and Legally released Bonded Labour) and 11 broadly defined occupational un-organised workers (in Urban Sector) of the Socio-Economic Caste Census (SECC) 2011 database of the State under the AB-MGRSBY and have linked their eligibility with the ID card as decided by Government of Rajasthan. It also includes child of that family up to the age of one year without his name in the Identity Card.

AB-MGRSBY Guidelines mean the guidelines issued by MoHFW / NHA/RSHAA from time to time for the implementation of the AB-MGRSBY, to the extent modified by the Tender Documents pursuant to which the InsuranceContract has been entered into; provided that MoHFW/ NHA or the Rajasthan State Health Assurance Agency may, from time to time, amend or modify the AB-MGRSBY Guidelines or issue new AB-MGRSBY 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 Rajasthan State Health Assurance 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 Rajasthan State Health Assurance Agency and the Insurer.

Basic Sum Insured shall mean sum of Rs.5.00 lakhs per family per year. This cover shall be segmented into **Rs. 50 000 for secondary illnesses and Rs.4,50,000 for tertiary illness** per family per annum on family floater basis. This shall be called the **Basic Sum Insured**, which shall be fixed irrespective of the size of the AB- MGRSBY Beneficiary Family Unit, against which the beneficiary family unit may seek benefits as per the benefit package proposed under the AB-MGRSBY.

Beneficiary means a member of the AB-MGRSBY Beneficiary Family Units who is eligible to avail benefits under the Ayushman Bharat –Mahatma Gandhi Rajasthan SwasthyaBimaYojna

Beneficiary Family Unit **AB-MGRSBY Beneficiary Family Unit** refers to a family who is covered under National Food Security Act 2013 and/or eligible family of AYUSHMAN BHARAT-PRADHAN MANTRI JAN AROGYA YOJNA from the eligible categories of Socio-Economic Caste Census (SECC), 2011 which are resident of Rajasthan and have linked their eligibility with the identity card as decided by GoR shall be considered as eligible for benefits under the Scheme and be automatically covered under the Scheme. In addition to this, additional categories which get covered under the scheme in connection to **clause 2.2 of vol.I** shall also be considered as beneficiary family units from the date of their coverage under the scheme. Date of coverage shall be decided as per directions of RSHAA. Unit of coverage under the Scheme shall be a family and each family for this Scheme shall be called an AB- MGRSBY Beneficiary Family Unit, which will comprise all members in that family whose names are mentioned in the ID card as decided by GOR. In addition to this, children of that family up to the age of one year will also be considered the member of that family even without having name in the ID Card.

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

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 RSHAA 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 State Government.

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 State.

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 anaesthesia or local anaesthesia at an Empanelled Health Care Provider or Day Care Centre in less than 24 hours due to technological advancements, which would otherwise have required Hospitalization.

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

Empanelled Health Care Provider shall mean and refer to those public or private health care providers who are empanelled by the RSHAA for providing services to the Beneficiaries under the Ayushman Bharat – Mahatma Gandhi Rajasthan SwasthyaBimaYojna.

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.

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 Rajasthan State Health Assurance 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-MGRSBY.

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 State Government.

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 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.

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 Rajasthan State Health Assurance Agency and **Parties** means both the Insurer and the Rajasthan State Health Assurance 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 RSHAA 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 Rajasthan State Health Assurance 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 5.00 lakhs per family per year. This cover shall be segmented into **Rs. 50, 000 for secondary illnesses and Rs. 4,50,000 for tertiary illness** per family per annum on family floater basis covering in-patient care (IPD) and day care surgeries for treatment of diseases and medical conditions pertaining to secondary and / or tertiary treatment through a network of Empanelled Health Care Providers (EHCP) for the AB-MGRSBY Beneficiary Family Units validated by the State Government or Rajasthan State Health Assurance Agency (RSHAA).

Risk Premium means the sum agreed by the Parties as the annual premium to be paid by the Rajasthan State Health Assurance 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.

RSHAA mean Rajasthan State Health Assurance Agency refers to the society registered under Societies Act 1958 by the Department of Medical Health & Family Welfare, Government of Rajasthan for the purpose of coordinating and implementing the health insurance scheme/s in the state of Rajasthan.

Schedule means a schedule of this Insurance Contract.

Scheme shall mean the Ayushman Bharat – Mahatma Gandhi Rajasthan Swasthya Bima Yojana managed and administered by the RSHAA under the Department of Medical, Health and Family Welfare, Government of Rajasthan.

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 State Government.

Service Area refers to the entire State of Rajasthan covered and included under this Tender Document for the implementation of AB-MGRSBY.

Secondary and Tertiary illnesses shall mean the conditions covered in **Schedule 3** of the document.

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 State Government 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.

State Government refers to the duly elected Government in the State in which the tender is issued.

Tender Documents refers to this Tender Document including Volume I "Instruction to Bidders", Volume II "About AB-MGRSBY" and Volume III "Insurance Contract to be signed by

the Insurance Company” including all amendments, modifications issued by the RSHAA 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.

1.2 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 InsuranceContract) 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).
- g. The term "including" shall always mean "including, without limitation", for the purposes of this InsuranceContract.

- 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 InsuranceContract.
- j. The Schedules and Annexures 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 Annexures in this InsuranceContract shall, except where the context otherwise requires, be deemed to be references to Recitals, Clauses, Schedules and Annexures of or to this InsuranceContract.
- 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 or 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 Annexures 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 Annexures. In the event of any inconsistency between the Clauses, the Schedules and the Annexures, the Clauses shall prevail over the Schedules and the Annexures.
- 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.
- 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.

PART I

TERMS AND CONDITIONS OF INSURANCE

2. AB-MGRSBY 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 NFSA and/or 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 SECC, 2011 database in the Service Area shall be eligible to become Beneficiaries,
- b. All AB-MGRSBY Beneficiary Family Units, as defined under the National Food Security Act 2013 and/or 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), 2011 database of the State (as updated from time to time) which are resident in the Service Area (State of Rajasthan) and 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 an AB-MGRSBY 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 in unique family ID card decided by GoR which is linked with NFSA and/or SECC, 2011 database mentioned above 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

3.1 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.

- b. As on the date of commencement of the Policy Cover Period, the AB- MGRSBY Sum Insured in respect of the Risk Cover for each AB- MGRSBY Beneficiary Family Unit shall be 5.00 lakhs per family per year. This cover shall be segmented into **Rs. 50, 000 for secondary illnesses listed at Ann.2.3 (a) and Rs. 4,50,000 for tertiary illness listed at Ann.2.3 (b)**of Volume II of tender document, 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-MGRSBY Beneficiary Family Unit.
- c. The Insurer shall ensure that the Scheme's RC shall be provided to each AB-MGRSBY Beneficiary Family Unit on a family floater basis covering all the members of the AB-MGRSBY Beneficiary Family Unit including Senior Citizens and children less than the age of one year whose name is not in family ID card, 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 Government.
- 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 upto 5 days and up to 15 days of the discharge from the hospital for the same ailment/ surgery.

3.2 Benefit Package: AB-MGRSBY Cover

- a. The benefits within this Scheme under the Risk Cover are to be provided on a cashless basis to the AB-MGRSBY 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. The Insurer shall reimburse claims of public and private health care providers under the AB-MGRSBY 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 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-MGRSBY Beneficiary family as per the package rates defined in this document. Beneficiary will need to be clearly communicated in advance about the additional payment.
 - (iii) The follow up care prescription for identified packages are set out in **Schedule 3**.
 - (iv) In case of an AB-MGRSBY 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 & subsequent treatment package shall be at 25% of the package rate.
 - (v) Surgical and Medical packages will not be allowed to be availed at the same time.
 - (vi) Certain packages as mentioned in **Schedule 3** will only be reserved for Public EHCPs as decided by the RSHAA. Certain packages as indicated in **Schedule 3** have differential pricing. Hospitals, located in the backward districts where number of private hospitals are less than 10 in existing scheme (Baran, Banswara, Bundi, Chittorgarh, Dholpur, Dungarpur, Jaisalmer, Pratapgarh and Rajasamand) including three aspirational districts (i.e. Baran, Dholpur and Jaisalmer).
- e. 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) Pre and Post Hospitalisation expenses: Pre and Post Hospitalisation expenses: Expenses incurred for consultation, diagnostic tests and medicines before the admission of the patient in the same hospital upto 5 days and up to 15 days of the discharge from the hospital for the same ailment/ surgery. After expiry of 15 days period patient will have to bear the cost of follow up related to that package. However if due to neglegency of hospital any complications or failure occurs even after expiry of 15 days post discharge and patient is treated in the same hospital then hospital shall bear the expenses related to treatment.

- f. 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.
- g. Package list included in **Schedule 3** can be revised and updated by NHA/Gol which shall come into effect from the date of notification issued by NHA.
- h. Once revised by NHA/Gol, packages and rates shall remain same for 2 years of the execution of insurance contract.
- i. The RSHAA and Insurer shall publish the Package Rates on its website in advance of each Policy Cover Period.
- j. 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-MGRSBY 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-MGRSBY 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

The benefits under the AB-MGRSBY Risk Cover shall only be available to an AB-MGRSBY Beneficiary through an EHCP after Aadhaar based identification as far as possible. After identification of family unit beneficiaries will be identified using biometric method of identification as far as possible. However, in case of failure of biometric identification or if aadhaar card is not issued for a patient, any specified identification document (as laid down in scheme guidelines) produced by the beneficiary at the point of contact.

- a. For this purpose the benefits under the AB-MGRSBY Cover shall, subject to the available AB-MGRSBY Sum Insured, be available to the AB-MGRSBY Beneficiary on a cashless basis at any EHCP.
- b. 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 RSHAA for offering such tertiary level services.

4. Identification of AB-MGRSBY Beneficiary Family Units

- a. Identification of AB- MGRSBY Beneficiary Family Units will be based on the unique ID as decided by Government of Rajasthan for the families related to National Food Security Act, 2013 and/or 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), 2011 database of the State

After identification of family unit beneficiaries will be identified using biometric method of identification as far as possible. However, in case of failure of biometric identification or if aadhaar card is not issued for a patient, any specified identification document (as laid down in scheme guidelines) produced by the beneficiary at the point of contact.

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

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-MGRSBY, 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 fulfil the minimum criteria for offering tertiary treatment services as prescribed by the RSHAA would be specifically designated for providing such tertiary care packages.
- d. The RSHAA shall be responsible for empanelment and periodic renewal of empanelment of health care providers for offering services under the AB-MGRSBY. The RSHAA may undertake this function either directly or through the selected Insurance Company. However, the final decision regarding empanelment of hospital will rest with RSHAA.
- e. Under circumstances of any dispute, final decision related to empanelment of health care providers shall vest exclusively with the RSHAA.
- f. Detailed guidelines regarding empanelment of health care providers are provided at **Schedule 5**.

6. Agreement with Empanelled Health Care Providers

- a. Once a health care provider is found to be eligible for empanelment, the RSHAA 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 2 years or the agreement period of Insurance agreement, whichever is earlier which may be renewed in accordance with clause 8 (d) of Volume II of tender document**, unless the EHCP is de-empanelled in accordance with the **AB-MGRSBY guidelines** and its agreement terminated in accordance with its terms. In any case the agreement shall not be increased beyond the date of completion/termination of insurance agreement between RSHAA and Insurance Company from the date of execution of provider service agreement.
- 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 RSHAA and the Insurer or tripartite Provider Service Agreement with the EHCP.
- e. If the Insurer or its outsource agency or any of its representatives violates the provisions of **Clause 6(d)** above, it shall be deemed as a material breach and the RSHAA 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-MGRSBY guidelines. All Private EHCPs shall be responsible for all costs related to hardware and maintenance of the IT infrastructure.

7. De-empanelment of Health Care Providers

- a. The RSHAA, reserves the right to suspend or de-empanel an EHCP from the AB-MGRSBY, 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 State of Rajasthan shall be covered under one policy. The Insurer shall issue a Policy before the commencement of the Policy Cover Period for State.
- b. The first Policy Cover Period under the Policy for the State of Rajasthan shall commence from the date **13/12/2019**.
- c. The terms and conditions set out in each Policy issued by the Insurer to the Rajasthan State Health Assurance 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 the State of Rajasthan in accordance with **Clause 8(a)**, the Insurer agrees that the Policy Cover Period for the State shall commence on the date determined and that it shall provide the eligible Beneficiaries in the State 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 the State of Rajasthan by the Insurer, the terms of the Insurance Contract shall prevail for the purpose of determining the Insurer's obligations and liabilities to the RSHAA and the AB-MGRSBY Beneficiaries.

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 2 years, extendable for another 01 year with mutual consent of parties with starting date **13/12/2019**.

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 **13/12/2019**, until **2359** hours on the date of expiration **12/12/2020**. Provided that upon early termination of this Insurance Contract, the Policy Cover Period for the State of Rajasthan 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 State during the Policy Cover Period shall not result in the termination of the Policy Cover Period for the State.

9.3 Policy Cover Period for the AB-MGRSBY Beneficiary Family Unit

- a. During the first Policy Cover Period for the State of Rajasthan, the policy cover shall commence **from 0000 hours on the date indicated by the RSHAA.**
- b. The end date of the policy cover for the State of Rajasthan is 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.

9.4 Cancellation of Policy Cover

Upon early termination of the Insurance Contract between the RSHAA 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.**

If any point of time, Insurance Company fails to fulfill its contractual obligations then RSHAA reserves the right to take over the scheme and run on trust mode; using the same TPA and its associated infrastructure on same rates. Insurer shall include this clause in its contract with TPA and shall also share a copy with RSHAA at the time of execution of Insurance Contract with RSHAA.

10. Premium and Premium Payment

10.1 Payment of Premium

The RSHAA shall ensure payment of the premium as per the following schedule:

- a. The premium would be paid every year in four quarterly instalments on or before the first day of the quarter every year. The policy year being reckoned from the date of commencement of the policy. Amount for the premium of first quarter shall be arrived on number of beneficiary families showing on portal 7 days prior to the commencement of first quarter.
- b. The premium amount will be in proportion to the number of beneficiary families showing on portal 7 days prior to the commencement of that quarter.
- c. Calculation of the premium will be done monthly on Pro-rata basis, based on addition of number of beneficiary families showing on portal in intermediate period between two quarters. This premium amount will be paid with the premium installment of next quarter.

- d. Detailed premium payment guidelines are provided at **Schedule 8**.

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

- a. The RSHAA shall issue a letter to the Insurer stating the Insurer's average Claim Ratio for all 12 months of Policy Cover Period for the State. In the letter, the RSHAA 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**.
- 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 RSHAA within 30 days. The percentage that will be needed to be refunded will be as per the following:
 - i. Administrative cost allowed 10% if claim ratio less than 60%.
 - ii. Administrative cost allowed 12% if claim ratio between 60-70%.
 - iii. Administrative cost allowed 15% if claim ratio between 70-85%.
- c. The entire surplus as determined through formula mentioned above should be refunded by the insurer to the RSHAA within 30 days.
- d. An amount of **1% of the premium** to be paid shall be deducted from the premium paid as per the schedule for purposes of carrying out IEC, monitoring and evaluation activities by RSHAA. This amount shall be included in the administrative cost mentioned in **Clause 10.2.b**.
- e. 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 RSHAA for every 7 days of delay beyond such 60 day period.
- f. If the Insurer fails to refund the Premium within such 90-day period and/ or the default interest thereon, the RSHAA shall be entitled to recover such amount as a debt due from the Insurer through means available within law.

10.3 Taxes

The Insurer shall protect, indemnify and hold harmless the Rajasthan State Health Assurance 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 Rajasthan State Health Assurance 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.

10.4 Premium All Inclusive

Except as expressly permitted, the Insurer shall have no right to claim any additional amount from the Rajasthan State Health Assurance 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.

11. Cashless Access of Services

- a. The AB-MGRSBY 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. In case cost of package exceeds the amount available in beneficiary Risk Cover as specified in **clause 6 (f) of Vol. II of tender document**, EHCP shall be up to the ceiling amount of Risk Cover, Surplus amount shall be borne by the beneficiary after following the procedure as mentioned in **clause 6 a (IV) of MTD Vol II**.
- c. The Insurer shall ensure that each EHCP shall at a minimum possess the Hospital IT Infrastructure required to access the AB-MGRSBY Beneficiary Database and undertake verification based on the Beneficiary Identification process laid out, using unique AB-MGRSBY Family ID/card and also ascertain the balance available under the AB-MGRSBY 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 SwasthyaMargdarshak that will be deputed by each EHCP (at the cost of the EHCP) that will be responsible for the administration of the AB-MGRSBY 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-MGRSBY Beneficiary Family Unit as per details mentioned in **Schedule 4** and ensure:
 - (i) That the patient is admitted for a covered procedure and package for such an intervention is available.
 - (ii) AB-MGRSBY Beneficiary has balance in her/ his AB-MGRSBY Cover amount.

12. 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-MGRSBY.

- c. Request for hospitalization shall be forwarded by the EHCP after obtaining due details from the treating doctor and documents laid down under Minimum Document Protocol (MDP), 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 12d**, 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 6 hours for emergencies; except for specified packages. 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. However in case of auto approval of pre authorization request, penalty as mentioned in penalty clause shall be imposed on insurer. Later, if the claim becomes liable for rejection due to inadequacy for document at pre-authorization stage insurer shall be charged for claim amount for such cases.
- g. The RAL form should be duly filled with clearly mentioned Yes or No. There should be no nil, or blanks, which will help in providing the outcome at the earliest.
- h. Pre-auth. to be processed in consultation with specialist. No claim could be rejected without having been examined by a specialist doctor of that particular speciality.
- i. The Insurer needs to file a daily report to the RSHAA explaining reasons for denial of every such pre-authorisation request.
- j. 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.
- k. Authorisation letter (AL) will mention the authorisation number. The EHCP must see that these rules are strictly followed.
- l. The authorisation is given only for the ailment covered and mentioned in the RAL for hospitalization.
- m. The entry on the AB-MGRSBY portal for claim amount blocking as well at discharge would record the authorisation number as well as package amount.

- n. In case the balance sum available is less than the specified amount for the Package, EHCP shall only charge the balance amount against the package from the AB-MGRSBY beneficiary after receiving consent as mentioned in **clause 6 (a) (iv) of volume II** of tender document.
- o. 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.
- p. In cases where the AB-MGRSBY 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-MGRSBY beneficiary was admitted.
- q. Detailed guidelines for hospitals transactions including pre-authorisation is provided at **Schedule 15**.

13.Portability of Benefits

- a. The benefits of AB-MGRSBY 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. Detailed guidelines of portability are provided at **Schedule 9**.

14.Claims Management

14.1 Claim Payments and Turn-around Time

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

- a. The Insurer shall require the Empanelled Health Care Providers to submit their Claims electronically within 24 hours of discharge in the defined format to be prescribed by the NHA/RSHAA/ however, in case of Public EHCPs this time may be relaxed as defined by RSHAA.
- 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 review with insurer and after that if it is not satisfied with the review, it can 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 State 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 by review or 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 submission of claim by EHCP**. If a claim is not rejected, the Insurer shall either make the payment (based on the applicable package rate) or shall conduct further investigation into the claim received from EHCP.
- e. The Insurer shall make the full Claim Payment without deduction of tax, for all CHCs, Sub divisional hospitals, Satellite hospitals, District Hospitals, Medical College and its associated hospitals and other government 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.

- i. Without prejudice to the foregoing, during the subsistence of any delay by the Rajasthan State Health Assurance 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.
- j. 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 Rajasthan State Health Assurance 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.
- k. The counting of days for the purpose of this Clause shall start from the date of receipt of the Claim.
- l. The Insurer shall make Claim Payments to each Empanelled Health Care Provider against Claims received on a daily basis through electronic transfer to such Empanelled Health Care Provider's designated bank account.
- m. The Insurer shall ensure that there is an online web portal for processing of all claim payments.
- n. 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.
- o. The Insurer shall submit details of:
 - (i) all Claims that are under investigation to the district nodal officer of the Rajasthan State Health Assurance Agency on a monthly basis for its review;
 - (ii) every Claim that is pending beyond 15 days to the Rajasthan State Health Assurance 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 Rajasthan State Health Assurance Agency.
- p. 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.

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

14.2 Right of Review, Appeal and Reopening of Claims

- a. The Empanelled Health Care Provider shall have a right of review at the level of insurer. The insurer will decide within **15 days** of review request and inform of its decision to the EHCP and the RSHAA.
- b. If EHCP still not satisfied with the review by the insurer, then it can 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.
- c. 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.
- d. RSHAA may prescribe token fees for hearing these appeals in order to avoid frivolous matters being forwarded to GRC/CRC. The details will be shared later.

14.3 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 exceed 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.

15.No Duty of Disclosure

- a. Notwithstanding the issue of the Tender Documents and any other information provided by the Rajasthan State Health Assurance 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 Rajasthan State Health Assurance 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 State, the Rajasthan State Health Assurance 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 RSHAA, 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 RSHAA 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 Rajasthan State Health Assurance Agency has made no and will make no material disclosures to the Insurer;
 - (ii) acknowledges and confirms that the Rajasthan State Health Assurance Agency shall not be liable to the Insurer for any misrepresentation or untrue, misleading,

incomplete or inaccurate statements made by the Rajasthan State Health Assurance 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 affects the Insurer's ability to provide the Covers.

16. 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 capacities 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 RSHAA.
- 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 RSHAA.
- d. The RSHAA shall take all such decision within the provisions of the Insurance Contract and be founded on the Principles of Natural Justice.
- e. The RSHAA 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-MGRSBY in the State 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 RSHAA 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 RSHAA, 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 Rajasthan State Health Assurance Agency of its proposed exercise of any of these remedies; and such notice are accompanied by reasonable documentary evidence of such fraudulent activity. An indicative list of fraudulent triggers has been set out in **Schedule 13**.

The Rajasthan State Health Assurance Agency shall have the right to conduct a random audit of any or all cases in which the Insurer has exercised such remedies against an Empanelled Health Care Provider and/or any Beneficiary. If the State Health Agency finds that the Insurer has wrongfully de-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.

17. Representations and warranties of the Insurer

17.1 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-MGRSBY Guidelines issued by MoHFW and/or the Rajasthan State Health Assurance 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-MGRSBY) 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 State 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.

PART II

PROJECT OFFICE

18. Project Office and District Offices

18.1 Project Office at the State Level

The Insurer shall establish a Project Office at a convenient place at Jaipur, Rajasthan for coordination with the RSHAA on a regular basis within 30 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 Rajasthan at the district headquarters of such district (each a District Office) within 30 days of signing of the contract.
- b. Each District Office shall be responsible for coordinating the Insurer's activities at the district level with the RSHAA'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-MGRSBY and for the performance of its obligations and discharge of its liabilities under the Insurance Contract:
 - (i) One State Coordinator who shall be responsible for implementation of the Scheme and performance of the Insurance Contract in the State.
 - (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 State 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 RSHAA 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 RSHAA and running of the website at the State level and updating data at regular intervals on the website. The website shall have information on AB-MGRSBY in the local language and English with functionality for claims settlement and account information access for the AB-MGRSBY 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 State level obligations with the State level administration of the RSHAA.
- 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 State/district level, exclusively for the purpose of the implementation of the AB-MGRSBY :
- (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 RSHAA 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 AyushmanMitras 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 AyushmanMitras at the network hospital.
 - (iv) To undertake the Pre-authorisation functions under AB-MGRSBY.
 - (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-MGRSBY 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 RSHAA.
- 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-MGRSBY 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 RSHAA within 30 days of all such appointments and replacements. The Insurer shall ensure that its employees coordinate and consult with the SHA's corresponding personnel for the successful implementation of AB-MGRSBY 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 RSHAA 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 SwasthyaMargdarshak for all EHCPs in the state at least once every 6 months, that is, at least twice during each Policy Cover Period. 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 above level institutes) at least once every 6 months, that is, at least twice during each Policy Cover Period for the state 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 State 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. State 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 centres, ASHA etc. The responsibility of distributing booklets will lie with the RSHAA. Such booklets shall contain at least the following details:
 - (i) Details about AB-MGRSBY ;
 - (ii) Process for utilizing the Covers under AB-MGRSBY ;
 - (iii) List of Exclusions;
 - (iv) Start and end date of the Policy Cover Period for that State;
 - (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-MGRSBY.
- e. Ensuring availability of Policy number for the Policy for State 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 RSHAA before the commencement of each Policy Cover Period.

20.2 Rajasthan State Health Assurance Agency's Obligations

The RSHAA shall complete the following activities before the start of the policy in the State:

- a. Provide the Beneficiary Database in the format prescribed by the AB-MGRSBY Guidelines to the insurer prior to the commencement of each Policy Cover Period at least 7 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-MGRSBY within 30 days of the signing of this Insurance Contract.
- c. Set up State 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-MGRSBY

21. Service beyond Service Area

To ensure true portability of the AB-MGRSBY 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, State Governments shall enter into arrangement with ALL other States 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 RSHAA; 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 RSHAA in the format prescribed by the RSHAA 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/RSHAA 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 RSHAA and any number of authorized representatives of the RSHAA or its advisors/ consultants with access to the various modules on the MIS dashboard. The RSHAA 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 RSHAA regarding health-service usage patterns, Claims data and such other information regarding the delivery of benefits as may be required by the RSHAA 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 RSHAA and/ or to the MoHFW, GoI and to submit such reports in formats as required by and specified by the RSHAA from time to time.
- f. All data generated 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 RSHAA and data shall be shared to NHA for details analysis. The Insurer undertakes to handover all such information and data to the RSHAA within 10 days of the expiration or cancellation of the Policy for that State or State cluster and on the expiration or early termination of the Insurance Contract.

24. Monitoring and Control

24.1 Scope of Monitoring

- a. Monitoring under AB-MGRSBY shall include supervision and monitoring of all the activities under the AB-MGRSBY undertaken by the Insurer and ensuring that the Insurer complies with all the provisions of the Insurance Contract signed with the Rajasthan State Health Assurance Agency (RSHAA) and all contracts and sub-contracts/ agreements issued by the Insurer pursuant to the Insurance Contract with the RSHAA 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

24.2.1 General Monitoring Obligations

Under the AB-MGRSBY, 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 RSHAA. 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-MGRSBY 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.

24.2.2 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 RSHAA 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 RSHAA 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.

24.2.3 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 Rajasthan State Health Assurance Agency

24.3.1 Audits by the Rajasthan State Health Assurance Agency

- a. Audit of the audits undertaken by the Insurer: The RSHAA 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 RSHAA 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 RSHAA shall constitute a Claims Review Committee (CRC) that shall look into minimum 10% of claims rejected or partially settled by the Insurer to assure itself of the legitimacy of the Insurer's decisions.
 - (ii) Claims for which EHCP, feels are wrongly rejected, then it may file review with IC and IC will decide such claims within 15 days.
 - (iii) If EHCP is still aggrieved with the review by IC, then the matter may be filed in GRC/CRC. GRC may forward cases to CRC for examination.
 - (iv) CRC shall examine the case within as soon as possible 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 GRC/CRC 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.

(v) Concurrent Audits: The RSHAA 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 State Health Agency

- a. The RSHAA 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 SHA.

24.3.3 Performance Review and Monitoring Meetings

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

- 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 RSHAA 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 RSHAA on the Insurer shall have to be paid by the Insurer within 60 days of such demand.
- d. Based on the review the RSHAA shall have the right to issue rectification orders demanding the performance to be brought up to the levels desired as per the AB-MGRSBY 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 RSHAA.
- g. If the RSHAA 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 RSHAA 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 RSHAA shall impose the following penalties on the Insurer which have been referred to in the other clauses of this Contract and Tender Document:

No.	Additional Defaults	Penalty
(i)	If premium refund is not made by the Insurer to the RSHAA within 30 days of the communication for refund sent by the RSHAA 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 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
(iii)	For claims outside State, 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 RSHAA 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 RSHAA.
- 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 Rajasthan State Health Assurance Agency of the intermediaries or service providers that it wishes to appoint on or before the date of execution of this Insurance Contract.

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 10 th day of the month following the end of the quarter
(iii)	Claims/ Utilization Summary Reports	Monthly	Within 5 th day of the month following the end of the month
(iv)	Overall Scheme Progress Reports	Monthly	Within 10 th day of the month following the end of the quarter

- b. All reports shall be uploaded by the Insurer online on the RSHAA web portal.
- c. The Insurer shall receive auto-acknowledgement immediately on submission of the report.
- d. The RSHAA shall review all progress reports and provide feedback, if any, to the Insurer.
- e. All Audits reports shall be reviewed by the RSHAA and based on the audit observations, determine remedial actions, wherever required.

PART IV

COORDINATION AND GRIEVANCE REDRESSAL

27.Coordination Committee

27.1 Constitution and Membership

- a. The RSHAA shall, within 15 days of the date of execution of this Insurance Contract, as far as possible, 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) Principal Secretary (Health and Family Welfare) or any other representative designated by her/ him (Chairperson).
 - (ii) Mission Director NHM.
 - (iii) Director Health Services.
 - (iv) The State Nodal Officer and one other member nominated by the SHA.
 - (v) The State Coordinator (s) of the Insurance Company (ies) and one other member from the Corporate/ regional office of the Insurer.State may add additional members, if required.

27.2 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 RSHAA 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 agree upon.

28.Grievance Redressal

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

information in pre-agreed format of any complaint / grievance received by oral, written or any other form of communication.

Under the Grievance Redressal Mechanism of AB-MGRSBY, 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**.

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 Rajasthan State Health Assurance 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 Rajasthan State Health Assurance Agency within 45 days of the date of expiration of the Policy Cover Period for that Policy as far as possible.

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

29.2 Termination by the Rajasthan State Health Assurance Agency

- a. The Rajasthan State Health Assurance 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 RSHAA 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 RSHAA, or any part thereof, shall be in arrears and unpaid within 60 days of receipt of a written notice from the RSHAA 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 RSHAA; 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 RSHAA unless such event has occurred because of a Force Majeure Event, or due to reasons solely attributable to the RSHAA 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 SHA, 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-MGRSBY 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 Rajasthan State Health Assurance 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 Rajasthan State Health Assurance Agency will be entitled to terminate this Insurance Contract by issuing a final termination notice (**Final Termination Notice**).

- c. RSHAA will provide pro-rata 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 State 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 Rajasthan State Health Assurance Agency that remains uncured despite receipt of a 60 day cure notice from the Insurer (a **State Health Agency Event of Default**), provided that such event is not attributable to a Force Majeure Event.
- b. Upon the occurrence of a State Health Agency Event of Default (non-payment of first instalment 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 Rajasthan State Health Assurance Agency. If the RSHAA fails to remedy or rectify the State 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 State 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 Rajasthan State Health Assurance 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 State:

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

Where:

TC is the sum to be paid by the Insurer to the Rajasthan State Health Assurance Agency on the Termination Date in respect of the State;

P is the Premium per Beneficiary Family Unit that has been or has to be paid by the Rajasthan State Health Assurance 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 State of Rajasthan, for whom the Premium has been or has to be paid by the Rajasthan State Health Assurance 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 Rajasthan State, 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 Rajasthan State Health Assurance 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 RSHAA may issue a written request to the Insurer seeking a migration of the Policies for all the districts in the Service Area (**MigrationRequest**) to another insurance company (**NewInsurer**).
- b. Once the RSHAA has issued such a MigrationRequest:
 - (i) The RSHAA 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 RSHAA 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 RSHAA 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 RSHAA in the format prescribed by the RSHAA 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 risks under migration process has been completed and the New Insurer assumes all of 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 RSHAA, 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-MGRSBY in favour of the Rajasthan State Health Assurance 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 State 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;

If any point of time, Insurance Company fails to fulfill its contractual obligations, RSHAA reserves the right to takeover the scheme and run on trust mode using same TPA and it's associated infrastructure on same rates. Insurer shall include this clause in its contract with TPA and shall also share a copy with RSHAA at the time of execution of Insurance Contract with RSHAA.

30. Force Majeure

30.1 Definition of Force Majeure Event

A **Force Majeure Event** shall mean the occurrence in the State of Rajasthan 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 fulfil 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 State of Rajasthan unless the loss, damage or delay was directly caused by 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
- 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.

30.5 Resumption 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.

30.6 Termination 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.

31.ASSIGNMENT

31.1 Assignment by Insurer

Except as approved in advance by the Rajasthan State Health Assurance 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 State Health Agency

The State 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 Rajasthan Medicare Relief Societies may assign all or part of their right to receive Claims Payments from the Insurer in favour of the Government of Rajasthan or any other department, organization or public body that is under the ownership and/or control of the Government of Rajasthan.

On and from the date of receipt of a written notice from the public Empanelled Health Care Providers in the Service Area or from the Government of Rajasthan, 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-MGRSBY 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 Rajasthan State Health Assurance 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 RajasthanState Health Assurance Agency shall be free to issue AB-MGRSBY 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-MGRSBY Guidelines issued during the Term, whether or not the provisions or terms of such AB-MGRSBY 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: State 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.

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 Jaipur, Rajasthan 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

SIGNED, SEALED and DELIVERED

For and on behalf of
State of _____

For and on behalf of
Insurance Company_____

Represented by

Represented by

In the presence of:

In the presence of:

(1)

(1)

(2)

(2)

Schedules: Volume III

Schedule 1: AB-MGRSBY Beneficiaries

AB-MGRSBY Beneficiaries and Beneficiary Family Unit

- a. All AB- MGRSBY Beneficiary Family Units means a family who is covered under National Food Security Act, 2013 and/or eligible family of AYUSHMAN BHARAT-PRADHAN MANTRI JAN AROGYA YOJNA from the eligible categories of Socio-Economic Caste Census (SECC), 2011 which are resident of Rajasthan and have linked their eligibility with the identity card as decided by GoR shall be considered as eligible for benefits under the Scheme and be automatically covered under the Scheme.
- b. In addition to this, additional categories which gets covered under the scheme in connection to **clause 2.2 of vol. I** shall also be considered as beneficiary family units from the date of their coverage under the scheme. Date of coverage shall be decided as per directions of RSHAA.

Unit of coverage under the Scheme shall be a family and each family for this Scheme shall be called an AB-MGRSBY Beneficiary Family Unit, which will comprise all members in that family whose names are mentioned in the ID card as decided by GOR. In addition to this, children of that family up to the age of one year will also be considered the member of that family even without having name in the ID Card.

Schedule 2: Exclusions to the Policy

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

- 1. **Conditions that do not require hospitalization:** Condition that do not require hospitalization and can be treated under Out Patient Care. Out Patient Diagnostic, unless necessary for treatment of a disease covered under Medical and Surgical procedures or treatments or day care procedures(as applicable), will not be covered.*
- 2. Except those expenses covered under pre and post hospitalisation expenses, further expenses incurred at Hospital or Nursing Home primarily for evaluation / diagnostic purposes only during the hospitalized period and expenses on vitamins and tonics etc. unless forming part of treatment for injury or disease as certified by the attending physician.*
- 3. Any dental treatment or surgery which is corrective, cosmetic or of aesthetic procedure, filling of cavity, root canal including wear and tear etc. unless arising from disease, illness or injury and which requires hospitalisation for treatment.*
- 4. **Congenital external diseases:** Congenital external diseases or defects or anomalies, Convalescence, general debility, “run down” condition or rest cure.*
- 5. **Fertility related procedures:** Hormone replacement therapy for Sex change or treatment which results from or is in any way related to sex change.*
- 6. **Drugs and Alcohol Induced illness:** Diseases, illness or injury due to or arising from use, misuse or abuse of drugs or alcohol or use of intoxicating substances, or such abuse or addiction.*
- 7. **Vaccination:** Vaccination, inoculation or change of life or cosmetic or of aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness. Circumcision (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident).*
- 8. **Suicide:** Intentional self-injury/suicide.*
- 9. Persistent Vegetative State.*

Schedule 3: Packages and Rates - Hospital Packages under AB-NHPM

- Package list included in **Schedule 3** can be revised and updated by NHA/Gol which shall come into effect from the date of notification issued by NHA.
- Once revised by NHA/Gol, packages and rates shall remain same for 2 years of the execution of insurance contract.
- Secondary illnesses include those packages as defined in the secondary packages list given below for which the risk cover is Rs.50,000 per eligible family per annum.
- Tertiary illnesses include those packages as defined in the tertiary packages list given below for which the risk cover is Rs.4,50,000 per eligible family per annum.
- Pacakges reserved for government EHCPs is given in the list below.

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S.No	Specialty	No. of packages	No. of packages mandated for pre-authorization
1	Cardiology		
2	Cardio-thoracic surgery		
3	Cardio-vascular surgery		
4	Ophthalmology		
5	ENT		
6	Orthopaedics		
7	Polytrauma		
8	Urology		
9	Obstetrics & Gynaecology		
10	General Surgery		
11	Neurosurgery		
12	Interventional Neuroradiology		
13	Plastic & reconstructive		
14	Burns management		
15	Oral and Maxillofacial Surgery		
16	Paediatric medical management		
17	Neo-natal		
18	Paediatric cancer		
19	Paediatric surgery		
20	Medical packages		
21	Oncology		
22	Emergency Room Packages (Care requiring less than 12 hrs stay)		
23	Mental Disorders Packages		
	Total		

ALL PACKAGES WILL INCLUDE DRUGS, DIAGNOSTICS, CONSULTATIONS, PROCEDURE, STAY.

Performance-linked Incentive:

A performance-linked payment system has been designed to incentivize hospitals to promote equity in access, hospitals providing services in backward districts where number of private hospitals are less than 10 in existing scheme (Baran, Banswara, Bundi, Chittorgarh, Dholpur, Dungarpur, Jaisalmer, Pratapgarh and Rajasamand) including three aspirational districts (i.e. Baran, Dholpur and Jaisalmer) will receive an additional 10%.

Remaining details includeing package list to be provided later.

Schedule 4: Guidelines for Identification of AB-MGRSBY Beneficiary Family Units

- A. Beneficiary identification will include the following broad steps:
SwasthyaMargdarshak ensures eligibility of the family and beneficiary in the scheme through software by either of the followings:
1. Family Identification:
 - a. By entering of the ID Card number as prescribed by GoR or its acknowledgement slip number
 - b. By entering of the Aadhar Card Number of beneficiary which is/are linked with the unique family identity card
 - c. By entering of the HHID no. of eligible SECC family linked with unique family identity card.
 2. Beneficiary Identification:
 - i) Beneficiary will be identified preferably by Aadhar based biometric verification.
 - ii) In case of Aadhar based verification of beneficiary is not possible, than an alternative mechanism as decided by RSHAA will be followed.
 - iii) In case, patient is child less than five years than identification of the child will be done based on any family member listed in the unique family card.
- B. Addition of new family members will be allowed as per existing rules for addition in the existing family ID card .This requires at least one other family member has been approved through portal recognized by RSHAA. Proof of being part of the same family is required in the form of
- i) Name of the new member is in the family State defined family card
 - ii) A marriage certificate relating to marriage to a family member existing in the family.
 - iii) A birth certificate relating to a birth to a family member existing in the family is available.

These guidelines are only indicative in nature and RSHAA reserves the rights to modify or change, if required.

Schedule 5: Guidelines for Empanelment of Health Care Providers and Other Related Issues

1.1. Basic Principles

For providing the benefits envisaged under the Scheme, the Rajasthan State Health Assurance Agency (RSHAA) through State Empanelment Committee (SEC) will empanel private and public health care service providers.

At the district level, District Empanelment Committee (DEC) will be formed which will be responsible for hospital empanelment related activities at the district level and to assist the State Empanelment Committee (SEC) in empanelment and disciplinary proceedings with regards to network providers in their districts. The detailed guidelines/circular on empanelment will be issued by RSHAA.

1.2. Process of Empanelment

A. Empanelment requirements

- i) RSHAA will empanel hospitals only in the state of Rajasthan.
- ii) All public facilities with capability of providing inpatient services (Community Health Centre level and above) are deemed empaneled under AB-MGRSBY. The State Health Department shall ensure that the enabling infrastructure and guidelines are put in place to enable all public health facilities to provide services under AB-MGRSBY.
- iii) Employee State Insurance Corporation (ESIC) hospitals will also be eligible for empanelment in AB-MGRSBY, based on the approvals.
- iv) For private providers and not for profit hospitals, a tiered approach to empanelment will be followed. Empanelment criteria are prepared for various types of hospitals / specialties catered by the hospitals and attached in **Annex 1**.
- v) Hospitals in backward districts where number of private hospitals are less than 10 in existing scheme (Baran, Banswara, Bundi, Chittorgarh, Dholpur, Dungarpur, Jaisalmer, Pratapgarh and Rajasamand) including three aspirational districts (i.e. Baran, Dholpur and Jaisalmer) will receive an additional 10% Criteria for empanelment have been divided into two broad categories as given below.

Category 1: General Criteria	Category 2: Specialty Criteria
All the hospitals empaneled under AB-MGRSBY for providing general care have to meet the minimum criteria established under the Mission detailed in Annex 1. No exceptions will be made for any hospital at any cost.	Hospitals would need to be empaneled separately for certain tertiary care packages authorized for one or more specialties (like Cardiology, Oncology, and Neurosurgery etc.). This would only be applicable for those hospitals who meet the general criteria for the AB-MGRSBY.

Detailed empanelment criteria have been provided as [Annex 1](#).

State Government will have the flexibility to **revise/relax** the empanelment criteria based, barring minimum requirements of Quality as highlighted in Annex 1, as per local context, availability of providers, and the need to balance quality and access. The same will have to be incorporated in the web-portal for online empanelment of hospitals.

Hospitals will undergo a renewal process for empanelment once every 2 years or till the expiry of validity of Insurance Contract whichever is earlier to determine compliance to minimum standards.

National Health Agency may revise the empanelment criteria at any point during the programme, if required and the states will have to undertake any required re-assessments for the same.

1.3. Awareness Generation and Facilitation

The state government shall ensure that maximum number of eligible hospitals participate in the AB-MGRSBY, and this need to be achieved through IEC campaigns, collaboration with and district, sub-district and block level workshops.

The state and district administration should strive to encourage all eligible hospitals in their respective jurisdictions to apply for empanelment under AB-MGRSBY. The RSHAA shall organize a district workshop to discuss the details of the Mission (including empanelment criteria, packages and processes) with the hospitals and address any query that they may have about the mission.

Representatives of both public and private hospitals (both managerial and operational persons) including officials from Insurance Company will be invited to participate in this workshop.

1.4. Online Empanelment

A. A web-based platform is being provided for empanelment of hospitals for AB-

MGRSBY.

- B. The hospitals can apply through this portal only, as a first step for getting empaneled in the programme.
- C. This web-based platform will be the interface for application for empanelment of hospitals under AB-MGRSBY.
- D. Following the workshop, the hospitals will be encouraged to initiate the process of empanelment through the web portal. Every hospital willing to get empaneled will need to visit the web portal, as defined in the detail guidelines and create an account for themselves.
- E. Availability of PAN CARD number (not for public hospitals) and functional mobile number of the hospital will be mandatory for creation of this account / Login ID on the portal for the hospital.
- F. Once the login ID is created, hospital shall apply for empanelment through an online application on the web portal as defined in the detail guidelines.
- G. Each hospital will have to create a primary and a secondary user ID at the time of registration. This will ensure that the application can be accessed from the secondary user ID, in case the primary user is not available for some reason.
- H. All the required information and documents will need to be uploaded and submitted by the hospital through the web portal.
- I. Hospital will be mandated to apply for all specialties for which requisite infrastructure and facilities are available with it. Hospitals will not be permitted to choose specific specialties it wants to apply for unless it is a single specialty hospital.
- J. After registering on the web-portal, the hospital user will be able to check the status of their application. At any point, the application shall fall into one of the following categories:
 - i) Hospital registered but application submission pending
 - ii) Application submitted but document verification pending
 - iii) Application submitted with documents verified and under scrutiny by DEC/SEC.
 - iv) Application sent back to hospital for correction
 - v) Application sent for field inspection
 - vi) Inspection report submitted by DEC and decision pending at SEC level
 - vii) Application approved and contract pending
 - viii) Hospital empaneled
 - ix) Application rejected
 - x) Hospital de-empaneled
 - xi) Hospital blacklisted (2 years)

1.5. Role of DEC

- A. After the empanelment request by a hospital is filed, the application should be scrutinized by the DEC and processed completely within 15 days of receipt of application.
- B. A login account for a nodal officer from DEC will be created by SEC. This login ID will be used to download the application of hospitals and upload the inspection report.
- C. As a first step, the documents uploaded have to be correlated with physical - verification of original documents produced by the hospital. In case any documents are found wanting, the DEC may return the application to the hospital for rectifying any errors in the documents.
- D. After the verification of documents, the DEC will physically inspect the premises of the hospital and verify the physical presence of the details entered in the empanelment application, including but not limited to equipment, human resources, service standards and quality and submit a report in a said format through the portal along with supporting pictures/videos/document scans.
- E. DEC will ensure the visits are conducted for the physical verification of the hospital. The verification team will have at least one qualified medical doctor (minimum MBBS).
- F. The team will verify the information provided by the hospitals on the web-portal and will also verify that hospitals have applied for empanelment for all specialties as available in the hospital.
- G. In case during inspection, it is found that hospital has not applied for one or more specialties but the same facilities are available, then the hospital will be instructed to apply for the missing specialties within a stipulated a timeline (i.e. 7 days from the inspection date).
 - i) In this case, the hospital will need to fill the application form again on the web portal. However, all the previously filled information by the hospital will be pre-populated and hospital will be expected to enter the new information.
 - ii) If the hospital does not apply for the other specialties in the stipulated time, it will be disqualified from the empanelment process.
- H. In case during inspection, it is found that hospital has applied for multiple specialties, but all do not conform to minimum requirements under AB-MGRSBY then the hospital will only be empaneled for specialties that conform to AB-MGRSBY norms.
- I. The team will recommend whether hospital should be empaneled or not based on their field-based inspection/verification report.
- J. DEC team will submit its final inspection report to the state. The district nodal officer has to upload the reports through the portal login assigned to him/her.

- K. The DEC will then forward the application along with its recommendation to the SEC.

1.6. Role of SEC

- A. The SEC will consider, among other things, the reports submitted by the DEC and recommendation approve or deny or return back to the hospital the empanelment request.
- B. In case of refusal, the SEC will record in writing the reasons for refusal and either directs the hospital to remedy the deficiencies, or in case of egregious emissions from the empanelment request, either based on documentary or physical verification, direct the hospital to submit a fresh request for empanelment on the online portal.
- C. The SEC will also consider recommendations for relaxation of criteria of empanelment received from DEC or from the RSHAA and approve them to ensure that sufficient number and specialties of empaneled facilities are available in the states.
- D. Hospital will be intimated as soon as a decision is taken regarding its empanelment and the same will be updated on the AB-MGRSBY web portal. The hospital will also be notified through SMS/email of the final decision. If the application is approved, the hospital will be assigned a unique national hospital registration number under AB-MGRSBY.
- E. If the application is rejected, the hospital will be intimated of the reasons on the basis of which the application was not accepted and comments supporting the decision will be provided on the AB-MGRSBY web portal. Such hospitals shall have the right to file a review against the rejection with the State Health Agency within 15 days of rejection through the portal. In case the request for empanelment is rejected by the RSHAA in review, the hospitals can approach the Grievance Redressal Mechanism for remedy.
- F. In case the hospital chooses to withdraw from AB-MGRSBY, it will only be permitted to re-enter/ get re-empaneled under AB-MGRSBY after a period of 6 months.
- G. If a hospital is blacklisted for a defined period due to fraud/abuse, after following due process by the State Empanelment Committee, it can be permitted to re-apply after cessation of the blacklisting period or revocation of the blacklisting order, whichever is earlier.
- H. There shall be no restriction on the number of hospitals that can be empaneled under AB-MGRSBY in a district.
- I. *Final decision on request of a Hospital for empanelment under AB-MGRSBY shall be completed within **30 days** of receiving such an application.*

1.7. Signing of Contract

- A. Within **7 days** of approval of empanelment request by SEC, the State Government will sign a contract with the empaneled hospitals as per the template defined in the tender document.
- B. Tripartite agreement will be made between the Insurance Company, RSHAA and the hospital.
- C. Each empaneled hospital will need to provide a name of nodal officers who will be the focal point for the AB-MGRSBY for administrative and medical purposes.
- D. Once the hospital is empaneled, a separate admin user for the hospital will be created to carry out transactions for providing treatment to the beneficiaries.

1.8. Process for Disciplinary Proceedings and De-Empanelment

A. Institutional Mechanism

- i) De-empanelment process can be initiated by RSHAA after conducting proper disciplinary proceedings against empaneled hospitals on misrepresentation of claims, fraudulent billing, wrongful beneficiary identification, overcharging, charging money from patients unnecessarily, unnecessary procedures, false/misdiagnosis, referral misuse and other frauds that impact delivery of care to eligible beneficiaries. If any point of time Insurance Company finds any such misconduct on the part of the hospital, they can submit recommendation regarding the same to RSHAA. RSHAA reserves the right to investigate and validate the facts behind such recommendation and after that may take necessary action.
- ii) Hospital can contest the action of de-empanelment by Insurance Company with SEC/SHA. If hospital is aggrieved with actions of SEC/RSHAA, the former can approach the RSHAA to review its decision, following which it can request for redressal through the Grievance Redressal Mechanism as per guidelines.
- iii) In case of implementation through the insurance mode, the SEC and DEC will mandatorily include a representative of the Insurance Company when deliberating and deciding on disciplinary proceedings under the scheme.
- iv) The SEC may also initiate disciplinary proceedings based on field audit reports/survey reports/feedback reports/ complaints filed with them/ complaints.
- v) For disciplinary proceedings, the DEC may consider submissions made by the beneficiaries (through call centre/ mera hospital or any other application/ written submissions/Emails etc.) or directions from SEC or information from other sources to investigate a claim of fraud by a hospital.
- vi) On taking up such a case for fraud, after following the procedure defined, the DEC

will forward its report to the SEC along with its recommendation for action to be taken based on the investigation.

- vii) The SEC will consider all such reports from the DEC's and pass an order detailing the case and the penalty provisions levied on the hospital.
- viii) Any disciplinary proceeding so initiated shall have to be completed within 30 days.

B. Steps for Disciplinary Proceedings

Step 1 - Putting the provider on "Watch-list"

Based on the claims, data analysis and/or the provider visits, if there is any doubt on the performance of a Provider, the SEC on the request of the IC or the RSHAA or on its own findings or on the findings of the DEC, can put that hospital on the watch list. The data of such hospital shall be analysed very closely on a daily basis by the RSHAA/SEC for patterns, trends and anomalies and flagged events/patterns will be brought to the scrutiny of the DEC and the SEC as the case may be.

The IC shall notify such service provider that it has been put on the watch-list and the reasons for the same.

Step 2 – Issuing show-cause notice to the hospital

Based on the activities of the hospital if the insurer RSHAA believes that there are clear grounds of hospital indulging in wrong practices, a showcause notice shall be issued to the hospital. Hospital will need to respond to the notice within 7 days of receiving it.

Step 3 - Suspension of the hospital

A Provider can be temporarily suspended in the following cases:

- i) For the Providers which are on the "Watch-list" or have been issued showcause notice if the SEC observes continuous patterns or strong evidence of irregularity based on either claims data or field visit of the hospital or in case of unsatisfactory reply of the hospital to the showcause notice, the hospital may be suspended from providing services to beneficiaries under the scheme and a formal investigation shall be instituted.
- ii) If a Provider is not in the "Watch-list", but the SEC observes at any stage that it has data/ evidence that suggests that the Provider is involved in any unethical Practice/ is not adhering to the major clauses of the contract with the Insurance Company / Involved in financial fraud related to health insurance patients, it may immediately suspend the Provider from providing services to policyholders/insured patients and a formal investigation shall be instituted.

A formal letter shall be send to the concerned hospital regarding its suspension with mentioning the time frame within which the formal investigation will be completed.

Step 4 - Detailed Investigation

The detailed investigation shall be undertaken for verification of issues raised in disciplinary proceedings and may include field visits to the providers (with qualified allopathic doctor as part of the team), examination of case papers, talking with the beneficiary/ policyholders/insured (if needed), examination of provider records etc. If the investigation reveals that the report/ complaint/ allegation against the provider is not substantiated, the Insurance Company/SHA would immediately revoke the suspension (in case of suspension) on the direction of the SEC. A letter regarding revocation of suspension shall be sent to the provider within 24 hours of that decision.

Step 5 – Presentation of Evidence to the SEC

The detailed investigation report should be presented to the SEC and the detailed investigation should be carried out in stipulated time period of not more than 7 days. The insurance company will present the findings of the detailed investigation. If the investigation reveals that the complaint/allegation against the provider is correct, then the following procedure shall be followed:

- i) The hospital must be issued a “show-cause” notice seeking an explanation for the aberration.
- ii) In case the proceedings are under the SEC, after receipt of the explanation and its examination, the charges may be dropped or modified or an action can be taken as per the guidelines depending on the severity of the malafide/error. In cases of de-empanelment, a second show cause shall be issued to the hospital to make a representation against the order and after considering the reply to the second show cause, the SEC can pass a final order on de-empanelment. If the hospital is aggrieved with actions of SEC/RSHAA, the former can approach the RSHAA to review its decision, following which it can request for redressal through the Grievance Redressal Mechanism as per guidelines.
- iii) In case the preliminary proceedings are under the DEC, the DEC will have to forward the report to the SEC along with its findings and recommendations for a final decision. The SEC may ask for any additional material/investigation to be brought on record and to consider all the material at hand before issuing a final order for the same.

The entire process should be completed within 30 days from the date of suspension. The disciplinary proceedings shall also be undertaken through the online portal only.

Step 6 - Actions to be taken after De- empanelment

Once the hospital has been de-empaneled, following steps shall be taken:

- i) A letter shall be sent to the hospital regarding this decision.
- ii) A decision may be taken by the SEC to ask the RSHAA to lodge an FIR in case there is suspicion of criminal activity.
- iii) This information shall be sent to all the other Insurance Companies as well as other regulatory bodies and the MoHFW/ NHA.

- iv) The RSHAA may be advised to notify the same in the local media, informing all policyholders/insured about the de-empanelment ensuring that the beneficiaries are aware that the said hospital will not be providing services under AB-MGRSBY.
- v) A de-empaneled hospital cannot re-apply for empanelment for at least 2 years after de-empanelment. However, if the order for de-empanelment mentions a longer period, such a period shall apply for such a hospital.
- vi) Healthcare personnel (Treating doctors, radiologist, Pathologist) and diagnostic center found associated with fraud in a particular hospital may be debarred from working in other EHCPs under the scheme by RSHAA and appropriate legal action may also be taken.

C. Gradation of Offences

On the basis of the investigation report/field audits, the following charges may be found to be reasonably proved and a gradation of penalties may be levied by the SEC. However, this tabulation is intended to be as guidelines rather than mandatory rules and the SEC may take a final call on the severity and quantum of punishment on a case to case basis.

Penalties for Offences by the Hospital			
Case Issue	First Offence	Second Offence	Third Offence
Illegal cash payments by beneficiary	Full Refund to the beneficiary on production of original receipt and compensation 3 times of illegal payment to the RSHAA.	In addition to actions as mentioned for first offence, Rejection of claim for the case	De-empanelment/black-listing
Billing for services not provided	Rejection of claim and penalty of 3 times the amount claimed for services not provided to be paid to RSHAA	Rejection of claim and penalty of 8 times the amount claimed for services not provided to be paid to RSHAA.	De-empanelment
Up coding/ Unbundling/ Unnecessary Procedures	Rejection of claim and penalty of 8 times the excess amount claimed due to up coding /unbundling/Unnecess	Rejection of claim and penalty of 16 times the excess amount claimed due to up coding/unbundling/Unnecess	De-empanelment

	ary Procedures, to be paid to RSHAA.	ary Procedures, to be paid to RSHAA.	
Wrongful beneficiary Identification	Rejection of claim and penalty of 3 times the amount claimed for wrongful beneficiary identification to be paid to RSHAA	Rejection of claim and penalty of 8 times the amount claimed for wrongful beneficiary identification to be paid to RSHAA	De-empanelment
Non-adherence to AB- MGRSBY quality and service standard	In case of minor gaps, warning period of 2 weeks for rectification, for major gaps, Suspension of services until rectification of gaps and validation by SEC/ DEC	Suspension until rectification of gaps and validation by SEC/ DEC	De-empanelment

All these penalties are recommendatory and the SEC may inflict larger or smaller penalties depending on the severity/regularity/scale/intentionality on a case to case basis with reasons mentioned clearly in a speaking order.

These guidelines are only indicative in nature and RSHAA reserves the rights to modify or change, if required.

Annex 1: Detailed Empanelment Criteria

Category 1: Essential criteria:

A Hospital would be empaneled as a network private hospital with the approval of the Rajasthan State Health Assurance Agency if it adheres with the following minimum criteria:

1. Should have at least 10 inpatient beds with adequate spacing and supporting staff as per norms.
 - i. Exemption may be given for single-specialty hospitals like Eye and ENT.
 - ii. General ward - @80sq ft. per bed, or more in a Room with Basic amenities-bed, mattress, linen, water, electricity, cleanliness, patient friendly common washroom etc. Non-AC but with fan/Cooler and heater in winter.
2. It should have adequate and qualified medical and nursing staff (doctors¹& nurses²), physically in charge round the clock; (necessary certificates to be produced during empanelment).
3. Fully equipped and engaged in providing Medical /Surgical services, commensurate to the scope of service/ available specialties and number of beds.
 - i. Round-the-clock availability (or on-call) of a Surgeon and Anesthetist where surgical services/ day care treatments are offered.
 - ii. Round-the-clock availability (or on-call) of an Obstetrician, Paediatrician and Anesthetist where maternity services are offered.
 - iii. Round-the-clock availability of specialists (or on-call) in the concerned specialties having sufficient experience where such services are offered (e.g. Orthopaedics, ENT, Ophthalmology, Dental, general surgery (including endoscopy) etc.)
4. Round-the-clock support systems required for the above services like Pharmacy, Blood Bank, Laboratory, Dialysis unit, Endoscopy investigation support, Post op ICU care with ventilator support, X-ray facility (mandatory) etc., either 'In-House' or with 'Outsourcing arrangements', preferably with NABL accredited laboratories, with appropriate agreements and in nearby vicinity.
5. Round-the-clock Ambulance facilities (own or tie-up).
6. 24 hours emergency services managed by technically qualified staff wherever emergency services are offered
 - i. Casualty should be equipped with Monitors, Defibrillator, Nebulizer with accessories, Crash Cart, Resuscitation equipment, Oxygen cylinders with flow meter/ tubing/catheter/face mask/nasal prongs, suction apparatus etc. and with attached toilet facility.
7. Mandatory for hospitals wherever surgical procedures are offered:
 - i. Fully equipped Operation Theatre of its own with qualified nursing staff under its employment round the clock.
 - ii. Post-op ward with ventilator and other required facilities.

8. Wherever intensive care services are offered it is mandatory to be equipped with an Intensive Care Unit (For medical/surgical ICU/HDU/Neonatal ICU) with requisite staff
 - i. The unit is to be situated in close proximity of operation theatre, acute care medical, surgical ward units, labour room and maternity room as appropriate.
 - ii. Suction, piped oxygen supply and compressed air should be provided for each ICU bed.
 - iii. Further ICU- where such packages are mandated should have the following equipment:
 - 1) Piped gases
 - 2) Multi-sign Monitoring equipment
 - 3) Infusion of inotropic support
 - 4) Equipment for maintenance of body temperature
 - 5) Weighing scale
 - 6) Manpower for 24x7 monitoring
 - 7) Emergency cash cart
 - 8) Defibrillator.
 - 9) Equipment for ventilation.
 - 10) In case there is common Paediatric ICU then Paediatric equipments, e.g.: paediatric ventilator, Paediatric probes, medicines and equipment for resuscitation to be available.
 - iv. HDU (high dependency unit) should also be equipped with all the equipment and manpower as per HDU norms.
9. Records Maintenance: Maintain complete records as required on day-to-day basis and is able to provide necessary records of hospital / patients to the Society/Insurer or his representative as and when required.
 - i. Wherever automated systems are used it should comply with MoHFW/ NHA EHR guidelines (as and when they are enforced)
 - ii. All AB-MGRSBY cases must have complete records maintained
 - iii. Share data with designated authorities for information as mandated.
10. Legal requirements as applicable by the local/state health authority.
11. Adherence to Standard treatment guidelines/Clinical Pathways for procedures as mandated by NHA/RSHAA from time to time.
12. Registration with the Income Tax Department.
13. NEFT enabled bank account
14. Telephone/Fax
15. Safe drinking water facilities/Patient care waiting area
16. Uninterrupted (24 hour) supply of electricity and generator facility with required capacity suitable to the bed strength of the hospital.
17. Waste management support services (General and Bio Medical) – in compliance with the bio-medical waste management act and certificate from State Pollution Control Board.
18. Appropriate fire-safety measures.
19. Provide space for a separate kiosk for AB-MGRSBY beneficiary management (AB-MGRSBY non-medical³ coordinator) at the hospital reception.
20. Ensure a dedicated medical officer to work as a medical⁴ co-ordinator towards AB-MGRSBY beneficiary management (including records for follow-up care as prescribed)

21. Ensure appropriate promotion of AB-MGRSBY in and around the hospital (display banners, brochures etc.) towards effective publicity of the scheme in co-ordination with the RSHAA/ district level AB-MGRSBY team.
22. IT Hardware requirements (desktop/laptop with internet, printer, webcam, scanner/ fax, bio-metric device etc.) as mandated by the RSHAA.

Category 2: Advanced criteria:

Over and above the essential criteria required to provide basic services under AB- MGRSBY (as mentioned in Category 1) those facilities undertaking defined speciality packages (as indicated in the benefit package for specialities mandated to qualify for advanced criteria) should have the following:

1. These empanelled hospitals may provide specialized services such as Cardiology, Cardiothoracic surgery, Neurosurgery, Nephrology, Reconstructive surgery, Oncology, Paediatric Surgery, Neonatal intensive care etc.
2. A hospital could be empanelled for one or more specialities subject to it qualifying to the concerned speciality criteria for respective packages
3. Such hospitals should be fully equipped with ICCU/SICU/ NICU/ relevant Intensive Care Unit in addition to and in support of the OT facilities that they have.
4. Such facilities should be of adequate capacity and numbers so that they can handle all the patients operated in emergencies.
 - i. The Hospital should have sufficient experienced specialists in the specific identified fields for which the Hospital is empanelled as per the requirements of professional and regulatory bodies/ as specified in the clinical establishment act/ State regulations.
 - ii. The Hospital should have sufficient diagnostic equipment and support services in the specific identified fields for which the Hospital is empanelled as per the requirements specified in the clinical establishment act/ State regulations.
5. Indicative domain specific criteria are as under:

A. Specific criteria for Cardiology/ CTVS

1. CTVS theatre facility (Open Heart Tray, Gas pipelines Lung Machine with TCM, defibrillator, ABG Machine, ACT Machine, Hypothermia machine, IABP, cautery etc.)
2. Post-op with ventilator support
3. ICU Facility with cardiac monitoring and ventilator support
4. Hospital should facilitate round the clock cardiologist services.
5. Availability of support speciality of General Physician & Paediatrician
6. Fully equipped Catheterization Laboratory Unit with qualified and trained Paramedics.

B. Specific criteria for Cancer Care

1. For empanelment of Cancer treatment, the facility should have a Tumour Board which decides a comprehensive plan towards multi-modal treatment of the patient or if not then appropriate linkage mechanisms need to be established to the nearest regional cancer centre (RCC). Tumor Board should consist of a qualified team of Surgical, Radiation and Medical /Paediatric Oncologist in order to ensure the most appropriate treatment for the patient.

2. Relapse/recurrence may sometimes occur during/ after treatment. Retreatment is often possible which may be undertaken after evaluation by a Medical/ Paediatric Oncologist/ Tumor Board with prior approval and pre-authorization of treatment.
3. For extending the treatment of chemotherapy and radiotherapy the hospital should have the requisite Pathology/ Haematology services/ infrastructure for radiotherapy treatment viz. for cobalt therapy, linear accelerator radiation treatment and brachytherapy available in-house. In case such facilities are not available in the empanelled hospital for radiotherapy treatment and even for chemotherapy, the hospital shall not perform the approved surgical procedure alone but refer the patients to other centres for follow-up treatments requiring chemotherapy and radiotherapy treatments. This should be indicated where appropriate in the treatment approval plan.
4. Further hospitals should have following infrastructure for providing certain specialized radiation treatment packages such as stereotactic radiosurgery/ therapy.
 - i. Treatment machines which are capable of delivering SRS/SRT
 - ii. Associated Treatment planning system
 - iii. Associated Dosimetry systems

C. Specific criteria for Neurosurgery

1. Well Equipped Theatre with qualified paramedical staff, C-Arm, Microscope, neurosurgery compatible OT table with head holding frame (horse shoe, may field / sugita or equivalent frame).
2. ICU facility
3. Post-op with ventilator support
4. Facilitation for round the clock MRI, CT and other support bio-chemical investigations.
5. Hospital should facilitate round the clock Neurosurgeon, Anesthetist services.

D. Specific criteria for Burns, Plastic & Reconstructive surgery

1. The Hospital should have full time / on - call services of qualified plastic surgeon and support staff with requisite infrastructure for corrective surgeries for post burn contractures.
2. Isolation wards having monitor, defibrillator, central oxygen line and all OT equipment.
3. Well Equipped Theatre
4. Intensive Care Unit.
5. Post-op with ventilator support
6. Trained Paramedics
7. Post-op rehab/ Physiotherapy support/ Psychology support.

E. Specific criteria for /Paediatric Surgery

1. The Hospital should have full time/on call services of paediatric surgeons
2. Well-equipped theatre
3. ICU support
4. Support services of paediatrician
5. Availability of mother rooms and feeding area.
6. Availability of radiological/ fluoroscopy services (including IITV), Laboratory services and Blood bank.

F. Specific criteria for specialized new born care.

1. The hospital should have well developed and equipped neonatal nursery/Neonatal ICU (NICU) appropriate for the packages for which empanelled, as per norms
2. Availability of radiant warmer/ incubator/ pulse oximeter/ photo therapy/ weighing scale/ infusion pump/ ventilators/ CPAP/ monitoring systems/ oxygen supply / suction / infusion pumps/ resuscitation equipment/ breast pumps/ bilimeter/ KMC (Kangaroo Mother Care) chairs and transport incubator - in enough numbers and in functional state; access to hematological, biochemistry tests, imaging and blood gases, using minimal sampling, as required for the service packages
3. For Advanced Care and Critical Care Packages, in addition to 2. above: parenteral nutrition, laminar flow bench, invasive monitoring, in-house USG. Ophthalmologist on call.
4. Trained nurses 24x7 as per norms
5. Trained Paediatrician(s) round the clock
6. Arrangement for 24x7 stay of the Mother – to enable her to provide supervised care, breastfeeding and KMC to the baby in the nursery/NICU and upon transfer therefrom; provision of bedside KMC chairs.
7. Provision for post-discharge follow up visits for counselling for feeding, growth / development assessment and early stimulation, ROP checks, hearing tests etc.

G. Specific criteria for Polytrauma

1. Shall have Emergency Room Setup with round the clock dedicated duty doctors.
2. Shall have the full-time service availability of Orthopaedic Surgeon, General Surgeon, and anaesthetist services.
3. The Hospital shall provide round the clock services of Neurosurgeon, Orthopaedic Surgeon, CT Surgeon, General Surgeon, Vascular Surgeon and other support specialists as and when required based on the need.
4. Shall have dedicated round the clock Emergency theatre with C-Arm facility, Surgical ICU, Post-Op Setup with qualified staff.
5. Shall be able to provide necessary diagnostic support round the clock including specialized investigations such as CT, MRI, emergency biochemical investigations.

H. Specific criteria for Nephrology and Urology Surgery

1. Dialysis unit
2. Well-equipped operation theatre with C-ARM
3. Endoscopy investigation support
4. Post op ICU care with ventilator support
5. Sew lithotripsy equipment
6. Hospital should facilitate round the clock Urologist, Nephrologist and Anaesthetist's services.

Schedule 6: Service Agreement with Empaneled Health Care Providers

To be provided later.

Schedule 7: List of Empanelled Health Care Providers under the Scheme.

To be provided later.

Schedule 8: Premium Payment Guidelines

A. Release of Premium Payment

- i) A flat premium per family, irrespective of the number of members under AB- MGRSBY in that family, will be determined through open tendering process.
- ii) The modalities that will be adhered for release of premium for the implementation of AB- MGRSBY will be as under:

I – Number of Eligible Beneficiary Families

The premium for the targeted beneficiary families will be as per the eligibility criteria of AB- MGRSBY based on the NFSA and /or SECC,2011 Database through unique family identity card as decided by GoR

II-Stage of Release of Premium:

Rajasthan State Health Assurance Agency(RSHAA) will, on behalf of the Beneficiary Family Units that are targeted/identified by the RSHAA and covered by the Insurer, pay the Premium for the Cover to the Insurer in accordance with the following schedule:

- a. The premium would be paid every year in four quarterly instalments on or before the first day of the quarter every year. The policy year being reckoned from the date of commencement of the policy. Amount for the premium of first quarter shall be arrived on number of beneficiary families showing on portal 7 days prior to the commencement of first quarter.
- b. The premium amount will be in proportion to the number of beneficiary families showing on portal 7 days prior to the commencement of that quarter.
- c. An amount of 1 % of the premium to be paid,shall be deducted from the premium paid as per the schedule for the purposes of carrying out IEC,monitoring& evaluation

by RSHAA. This amount shall be included in the administrative cost mentioned in the **clause 10.2.b**

- d. For the beneficiary families that may be included during intermediate period between two quarters, premium amount will be paid with the premium installment of next quarter. Calculation of this premium amount will be done monthly on Pro-rata basis, based on addition of families in every month of the quarter.

B. Refund of Premium

The Insurer will be required to refund premium as stipulated below if they fail to reach the claim ratio specified in comparison with the premium paid (excluding GST & Other taxes / Duties) below in the full period of insurance policy period. The premium refund shall be as per the formula below:

- I. The RSHAA shall issue a letter to the Insurer stating the Insurer's average Claim Ratio for all 12 months of Policy Cover Period. In the letter, the RSHAA shall indicate the amount of premium that the Insurer shall be obliged to refund. The amount of premium to be refunded shall be calculated based on the provisions as mentioned below.
- II. 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 RSHAA within 30 days. The percentage that will be need to be refunded will be as per the following:
 - a. Administrative cost allowed 10% if claim ratio less than 60%.
 - b. Administrative cost allowed 12% if claim ratio between 60-70%.
 - c. Administrative cost allowed 15% if claim ratio between 70- 85%.
- Administrative costs includes 1% of the premium deducted for IEC and monitoring & evaluation purposes.
- III. The entire surplus as determined through formula mentioned above should be refunded by the insurer to the RSHAA within 30 days.
- IV. If the Insurer delays payment of or fails to pay the refund amount within 30 days from the date of communication by RSHAA, then the Insurer shall be

liable to pay interest at the rate of one percent of the refund amount due and payable to the RSHAA for every 7 days of delay beyond such 30 day period.

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

D. No Separate Fees, Charges or Premium

The Insurer shall not charge any Beneficiary Family Unit or any of the Beneficiaries any separate fees, charges, commission or premium, by whatever name called, for providing the benefits. However, the aforesaid provision shall not be applicable, if in case, the beneficiary is required to take treatment above the amount of risk cover.

These guidelines are only indicative in nature and RSHAA reserves the rights to modify or change, if required.

Schedule 9: Claims Management Guidelines including Portability

All Empanelled Health Care Providers (EHCP) will make use of IT system of AB- MGRSBY to manage the claims related transactions. IT system of AB- MGRSBY has been developed for online transactions and all stakeholders are advised to maintain online transactions preferably to ensure the claim reporting in real time. However, keeping in mind the connectivity constraints faced by some districts an offline arrangement has also been included in the IT system that has to be used only when absolute. The AB- MGRSBY strives to make the entire claim management paperless that is at any stage of claim registration, intimation, payment, investigation by EHCP or by the Insurer the need of submission of a physical paper shall not be required. This mean that this claim data will be sent electronically through IT system to the Central/ State server. The NHA, RSHAA, Insurer and EHCP shall be able to access this data with respect to their respective transaction data only.

Once a claim has been raised (has hit the Central/State server), the following will need to be adhered to by the Insurance Company regarding claim settlement:

1. Claim Payments and Turn-around Time

The Insurer shall follow the following process regarding the processing of claims received from the EHCP:

- A. The Insurer or the agency (IRDAI compliant only) appointed by it shall decide on the acceptance or rejection of any claim received from an EHCP. Any rejection notice issued by the Insurer or the agency to EHCP shall clearly state that rejection is subject to the EHCP's right to appeal against rejection of the claim.
- B. If a claim is not rejected, the Insurer shall either make the payment (based on the applicable package rate) or shall conduct further investigation into the claim received from EHCP.
- C. The process specified in Clause A and B above (rejection or payment including investigation) in relation to claim shall be carried out in such a manner that it is completed (Turn-around Time, TAT) shall be no longer than 15 calendar days (irrespective of the number of working days).
- D. The EHCP is expected to upload all claim related documents within 24 hours of discharge of the beneficiary.
- E. The counting of days for TAT shall start from the date of claim submission.
- F. The Insurer shall make claim payments to each EHCP against payable claims on a weekly basis through electronic transfer to such EHCP's designated bank account.

Insurer is then also required to provide the details of such payments against each paid claim on the online portal (IT System of AB-MGRSBY).

- G. All claims investigations shall be undertaken by a qualified and experienced medical staff/team, with at least one MBBS degree holder, appointed by the Insurer or its representative, to ascertain the nature of the disease, illness or accident and to verify the eligibility thereof for availing the benefits under this Agreement and relevant Cover Policy. The Insurer's medical staff shall not impart any advice on any treatment or medical procedures or provide any guidance related to cure or other care aspects. However, the Insurance Company can ensure that the treatment was in conformity to the Standard Treatment Guidelines, if implemented.
- H. The Insurer will need to update the details on online portal (IT system of AB-MGRSBY) of:
- i) All claims that are under investigation on a fortnightly basis for review; and
 - ii) Every claim that is pending beyond 15 days, along with its reasons for delay in processing such Claim.
 - iii) The Insurer may collect at its own cost, complete Claim papers (including diagnostic reports) from the EHCP, if required for audit purposes for claims under investigation. This shall not have any bearing on the Claim Payments to the Empanelled Health Care Provider.

2. Penalty on Delay in Settlement of Claims

There will be a penalty for delay in settlement of claims by the Insurance Company beyond the turnaround time of 15 days. A penalty of 1% of claimed amount per week for delay beyond 15 days to be paid directly to the hospitals by the Insurance Company. This penalty will become due after 30 days in case of Inter-State claims or portability of benefits

3. Update of Claim Settlement

The Insurance Company will need to update the claim settlement data on the portal on a daily basis and this data will need to be updated within 24 hours of claims payment. Any claim payment which has not been updated shall be deemed to have been unpaid and the interest, as applicable, shall be charged thereon.

4. Right of Review, 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 Trust/Insurer, if the Empaneled Health Care Provider feels that the Claim is payable.

- A. Claims for which EHCP, are wrongly rejected, then it may file review with IC and IC will decide such claims within 15 days. A review may be made within thirty (30) days of the said rejection being intimated to the hospital
- B. If EHCP is still aggrieved with the review by IC, then the matter may be filed in GRC/CRC .
- C. GRC/CRC shall examine the case after review by IC; within 30 working days as far as possible and recommend its decision to the concerned GRC.
- D. An appeal may be made within thirty (30) days of the said rejection being intimated to the hospital to the District-level Grievance Committee (DGRC) which may decide the matter itself or can forward the matter to the claims review committee.
- E. RSHAA may prescribe token fees for hearing these appeals in order to avoid frivolous matters being forwarded to GRC/CRC. The details will be shared later.

5. Guidelines for Portability

An Empaneled Health Care Provider (EHCP) under AB-PMJAY in any state should provide services as per AB-PMJAY guidelines to beneficiaries from any other state also participating in AB-PMJAY. This means that a beneficiary will be able to get treatment outside the EHCP network of his/her Home State.

Any empaneled hospital under AB-PMJAY will not be allowed to deny services to any AB-MGRSBY beneficiary. All interoperability cases shall be mandatorily under pre-authorisation mode and pre-authorisation guidelines of the treatment delivery state in case of AB-PMJAY implementing States / UTs or indicative pre-authorisation guidelines as issued by NHA/RSHAA, shall be applicable.

Enabling Portability

To enable portability under the scheme, the stakeholders need to be prepared with the following:

- A. **States:** Each of the States participating in AB-PMJAY will sign MoU with Central Government which will allow all any the hospital empaneled hospitals by that state under AB-PMJAY to provide services to eligible beneficiaries of other States from across the country. Moreover, the state shall also be assured that its AB-PMJAY

beneficiaries will be able to access services at all AB-PMJAYempaneled hospitals seamlessly in other states across India.

- B. **Empaneled hospitals:** The Empaneled Hospital shall have to sign a tripartite contract with its insurance company and Rajasthan State Health Assurance Agency which explicitly agrees to provide AB-PMJAYservices to AB-PMJAY beneficiaries from both inside and outside the state and the Insurance Company agrees to pay to the EHCP through the inter-agency claim settlement process, the claims raised for AB-PMJAYbeneficiaries that access care outside the state in ABPMJAYempaneled healthcare provider network.
- C. **Insurance companies/Trusts:** The Insurance Company (IC) signs a contract with all other IC's and Trusts in the States / UTs under AB-PMJAYto settle down the interoperability related claims within 30 days settlement so that the final payment is made for a beneficiary by the Insurance Company or Trust of his/her home state.
- D. **IT systems:** The IT System will provide a central clearinghouse module where all inter-insurance, inter trust and trust-insurance claims shall be settled on a monthly/bi-monthly basis. The IT System will also maintain a Balance Check Module that will have data pushed on it in real time from all participating entities. The central database shall also be able to raise alerts/triggers based on suspicious activity with respect to the beneficiary medical claim history based on which the treatment state shall take necessary action without delay.
- E. **Grievance Redressal:** The Grievance Redressal Mechanism will operate as in normal cases except for disputes between Beneficiary of Home State and EHCP or IC of Treatment State and between Insurance Companies/Trusts of the Home State and Treatment State. In case of dispute between Beneficiary and EHCP or IC, the matter shall be placed before the SHA of the treatment state. In cases of disputes between IC/Trust of the two states, the mattershould be taken up by bilateral discussions between the SHAs and in case of non-resolution, brought to the NHA for mediation. The IC/Trusts of Home State should be able to raise real time flags for suspect activities with the Beneficiary State and the Beneficiary State shall be obligated to conduct a basic set of checks as requested by the Home State IC/Trust. These clauses

have to be built in into the agreement between the ICs and the Trusts. The NHA shall hold monthly mediation meetings for sorting out intra-agency issues as well as sharing portability related data analytics.

- F. **Fraud Detection:** Portability related cases will be scrutinized separately by the NHA for suspicious transactions, fraud and misuse. Data for the same shall be shared with the respective agencies for necessary action. The SHAs, on their part, must have a dedicated team for conducting real time checks and audits on such flagged cases with due diligence. The IC working in the State where benefits are delivered shall also be responsible for fraud prevention and investigation.

Implementation Arrangements of Portability

- A. **Packages and Package Rates:** The Package list for portability will be the list of mandatory AB-PMJAYpackages released by the NHA and package rates as applicable and modified by the Treatment State will be applicable. The Clause for honoring these rates by all ICs and Trusts shall have to be built into the agreement.

- Clauses for preauthorization requirements and transaction management system shall be as per the treatment state guidelines.
- The beneficiary balance, reservation of procedures for public hospitals as well as segmentation (into secondary/tertiary care or low cost/high cost procedures) shall be as per the home state guidelines.
- Therefore, for a patient from Rajasthan, taking treatment in Tamil Nadu for CTVS in an EHCP – balance check and reservation of procedure check will be as per Rajasthan rules, but TMS and preauthorization requirements shall be as per TN rules. The hospital claim shall be made as per TN rates for CTVS by the TN SHA (through IC or trust) and the same rate shall be settled at the end of every month by the Rajasthan SHA (through IC or trust).

- B. **Empanelment of Hospitals:** The SHA of every state in alliance with AB-PMJAYshall be responsible for empaneling hospitals in their territories. This responsibility shall

include physical verification of facilities, specialty related empanelment, medical audits, post procedure audits etc.

- For empanelment of medical facilities that are in a non AB-PMJAYstate, any AB-PMJAYstate can separately empanel such facilities. Such EHCP shall become a member of provider network for all AB-PMJAYimplementing States. NHA can also empanel a CGHS empaneled provider for AB-PMJAYin non AB-PMJAYstate.
- Each SHA which empanels such a hospital shall be separately and individually responsible for ensuring adherence of all scheme requirements at such a hospital.

C. Beneficiary Identification: In case of beneficiaries that have been verified by the home state, the treatment state EHCP shall only conduct identity verification and admit the patient as per the case.

- In case of beneficiaries that have not been so verified, the treatment EHCP shall conduct the Beneficiary Identification Search Process and the documentation for family verification (ration card/family card of home state) to the Home State Agency for validation.
- The Home State Agency shall validate and send back a response in priority with a service turnaround time of 30 minutes. In case the home agency does not send a final response (IC/Trust check), deemed verification of the beneficiary shall be undertaken and the record shall be included in the registry. The home state software will create a balance for such a family entry.
- The empaneled hospital will determine beneficiary eligibility and send the linked beneficiary records for approval to the Insurance company/trust of Treatment State which in turn will send the records to the Insurance company/trust in the home State of beneficiary. The beneficiary approval team of the Insurance company/trust in the home State of beneficiary will accept/reject the case and convey the same to the Insurance company/trust in the State of hospital which will then inform the same to the hospital. In case the beneficiary has an E-Card (that is, he/she has already undergone

identification earlier), after a KYC check, the beneficiary shall be accepted by the EHCP.

- If the NHA and the SHA agree to provide interoperability benefits to the entire Home State Beneficiary List, the identification module shall also include the Home State Beneficiary Database for validation and identification of eligible beneficiaries.

D. Balance Check: After identification and validation of the beneficiary, the balance check for the beneficiary will be done from the home state. The balance in the home state shall be blocked through the necessary API and updated once the claim is processed. The NHA may provide a centralised balance check facility.

E. Claim Settlement: A claim raised by the empaneled hospital will first be received by the Trust/Insurer of the Treatment State which shall decide based on its own internal processes. The approval of the claim shall be shared with the Home State Insurance Company/Trust which can raise an objection on any ground within 3 days. In case the Home State raises no objection, the Treatment State IC/Trust shall settle the claim with the hospital. In case the Home State raises an objection, the Treatment State shall settle the claim as it deems fit. However, the objection of the Home State shall only be recommendatory in nature and the Home State shall have to honor the decision of the Treatment State during the time of interagency settlement.

F. Fraud Management: In case the Trust/Insurer of the home State of beneficiary has identified fraudulent practices by the empaneled hospital, the Trust/Insurer should inform the SHA of the Treatment State of EHCP along with the supporting documents/information. The SHA of the Treatment State shall undertake the necessary action on such issues and resolution of such issues shall be mediated by the NHA during the monthly meetings.

G. Expansion of Beneficiary Set: In case, there is an alliance between AB-PMJAY and any State Scheme or AB-PMJAY has been expanded in the Home State, the above process for portability may be followed for all beneficiaries of the Home State.

- H. IT Platform:** The states using their own platform shall have to provide interoperability with the central transaction and beneficiary identification system to operationalize guidelines for portability for AB-PMJAY.
- I. Modifications:** The above guidelines may be modified from time to time by the National Health Agency and shall apply on all the states participating in the PMJAY.

These guidelines are only indicative in nature and RSHAA reserves the rights to modify or change, if required.

Schedule 10: Template for Medical Audit

Template for Medical Audit

Patient/Family ID No.		Hospital ID	
Patient Name		Hospital Name	
Case No.		Hospital Contact No.	
Date of Admission		Date of Discharge	
Date of Audit		Time of Audit	
Name of the Auditor		Contact No. (Auditor)	

Audit Observations

No.	Criteria	Yes	No	Comments
1.	Does each medical record file contain:			
a.	Is discharge summary included?			
b.	Are significant findings recorded?			
c.	Are details of procedures performed recorded?			
d.	Is treatment given mentioned?			
e.	Is patient's condition on discharge mentioned?			
f.	Is final diagnosis recorded with main and other conditions?			
g.	Are instructions for follow up provided?			
2.	Patient history and evidence of physical examination is evident.			
a.	Is the chief complaint recorded?			
b.	Are details of present illness mentioned?			
c.	Is relevant medical history of family members present?			
d.	Body system review?			
e.	Is a report on physical examination available?			
f.	Are details of provisional diagnosis mentioned?			
3.	Is an operation report available? (only if surgical procedure done)			
a.	Does the report include pre-operative diagnosis?			
b.	Does the report include post-operative diagnosis?			
c.	Are the findings of the diagnosis specified?			
d.	Is the surgeon's signature available on records?			
e.	Is the date of procedure mentioned?			
4.	Progress notes from admission to discharge			
a.	Are progress reports recorded daily?			
b.	Are progress reports signed and dated?			
c.	Are progress reports reflective of patient's admission status?			
d.	Are reports of patient's progress filed chronologically?			
e.	Is a final discharge note available?			
5	Are pathology, laboratory, radiology reports available (if			

No.	Criteria	Yes	No	Comments
	ordered)?			
6	Do all entries in medical records contain signatures?			
a.	Are all entries dated?			
b.	Are times of treatment noted?			
c.	Are signed consents for treatment available?			
7	Is patient identification recorded on all pages?			
8	Are all nursing notes signed and dated?			

Overall observations of the Auditor:

Significant findings:

Recommendations:

Date:

Signature of the Auditor

Schedule 11: Template for Hospital Audit

Template for Hospital Audit

Hospital Name		Hospital ID	
Hospital Address			
Hospital Contact No.			
Date of Audit		Time of Audit	
Name of the Auditor		Contact No. (Auditor)	

Audit Observations

No.	Criteria	Yes	No	Comments
1.	Was there power cut during the audit?			
2.	If yes, what was the time taken for the power back to resume electric supply?			
3.	Was an AB-MGRSBY kiosk present in the reception area?			
4.	Was any staff present at the kiosk?			
5.	Did you see the AB-MGRSBY Empanelled Hospital Board displayed near the kiosk in the reception area?			
6.	Was the kiosk prominently visible?			
7.	Was the kiosk operational in local language?			
8.	Were AB-MGRSBY brochures available at the kiosk?			
9.	Were the toilets in the OPD area clean?			
10.	Was drinking water available in the OPD area for patients?			

Overall observations of the Auditor:

Significant findings:

Recommendations:

Signature of the Auditor

Date:

Schedule 12: Key Performance Indicators

SN	KPIs	Time Frame	Penalty
1	Setting up of a State Project Office and Appointment of Project Head and other Staff (to be specified by RSHAA) for co-ordination and Scheme implementation	30 days after signing of Insurance Contract.	Rs. 25,000 per week and part thereof.
2	Establishment of District Offices	30 days after signing of Insurance Contract.	Rs. 5,000 per week (per district office) and part thereof.
3	Claims-related Activities:		
	a. Pre-authorisation	6 hours for emergency cases and 12 hours for all other cases; except for specified packages.	Automatic approval post 6 and 12 hours for emergency and non-emergency cases respectively.
	Rejection of claim by a non specialist.		Penalty for the same amount of claim rejected, payable to RSHAA.
	Pre-Auth Approval done without consultation with specialist.		Penalty of 5% of the claim amount, payable to RSHAA.
	Pre-Auth Rejection without query.		Penalty of 5% of the claim amount, payable to RSHAA.
	b. Scrutiny and Claim approval from EHCP	Within 15 days of claim submission for the first time excluding the days when the claim is pending with the network hospital.	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 RSHAA in making payment of the Premium that is due and payable, then the Insurer shall be liable to pay a penal interest to the EHCP at the rate of 1% of the Claim amount for every 15 days of delay beyond the 30-day period.

4	Delays in compliance to orders of the Grievance Redressal Committee (GRC)	Beyond 30 days.	Rs. 25,000 for the first month of delay in implementing GRC order, Rs. 50,000 per month for every subsequent month thereafter.
5	Completing minimum audit targets - both claims and medical audits (at least 5% of total claims for medical and claims audits)	Specified number of medical and claims audit reports to be submitted in the reporting quarter.	Rs. 10,000 for each audit report not submitted as per plan.
6	Timely submission of a specified minimum audit reports on a quarterly basis – both claims and medical audits <i>(To be implemented only when the IT Platform has developed the capability of allowing online filing of these reports)</i>	Specified number of medical & claims audit reports to be submitted within -7 days of completing the audit.	Rs. 10,000 for each audit report not submitted in time.

Schedule 13: Indicative Fraud Triggers

Claim History Triggers

1. Impersonation.
2. Mismatch of in house document with submitted documents.
3. Claims without signature of the AB-MGRSBY Beneficiary on pre-authorisation form.
4. Second claim in the same year for an acute medical illness/surgical.
5. Claims from multiple hospitals with same owner.
6. Claims from a hospital located far away from AB-MGRSBY Beneficiary's residence, pharmacy bills away from hospital/residence.
7. Claims for hospitalization at a hospital already identified on a "watch" list or black listed hospital.
8. Claims from members with no claim free years, i.e. regular claim history.
9. Same AB-MGRSBY Beneficiary claimed in multiple places at the same time.
10. Excessive utilization by a specific member belonging to the AB-MGRSBY Beneficiary Family Unit.
11. Deliberate blocking of higher-priced Package Rates to claim higher amounts.
12. Claims with incomplete/ poor medical history: complaints/ presenting symptoms not mentioned, only line of treatment given, supporting documentation vague or insufficient.
13. Claims with missing information like post-operative histopathology reports, surgical / anaesthetist notes missing in surgical cases.
14. Multiple claims with repeated hospitalization (under a specific policy at different hospitals or at one hospital of one member of the AB-MGRSBY Beneficiary Family Unit and different hospitals for other members of the AB-MGRSBY Beneficiary Family Unit), multiple claims towards the end of Policy Cover Period, close proximity of claims.

Admissions Specific Triggers

15. Members of the same AB-MGRSBY Beneficiary Family Unit getting admitted and discharged together.
16. High number of admissions.
17. Repeated admissions.
18. Repeated admissions of members of the AB-MGRSBY Beneficiary Family Unit.
19. High number of admission in odd hours.
20. High number of admission in weekends/ holidays.
21. Admission beyond capacity of hospital.
22. Average admission is beyond bed capacity of the EHCP in a month.
23. Excessive ICU admission.
24. High number of admission at the end of the Policy Cover Period.
25. Claims for medical management admission for exactly 24 hours to cover OPD treatment, expensive investigations.

26. Claims with Length of Stay (LoS) which is in significant variance with the average LoS for a particular ailment.

Diagnosis Specific Triggers

27. Diagnosis and treatment contradict each other.
28. Diagnostic and treatment in different geographic locations.
29. Claims for acute medical illness which are uncommon e.g. encephalitis, cerebral malaria, monkey bite, snake bite etc.
30. Ailment and gender mismatch.
31. Ailment and age mismatch.
32. Multiple procedures for same AB-MGRSBY Beneficiary – blocking of multiple packages even though not required.
33. One-time procedure reported many times.
34. Treatment of diseases, illnesses or accidents for which an Empanelled Health Care Provider is not equipped or empanelled for.
35. Substitution of packages, for example, Hernia as Appendicitis, Conservative treatment as Surgical.
36. Part of the expenses collected from AB-MGRSBY Beneficiary for medicines and screening in addition to amounts received by the Insurer.
37. ICU/ Medical Treatment blocking done for more than 5 days of stay, other than in the case of Critical Illness.
38. Overall medical management exceeds more than 5 days, other than in the case of Critical Illness.
39. High number of cases treated on an OOP basis at a given provider, post consumption of financial limit.

Billing and Tariff based Triggers

40. Claims without supporting pre/ post hospitalisation papers/ bills.
41. Multiple specialty consultations in a single bill.
42. Claims where the cost of treatment is much higher than expected for underlying etiology.
43. High value claim from a small hospital/nursing home, particularly in class B or C cities not consistent with ailment and/or provider profile.
44. Irregular or inordinately delayed synchronization of transactions to avoid concurrent investigations.
45. Claims submitted that cause suspicion due to format or content that looks "too perfect" in order. Pharmacy bills in chronological/running serial number or claim documents with colour photocopies. Perfect claim file with all criteria fulfilled with no deficiencies.
46. Claims with visible tempering of documents, overwriting in diagnosis/ treatment papers, discharge summary, bills etc. Same handwriting and flow in all documents from first prescription to admission to discharge. X-ray plates without date and side

printed. Bills generated on a "Word" document or documents without proper signature, name and stamp.

General

- 47. Qualification of practitioner doesn't match treatment.
- 48. Specialty not available in hospital.
- 49. Delayed information of claim details to the Insurer.
- 50. Conversion of OP to IP cases (compare with historical data).
- 51. Not dispensing post-hospitalization medication to AB-MGRSBY Beneficiaries.

Schedule 14: Indicators to Measure Effectiveness of Anti-Fraud Measures

1. Monitoring the number of grievances per 1,00,000AB-MGRSBY Beneficiaries.
2. Proportion of Emergency pre-authorisation requests.
3. Percent of conviction of detected fraud.
4. Share of pre-authorisation and claims audited.
5. Claim repudiation/ denial/ disallowance ratio.
6. Number of dis-empanelment/ number of investigations.
7. Share of AB-MGRSBY Beneficiary Family Units physically visited by Scheme functionaries.
8. Share of pre-authorisation rejected.
9. Reduction in utilization of high-end procedures.
10. AB-MGRSBY Beneficiary satisfaction.
11. Share of combined/ multiple-procedures investigated.
12. Share of combined/ multiple-procedures per 1,00,000 procedures.
13. Pre-authorisation pendency rate and Claim pendency rate per 100 cases decided OR percent of pre-authorisation decided after additional observation being attended + correlated with frauds detected as a consequence of this effort.
14. Instances of single disease dominating a geographical area/Service area are reduced.
15. Disease utilization rates correlate more with the community incidence.
16. Number of FIRs filed.
17. Number of enquiry reports against hospitals.
18. Number of enquiry reports against Insurer or RSHAA staff.
19. Number of charge sheets filed.
20. Number of judgments received.
21. Number of cases discussed in Empanelment and Disciplinary Committee.
22. Reduction in number of enhancements requested per 100 claims.
23. Impact on utilization.
24. Percent of pre-audit done for pre-authorisation and claims.
25. Percent of post-audit done for pre-authorisation and claims.
26. Number of staff removed or replaced due to confirmed fraud.
27. Number of actions taken against hospitals in a given time period.
28. Number of adverse press reports in a given time period.
29. Frequency of hospital inspection in a given time period in a defined geographical area.
30. Reduction in share of red flag cases per 100 claims.

Schedule 15 Guidelines for Hospital Transaction Process including pre-authorisation

AB-MGRSBY would be cashless & paperless at any of the empaneled hospitals. The beneficiaries shall not be required to pay any charge for the hospitalization expenses. The benefit also includes pre- and post-hospitalisation expenses. The scheme is an entitlement based and entitlement of the beneficiary is decided on the basis of family being figured in SECC, 2011 database.

The core principle for finalising the Balance Check and providing treatment at empaneled hospital guidelines for AB-MGRSBY is to construct a broad framework as guiding posts for simplifying the service delivery under the ambit of the policy and the technology.

1. IT platform to be used for AB-MGRSBY:

Responsibility of – State Government

IT platform for identification of beneficiaries and transactions at the Empaneled Health Care Provider (EHCP) will be provided by MoHFW/NHA/RSAA.

2. Preparatory Activities for State/ UT's:

The State will need to:

- A. Ensure that a Medical Officer as Nodal Officer at EHCP for AB- MGRSBY has been nominated.
- B. Ensure appointment of SwasthyaMargdarshak for the EHCP
- C. Ensure that a dedicated helpdesk for AB- MGRSBY at a prominent place at the EHCP
- D. Availability of printed booklets, in abundant quantities at the helpdesk, which will be given to beneficiaries along with the AB- MGRSBY e-cards, if beneficiary has not been issued the AB- MGRSBY e-card earlier.
- E. State/ Rajasthan State Health Assurance Agency (RSAA) shall identify and set-up team(s) which shall have the capacities to handle hardware and basic software support, troubleshooting etc.
- F. Training of EHCP staff and SwasthyaMargdarshak by the Insurer.

The State shall ensure availability of above, in order to carry out all the activities laid down in this guideline.

3. Process for Beneficiary identification, issuance of AB-MGRSBYe-card and transaction for service delivery

Responsibility of – SwasthyaMargdarshak or another authorised person at EHCP

Timeline – Ongoing

A. Beneficiary Verification & Authentication

i) Member may bring the following to the AB-MGRSBY helpdesk:

- Letter from MoHFW/NHA
- Any other defined document as prescribed by the State Government

ii) SwasthyaMargdarshak/Operator will check if AB-MGRSBY e-Card/ family ID/ Aadhaar Number is available with the beneficiary.

iii) *In case Internet connectivity is available at hospital*

- Operator/SwasthyaMargdarshak identifies the beneficiary's eligibility and verification status from AB-MGRSBY Central Server
- If beneficiary is eligible and verified under AB-MGRSBY, server will show the details of the members of the family with photo of each verified member
- If found OK then beneficiary can be registered for getting the cashless treatment.
- If patient is eligible but not verified then patient will be asked to produce Aadhaar Card/Number/ Ration Card/other Govt. recognised card for verification (in absence of Aadhaar).
- Beneficiary mobile number will be captured.
- If Aadhaar Card/Number is available and authenticated online then patient will be verified under scheme(as per the parameters defined in the software)
- Beneficiary gender and year of birth will be captured with AadhaareKYC or Ration Card
- If Aadhaar Card/Number is not available then beneficiary will be advised to get the Aadhaar Card/number within stipulated time.
- If Aadhar card of a beneficiary is not made/Aadhar based biometric verification is not possible, then an alternate mechanism may be adopted as decided by RSHAA.
-

iv) *In case Internet connectivity is not available at hospital*

- AB-MGRSBY Registration Desk at Hospital will call Central Helpline and using IVRS enters AadhaarID or number of the patient. IVRS will speak out the details of all beneficiaries in the family and hospital will choose the beneficiary who has come for treatment. It will also inform the verification status of the beneficiary
- If eligible and verified then beneficiary will be registered for getting treatment by sending an OTP on the mobile number of the beneficiary.
- In case beneficiary is eligible but not verified then she/he can be verified using Aadhaar OTP authentication and can get registered for getting cashless treatment.

v) *In case of emergency or in case person does not show e-Card/ID or*

AadhaarCard/Number and claims to be AB-MGRSBY/AB-PMJAY beneficiary and show some photo ID proof issued by Government, then beneficiary may get the treatment after getting TPIN (Telephonic Patient Identification Number) from the call centre and same will be recorded. Government Photo ID proof need not be insisted in case of emergency. In all such cases, relevant beneficiary proof will be supplied within specified time before discharge otherwise beneficiary will pay for the treatment to the Hospital.

- vi) If eligibility, verification and authentication are successful, beneficiary should be allowed for treatment

These details captured will be available at RSHAA/ Insurance Company level for their approval. Once approved, the beneficiary will be considered as successfully identified and verified under the scheme..

4. Package Selection

- A. The operator will check for the specialty for which the hospital is empaneled. Hospitals will only be allowed to view and apply treatment package for the specialty for which they are empaneled.
- B. Based on diagnosis sheet provided by doctor, operator should be able to block Surgical or Non-Surgical benefit package(s) using Scheme's IT system.
- C. Both surgical and non-surgical packages cannot be blocked together; either of the type can only be blocked.
- D. As per the package list, the mandatory diagnostics/documents will need to be uploaded along with blocking of packages.
- E. Some packages will be reserved for blocking only in public hospitals.
- F. The operator can block more than one package for the beneficiary. A logic will be built in for multiple package selection, such that reduced payment is made in case of multiple packages being blocked in the same hospitalization event.
- G. If a registered mobile number of beneficiary family is available, an SMS alert will be sent to the beneficiary notifying him of the packages blocked for him.
- H. At the same time, a printable registration slip needs to be generated and handed over to the patient or patient's attendant.
- I. If for any reason treatment is not availed for any package, the operator can unblock the package before discharge from hospital.

5. Pre-authorisation

- A. There would be defined packages which will require pre-authorization from the insurance company. The operator should be able to initiate a request to the insurance

company/trust for pre-authorization using the web application.

- B. The hospital operator will send all documents required for pre-authorization to the insurance company using the Centralized / States transaction management application.
- C. The documents needed may vary from package to package and hence a master list of all documents required for all packages will be available on the server.
- D. The request as well as approval of the form will be done using IT system or using API or using State's own IT system (whichever applicable)..
- E. In case of no or limited connectivity, the filled form can also be sent to the insurance company either through fax/ email, subject to guidelines issued by RSHAA. However, once internet connectivity is established, the form should also be submitted using online system as described above.
- F. The insurance company will have to approve or reject the request latest by 6 hours. If the insurance company fails to do so, the request will be considered deemed to be approved after 6 hours by default.
- G. In case of an emergency or delay in getting the response for pre-authorization request due to technical issues, provision will be there to get the pre-authorization code over the phone from Insurance Company or the call centre setup by Insurance Company. The documents required for the processing, may be sent using the transaction system within stipulated time.
- H. In case of emergency, insurance company will provide the pre-authorization code generated through the algorithm/ utility provided by MoHFW/NHA-NIC.
- I. Pre-authorization code provided by the Insurer will be entered by the operator and will be verified by the system.
- J. If pre-authorization request is rejected, Insurance Company will provide the reasons for rejection. Rejection details will be captured and stored in the transaction database.
- K. If the beneficiary or the hospital is not satisfied by the rejection reason, they can appeal through grievance system laid down by RSHAA.

6. Balance Check, Treatment, Discharge and Claim Request

- A. Based on selection of package(s), the operator will check from the Central/State Server if sufficient balance is available with the beneficiary to avail services.
- B. States using their own IT system for hospital transaction will be able to check and update balance from Central AB-PMJAY server using API.
- C. If balance amount under available covers is not enough for treatment, then remaining amount (treatment cost - available balance), will be paid by beneficiary (OOP expense will also be captured and stored) with signed consent letter of beneficiary.
- D. The hospital will only know if there is sufficient balance to provide the selected

- treatment in a yes or no response. The exact amount will not be visible to the hospital.
- E. SMS will be sent to the beneficiary registered mobile about the transaction and available balance.
 - F. List of diagnostic reports recommended for the blocked package will be made available and upload of all such reports will be mandatory before discharge of beneficiary.
 - G. Transaction System would have provision of implementation of Standard Treatment Guidelines for providing the treatment
 - H. After the treatment, details will be saved and beneficiary will be discharged with a summary sheet.
 - I. Treatment cost will be deducted from available amount and will be updated on the Central/State Server.
 - J. The operator fills the online discharge summary form and the patient will be discharged. In case of mortality, a flag will be raised against the deceased member declaring him as dead or inactive.
 - K. At the same time, a printable receipt needs to be generated and handed over to the patient or patient's attendant.
 - L. After discharge, beneficiary gets a confirmation and feedback call from the scheme's call centre; response from beneficiary will be stored in the database
 - M. Data (Transaction details) should be updated to Central/State Server and accessible to Insurance Company for Claim settlement. Claim will be presumed to be raised once the discharge information is available on the Central/State server and is accessible to the Insurance Company.
 - N. SMS will be sent to beneficiary registered mobile about the transaction and available balance.
 - O. After every discharge, claims would be deemed to be raised to the insurance company. An automated email alert will be sent to the insurance company specifying patient name, Patient or Family ID, registration number & date and discharge date. Details like Registration ID, Patient or Family ID, date and amount of claim raised will be accessible to the insurance company on Central/ State IT system. Also details like Registration-ID, Patient or Family ID, Date and amount of claim raised, date and amount of claim disbursement, reasons for different in claims raised and claims settled (if any), reasons for rejection of claims (if any) will be retrieved from the insurance company through APIs.
 - P. Once the claim is processed and the hospital gets the payment, the above-mentioned information along with payment transaction ID will be updated on portal/server by the insurance company for each claim separately.
 - Q. Hospital Transaction Management Module would be able to generate a basic MIS report of beneficiary admitted, treated and claim settled and in process and any other

report needed by Hospitals on a regular basis.

- R. Upon discharge, beneficiary will receive a feedback call from the Call centre where he can share his feedback about his/her hospitalisation experience.

7. Monitoring of Transaction Process at EHCP

Responsibility of – RSHAA and Insurance Company

Timeline – Continuous

RSHAA and Insurance Company will need to have very close monitoring of the process in order to ascertain challenges, if any, being faced and resolution of the same. Some examples of the parameters on which monitoring may be based are as follows:

- A. Number of EHCP and SwasthyaMargdarshaks.
- B. Time taken for verification.
- C. Time taken for approval of verification of beneficiaries.
- D. Number of admissions per family.
- E. Grievances received against SwasthyaMargdarshaks or EHCP
- F. Proportion of Emergency pre-authorisation requests
- G. Percent of conviction of detected fraud.
- H. Share of pre-authorisation and claims audited.
- I. Claim repudiation/ denial/ disallowance ratio
- J. Beneficiary satisfaction.

These guidelines are only indicative in nature and RSHAA reserves the rights to modify or change, if required.

Schedule 16: Guideline for Greivance Redressal

Grievance Department has to be manned by dedicated resources to address the grievances from time to time as per the instructions of the NHA. The District authorities shall act as a frontline for the redressal of Beneficiaries'/ Providers/ other Stakeholder's grievances. The District authorities shall also attempt to solve the grievance at their end. The grievances so recorded shall be numbered consecutively and the Beneficiaries / Providers shall be provided with the number assigned to the grievance. The District authorities shall provide the Beneficiaries / Provider with details of the follow-up action taken as regards the grievance as and when the Beneficiaries require it to do so. 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-MGRSBY, following set of three tier Grievance Redressal Committees at state level and NGRC at the national level, have been set up to attend to the grievances of various stakeholders at different levels.

These guidlines are only indicative in nature and RSHAA reserves the rights to modify or change, if required.

District Grievance Redressal Committee (DGRC)

The District Grievance Redressal Committee (DGRC) will be constituted by the Rajasthan State Health Assurance Agency(SHA) in each district within 15 days of signing of MoU with the Insurance Company.

- The District Magistrate or an officer of the rank of Addl. District Magistrate, who shall be the Chairperson of the DGRC.
- The CMO/ CMOH/ DM&HO/ DHO or equivalent rank officer shall be the Convenor of the DGRC.
- Representatives from the district level offices of the Departments of Rural Development.
- The District Coordinator of the Insurer.
- The District Grievance Nodal Officer (DGNO)
- The DGRC may invite other experts for their inputs for specific cases.

Note: DGNO shall try to resolve the complaint by forwarding the same to Action Taking Authority (ATA). If the complaint is not resolved or comments are not received over the same within 15 days of the complaint, then the matter may be referred to DGRC.

State Grievance Redressal Committee (SGRC)

The State Grievance Redressal Committee (SGRC) will be constituted by the Rajasthan State Health Assurance Agency within 15 days of signing of MoU with the Central Government.

- CEO of State Health Authority / State Nodal Agency shall be the Chairperson of the SGRC.

- Representatives of the Departments of Rural Development, Women & Child Development, Labour, Tribal Welfare.
- Director Health Services.
- Medical Superintendent of the leading state level government hospital.
- The State Grievance Nodal Officer (SGNO) of the RSHAA shall be the Convenor of SGRC.
- The SGRC may invite other experts for their inputs on specific cases.

Note:. If any party is not agreed with the decision of DGRC, then they may approach the SGRC against the decision of DGRC.

Appellate Authority.

The Appellate Authority will be constituted by the Rajasthan State Health Assurance Agency.

1. In case of any grievance between RSHAA and Insurance Company, Appellate Authority will be chaired by the Secretary of Department of Health & Family Welfare of the State
2. Appeal against the decision of SGRC shall lie to Appellate Authority.
3. Decision of Appellate Authority will be final and binding upon both the parties.

National Grievance Redressal Committee (NGRC)

The NGRC shall be formed by the MoHFW, GoI at the National level. The constitution of the NGRC shall be determined by the MoHFW in accordance with the Scheme Guidelines from time to time. Proposed members for NGRC are:

1. CEO of National Health Agency (NHA) - **Chairperson**
2. JS , Ministry of Health & Family Welfare- Member
3. Additional CEO of National Health Agency (NHA)- Member Convenor
4. Executive Director, IEC, Capacity Building and Grievance Redressal
5. NGRC can also invite other experts/ officers for their inputs in specific cases.

CEO (NHA) may designate Addl. CEO (NHA) to chair the NGRC.

Investigation authority for investigation of the grievance may be assigned to Regional Director- CGHS/Director Health Services/ Mission director NHM of the State/UT concerned.

NGRC will consider:

- a. The petition of any stakeholder aggrieved with the action or the decision of the Rajasthan State Health Assurance Agency / State Government
- b. Review of State-wise performance based monthly report for monitoring, evaluation and make suggestions for improvement in the Scheme as well as evaluation methodology
- c. Any other reference on which report of NGRC is specifically sought by the Competent Authority.

The Meetings of the NGRC will be convened as per the cases received with it for consideration or as per the convenience of the Chairman, NGRC.

1.9. Grievance Settlement of Stakeholders

If any stakeholder has a grievance against another one during the subsistence of the policy period or thereafter, in connection with the validity, interpretation, implementation or alleged breach of any provision of the scheme, it will be settled in the following way by the Grievance Committee:

A. Grievance of a Beneficiary

i) Grievance against insurance company, hospital, their representatives or any functionary

If a beneficiary has a grievance on issues relating to entitlement, or any other AB-MGRSBY related issue against Insurance Company, hospital, their representatives or any functionary, the beneficiary can call the toll free call centre number 14555 (or any other defined number by the State) and register the complaint. Beneficiary can also approach DGRC. The complaint of the beneficiary will be forwarded to the relevant person by the call centre as per defined matrix. The DGRC shall take a decision within 30 days of receiving the complaint.

If either of the parties is not satisfied with the decision, they can appeal to the SGRC within 30 days of the decision of the DGRC. The SGRC shall take a decision on the appeal within 30 days of receiving the appeal. The decision of the SGRC on such issues will be final.

Note: In case of any grievance from beneficiary related to hospitalisation of beneficiary (service related issue of the beneficiary) the timelines for DGRC to take decision is within 24 hours from the receiving of the grievance.

ii) Grievance against district authorities

If the beneficiary has a grievance against the District Authorities or an agency of the State Government, it can approach the SGRC for resolution. The SGRC shall take a decision on the matter within 30 days of the receipt of the grievance. The decision of SGRC shall be final.

B. Grievance of a Health Care Provider

i) Grievance against beneficiary, insurance company, their representatives or any other functionary

If a Health Care Provider has any grievance with respect to beneficiary, Insurance Company, their representatives or any other functionary, the Health Care Provider will approach the DGRC. The DGRC should be able to reach a decision within 30 days of receiving the complaint.

Step I- If either of the parties is not satisfied with the decision, they can go to the SGRC within 30 days of the decision of the DGRC, which shall take a decision within 30 days of receipt of appeal.

Step II- If either of the parties is not satisfied with the decision, they can go to the NGRC within 30 days of the decision of the SGRC, which shall take a decision within 30 days of receipt of appeal. The decision of NGRC shall be final.

C. Grievance of insurance company

- i) Grievance against district authorities/ health care provider

If Insurance Company has a grievance against District Authority / Health Care Provider or an agency of the State Government, it can approach the SGRC for resolution. The SGRC shall decide the matter within 30 days of the receipt of the grievance.

In case of dissatisfaction with the decision of the SGRC, the affected party can file an appeal before Appellate Authority within 30 days of the decision of the SGRC and Appellate Authority shall take a decision within 30 days of the receipt of appeal after seeking a report from the other party. The decision of Appellate Authority shall be final.

1.10. Functions of Grievance Redressal Committees

A. Functions of the DGRC:

The DGRC shall perform all functions related to handling and resolution of grievances within their respective Districts. The specific functions will include:

- i) Review grievance records.
- ii) Call for additional information as required either directly from the Complainant or from the concerned agencies which could be the Insurer or an EHCP or the RSHAA or any other agency/ individual directly or indirectly associated with the Scheme.
- iii) Conduct grievance redressal proceedings as required.
- iv) If required, call for hearings and representations from the parties concerned while determining the merits and demerits of a case.
- v) Adjudicate and issue final orders on grievances.
- vi) In case of grievances that need urgent redressal, develop internal mechanisms for redressing the grievances within the shortest possible time, which could include but not be limited to convening special meetings of the Committee.
- vii) Monitor the grievance database to ensure that all grievances are resolved within 30 days.

B. Functions of the SGRC:

The SGRC shall perform all functions related to handling and resolution of all grievances received either directly or escalated through the DGRC. The specific functions will include:

- i) Oversee grievance redressal functions of the DGRC including but not limited to monitoring the turnaround time for grievance redressal.
- ii) Act as an Appellate Authority for appealing against the orders of the DGRC.
- iii) Perform all tasks necessary to decide on all such appeals within 30 days of receiving such appeal.
- iv) Adjudicate and issue final orders on grievances.
- v) Nominate District Grievance Officer (DGO) at each District.
- vi) Direct the concerned Insurance Company to appoint District Nodal Officer of each district.

C. Functions of the NGRC:

The NGRC shall act as the final Appellate Authority at the National level for portability cases.

1.11. Lodging of Grievances/ Complaints

- A. If any stakeholder has a complaint (complainant) against any other stakeholder during the subsistence of the Policy Cover Period or thereafter, in connection with the validity, interpretation, implementation or alleged breach of the Insurance Contract between the Insurer and the RSHAA or a Policy or of the terms of their agreement (for example, the Services Agreement between the Insurer and an Empanelled Health Care Provider), then such complainant may lodge a complaint by online grievance redressal portal or letter or e-mail.
- B. For this purpose, a stakeholder includes: any AB- MGRSBY Beneficiary; an empanelled health care provider (EHCP); a De-empanelled Health Care Provider; the Insurer or its employees; the RSHAA or its employees or nominated functionaries for implementation of the Scheme (DNOs, State Nodal Officer, etc.); and any other person having an interest or participating in the implementation of the Scheme or entitled to benefits under the AB- MGRSBY Cover.
- C. A complainant may lodge a complaint in the following manner:
 - i) directly with the DGNO of the district where such stakeholder is located or where such complaint has arisen and if the stakeholder is located outside the Service Area, then with any DGNO located in the Service Area; or
 - ii) with the SHA: If a complaint has been lodged with the SHA, they shall forward such complaint to the concerned DGNO.
- D. Upon a complaint being received by the DGNO, the DGNO shall decide whether the substance of the complaint is a matter that can be addressed by the stakeholder against whom the complaint is lodged or whether such matter requires to be dealt

with under the grievance redressal mechanism.

- E. If the DGNO decides that the complaint must be dealt with under the grievance redressal mechanism, the DGNO shall refer such complaint to the Convener of the relevant Grievance Redressal Committee.
- F. If the DGNO decides that the complaint need not be dealt with under the grievance redressal mechanism, then the procedures set out in various process/guidelines shall apply.

1.12. Redressal of Complaints

- A. The DGNO shall enter the particulars of the complaint on the Web-based Central Complaints and Grievance Management System (CCGMS) established by the MoHFW.
- B. The CCGMS will automatically: (i) generate a Unique Complaint Number (UCN); (ii) categorize the nature of the complaint; and (iii) an e-mail or letter to be sent to the appropriate stakeholder to which such category of complaint is to be referred (including updating on phone).
- C. Once the UCN is generated, the DGNO shall send or cause to be sent an acknowledgement email/phone call to the complainant and provide the complainant with the UCN. Upon receipt of the UCN, the complainant will have the ability to track the progress of complaint resolution online through CCGMS and use the same at the time of calling the helpline for allowing easy retrieval of the specific complaint data.
- D. The stakeholder against whom a complaint has been lodged must send its comments/ response to the complainant and copy to the DGNO within 15 days. If the complaint is not addressed within such 15-day period, the DGNO shall send a reminder to such stakeholder for redressal within a time period specified by the DGNO.
- E. If the DGNO is satisfied that the comments/ response received from the stakeholder will addresses the complaint, then the DGNO shall communicate this to the complainant by e-mail and update the CCGMS.
- F. If the DGNO is not satisfied with the comments/ response received or if no comments/ response are received from the stakeholder despite a reminder, then the DGNO shall refer such complaint to the Convener of the relevant Grievance Redressal Committee depending on the nature of the complaint after which the procedures set out shall apply.

1.13. Grievance Redressal Mechanism

Upon escalation of a complaint for grievance redressal the following procedures shall apply:

- A. The DGNO/SGRC shall update the CCGMS to change the status of the complaint to a grievance, after which the CCGMS shall categorize the grievance and automatically refer it to the Convenor of the relevant Grievance Redressal Committee by way of e-mail.

- B. The Convenor of the relevant Grievance Redressal Committee shall place the grievance before the Grievance Redressal Committee for its decision at its next meeting.
- C. Each grievance shall be addressed by the relevant Grievance Redressal Committee within a period of 30 days of receipt of the grievance. For this purpose, each Grievance Redressal Committee shall be convened at least once every 30 days to ensure that all grievances are addressed within this time frame. Depending on the urgency of the case, the Grievance Redressal Committee may decide to meet earlier for a speedier resolution of the grievance.
- D. The relevant Grievance Redressal Committee shall arrive at a reasoned decision within 30 days of receipt of the grievance. The decision of the relevant Grievance Redressal Committee shall be taken by majority vote of its members present. Such decision shall be given after following the principles of natural justice, including giving the parties a reasonable opportunity to be heard.
- E. If any party to a grievance is not satisfied with the decision of the relevant Grievance Redressal Committee, it may appeal against the decision within 30 days to the relevant Grievance Redressal Committee or other authority having powers of appeal.
- F. If an appeal is not filed within such 30-day period, the decision of the original Grievance Redressal Committee shall be final and binding.
- G. A Grievance Redressal Committee or other authority having powers of appeal shall dispose of an appeal within 30 days of receipt of the appeal. The decision of the Grievance Redressal Committee or other authority with powers of appeal shall be taken by majority vote of its members. Such decision shall be given after following the principles of natural justice, including giving the parties a reasonable opportunity to be heard. The decision of the Grievance Redressal Committee or other authority having powers of appeal shall be final and binding.

1.14. Proceedings Initiated by the State Health Authority, State Grievance Redressal Committee, the National Health Authority

The RSHAA, SGRC and/ or the National Health Authority (NHA) shall have the standing to initiate *suo moto* proceedings and to file a complaint on behalf of itself and AB- MGRSBY Beneficiaries under the Scheme.

A. Compliance with the Orders of the Grievance Redressal Committees

- i) The Insurer shall ensure that all orders of the Grievance Redressal Committees by which it is bound are complied with within 30 days of the issuance of the order, unless such order has been stayed on appeal.
- ii) If the Insurer fails to comply with the order of any Grievance Redressal Committee within such 30-day period, the Insurer shall be liable to pay a penalty of Rs. 25,000 per month for the first month of such non-compliance and Rs. 50,000 per month thereafter until the order of such Grievance

Redressal Committee is complied with. The Insurer shall be liable to pay such penalty to the RSHAA within 15 days of receiving a written notice.

- iii) On failure to pay such penalty, the Insurer shall incur an additional interest at the rate of one percent of the total outstanding penalty amount for every 15 days for which such penalty amount remains unpaid.

B. Complaints/ Suggestions received through Social Media/Call centre

As Social Media channels will be handled by NHA, hence, the complaints/ suggestions raised through Social Media channels like, Facebook, twitter handles, etc. will be routed to the respective SGNO by NGNO (National Grievance Nodal Officer). SGNO needs to register the same on the Grievance portal and publish a monthly report on the action taken to the NGNO.

Complaint may also be lodged through Call center by beneficiary. Call center need to register the details like complaint details in the defined format and forward the same to State Grievance Nodal Officer of the State concerned. SGNO needs to upload the details of the complaint on the grievance portal and allocate the same to the concerned District. The Complaint / grievance will be redressed as per guidelines.

Note: Matrix for grievance referral under the Scheme is presented in the table below:

Aggrieved Party	Indicative Nature of Grievance	Grievance Against	Referred To
AB-MGRSBY Beneficiary	- Denied treatment - Money sought for treatment, despite Sum Insured under AB- MGRSBY Cover being available - Demanding more than Package Rate/ Pre-Authorized Amount, if Sum Insured under AB- MGRSBY Cover is insufficient or exhausted - AB-MGRSBY Card retained by Empanelled Health Care Provider - Medicines not provided against OPD Benefits or follow-up care	Hospital	DGNO
Empanelled Health Care Provider	- Claims rejected by Insurer or full Claim amount not paid - Suspension or de-empanelment of Empanelled Health Care Provider - Hospital IT Infrastructure not functioning , insurer not accepting manual	Insurer/ SHA	DGNO

Aggrieved Party	Indicative Nature of Grievance	Grievance Against	Referred To
	transaction		
Insurer	No space provided for District Office	DNO	SGNO
	- AB-MGRSBY Beneficiary Database not updated for renewal Policy Cover Period - Premium not received within time prescribed.	SHA	SGRC
Inter State/UT (Portability issues)			
AB-MGRSBY Beneficiary	- Denied treatment - Money sought for treatment, despite Sum Insured under AB- MGRSBY Cover being available - Demanding more than Package Rate/ Pre-Authorized Amount, if Sum Insured under AB- MGRSBY Cover is insufficient or exhausted - Medicines not provided against OPD Benefits or follow-up care	Hospital	DGNO of the State/UT where Beneficiary is applying/availing benefits of AB-MGRSBY (other than parent State/UT)
Empanelled Health Care Provider	Claims rejected by Insurer or full Claim amount not paid	Insurer/ SHA	SGRC of both parent State/UT and State/UT where the claim is raised State/UT

Schedule 17: Format of Actuarial Certificate for Determining Refund of Premium

[On the letterhead of the Insurer/Insurer's Appointed Actuary]

From:

[Name of Appointed Actuary]
[Designation of Appointed Actuary]
[Address of Insurer/Appointed Actuary]

Date: [●]

To:

Mr. [●]
CEO, Rajasthan State Health Assurance Agency,
Ayushman Bharat – Mahatma Gandhi Rajasthan SwasthyaBimaYojna (AB-MGRSBY),
SwasthyaBhawan, C-Scheme, Tilak Marg, Jaipur (Rajasthan).

Dear Sir,

Sub: Actuarial Certificate in respect of Pure Claim Ratio of [insert name of Insurer] for Policy Cover Period [●] to [●]

I/We, [insert name of actuary], are/am a/an registered actuary under the laws of India and are/is licensed to provide actuarial services.

[Insert name of Insurer] (the **Insurer**) is an insurance company engaged in the business of providing general insurance (including health insurance) services in India for the last [●] years. I/We have been appointed by the Insurer as its Appointed Actuary in accordance with the IRDA (Appointed Actuary) Regulations, 2000.

The Insurer has executed a contract dated [●] with Rajasthan State Health Assurance Agency for the implementation of the Ayushman Bharat – Mahatma Gandhi Rajasthan SwasthyaBimaYojna (AB-MGRSBY) (the **Insurance Contract**). The Premium payable by Rajasthan State Health Assurance Agency under the Insurance Contract for the Policy Cover Period from [●] to [●] (**Previous Policy Cover Period**) is ₹ [●] (Rupees [insert sum in words] only).

In accordance with the Insurance Contract, we are required to certify the Pure Claim Ratio for the full 12 months of the Previous Policy Cover Period for all the districts within the Service Area.

I, [insert name] designated as [insert title] at [insert location] of [insert name of actuary] do hereby certify that:

- (a) We have read the Insurance Contract and the terms and conditions contained therein.
- (b) In our fair and reasonable view and based on the information available to us, the Pure Claim Ratio for the full 12 months of the Previous Policy Cover Period has been determined by us in accordance with the formula below:

$$\text{Pure Claim Ratio} = \frac{C}{P_T} \times 100$$

= [insert calculation]
= [insert result]%

For the purposes of the formula above:

P_T is the total Premium collected by the Insurer in the Previous Policy Cover Period for all the Beneficiary Family Units covered by it. It is calculated as the product of the Premium per Beneficiary Family Unit in the Current Policy Cover Period and the total number of Beneficiary Family Units covered by the Insurer in the Current Policy Cover Period, i.e., Rs. [●] (Rupees *[insert sum in words]* only).

C is the total Claims paid by the Insurer to the Empanelled Health Care Providers in the full 12 months of the Previous Policy Cover Period, i.e., Rs. [●] (Rupees *[insert sum in words]* only);

- (c) In our fair and reasonable view and based on the information available to us, the Pure Claim Ratio of the Insurer in respect of all the districts within the Service Area in the full 12 months of the Previous Policy Cover Period is [●]% (*[insert sum in words]* percentage).

At *[insert place]*
Date: *[insert date]*

On behalf of *[insert name of Appointed Actuary]*

[Name]

[title]

Name and Counter Signature of Principal Officer of Appointed Actuary, along with Appointed Actuary's name and seal

On behalf of *[insert name of Appointed Actuary]*

[Name]

[title]

[Note. This counter signature is only required if the Appointed Actuary is an external actuarial firm.]