FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

Ayushman Bharat Pradhan Mantri Jan Arogya Yojna
Chief Minister Health Insurance Scheme
(AB PM-JAY CMHIS)
Nagaland

Policy Wordings

FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

PREAMBLE

This Policy is a contract of insurance issued by Future Generali India Insurance Company Limited (hereinafter called the 'Company') to the State Health Agency (SHA), Nagaland (hereinafter called the 'Insured') for the insurance hereinafter set forth in respect of "Ayushman Bharat Pradhan Mantri Jan Arogya Yojana Chief Minister Health Insurance Scheme (AB PM-JAY CMHIS)" for the state of Nagaland to cover the Beneficiary Family Units named in the Policy schedule. The Policy is based on the statements and declaration provided in the "Request for Proposal" by the SHA and is subject to receipt of the requisite premium in accordance to the method of premium payment as prescribed in the tender document.

All General Terms, Conditions, clauses, and exclusion, whether mentioned in this Policy documents or not, shall be read as per Tender Document for Implementation of "Ayushman Bharat Pradhan Mantri Jan Arogya Yojana Chief Minister Health Insurance Scheme (AB PM-JAY CMHIS)" in the State of Nagaland released by State Health Agency, State Government of Nagaland in the month of February 2024.

Abbreviations

AB PM-JAY	Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana
AL	Authorisation Letter (from the Insurer)
BFU	Beneficiary Family Unit
BIS	Beneficiary Identification System
BPL	Below Poverty Line
CGRMS	Central Grievance Redressal Management System
CMHIS	Chief Minister Health Insurance Scheme
CMHIS (EP)	CMHIS for Employees and Pensioners of the Government of Nagaland
CMHIS (GEN)	CMHIS for General Population
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
GoN	Government of Nagaland
GRC	Grievance Redressal Committee
INR	Indian Rupees
IRDAI	Insurance Regulatory Development Authority of India
KPI	Key Performance Indicator
MoHFW	Ministry of Health & Family Welfare, Government of India
NGRC	National Grievance Redressal Committee
NHA	National Health Authority
NHPS	Nagaland Health Protection Society (also referred to as the SHA)
NOA	Notice of Award
PMAM	Pradhan Mantri Arogya Mitra
PHC	Primary Health Centre
RAL	Request for Authorisation Letter (from the EHCP)
RC	Risk Cover
RSBY	Rashtriya Swasthya Bima Yojana
SECC	Socio Economic Caste Census
SGRC	State Grievance Redressal Committee
SGNO	State Grievance Nodal Officer
SHA	State Health Agency

1. Definitions and Interpretations

1.1 Definitions

The following words and expressions used in this policy Agreement and beginning with capital letters shall, unless the context otherwise requires, have the meaning ascribed to them below.
The other terms of interpretation shall be as per the clause no 1.2 of the insurance contract which is also part of the tender document.

1. **AB PM-JAY** shall refer to Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM- JAY), a Scheme managed and administered by the Ministry of Health and Family Welfare, Government of India through the National Health Authority (NHA) with the objective of providing 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 (EHCP) for the risk covers defined in this document and also for reducing out of pocket health care expenses.

2. **AB PM-JAY Beneficiary Family Unit** refers to those families including all its members figuring in the Socio-Economic Caste Census (SECC)-2011 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/ UT Government along with the existing enrolled RSBY Beneficiary Families not figuring in the SECC Database of the State and NFSA ration card holder families of Nagaland satisfying the eligibility criteria set forth in Clause 1.3 referred to as AB-PM JAY Beneficiary Family Unit henceforth in the document.

3. **AB PM-JAY CMHIS** means the converged Health Insurance Scheme of AB PM-JAY and Nagaland CMHIS. For the purpose of this document AB PM-JAY CMHIS and CMHIS shall mean the same scheme and these terms are used and will be interpreted interchangeably.

4. **AB PM-JAY CMHIS Guidelines** mean the guidelines issued by the Department of Health & Family Welfare (DoHFW) of Government of Nagaland (GoN) or the National Health Authority (NHA) from time to time for the implementation of the AB PM-JAY CMHIS, to the extent modified by the Tender Documents pursuant to which the Insurance Contract has been entered into; provided that the State Health Agency may, from time to time, amend or modify the Guidelines or issue new AB PM-JAY CMHIS Guidelines, which shall then be applicable to the Insurer.

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

6. **Beneficiary Family Unit** 'Family means father, mother, husband, wife, brother, sister, son, daughter and includes grand-father, grand-mother, grand-child, adoptive father or mother, adopted son or daughter living together as a single household.
   a. As regards Govt servants and Govt retirees, the definition of family shall be as per Central Services (Medial Attendance) Rules 1944 – a Govt servant's wife or husband, and parents, sisters widowed sisters, widowed daughters, minor brothers, children, stepchildren, divorced/separated daughters, and stepmother wholly dependent upon the Govt servant and are normally residing with the Government servant.

7. **Benefit Risk Cover or Benefit Cover** refers to the annual basic cashless hospitalization coverage of Rs. 5,00,000/- (Rupees five lakhs only) on a family floater basis, that all the insured families would receive under the AB PM-JAY CMHIS.

In addition, beneficiaries belonging to the category CMHIS (EP) i.e. Employees and other officials and Pensioners of the Government of Nagaland shall be eligible for top up cover of Rs.15,00,000/- (Rupees fifteen lakhs only) over and above basic cover.

8. **Benefit Package or Health Benefit Package** refers to the bundled package of services required to treat a condition/ailment/ disease that insured families would receive under AB PM-JAY CMHIS as defined in Clause 4.2 of this Insurance Contract and detailed in Schedule 3A and Schedule 3B of Insurance Contract.

9. **Nagaland Health Benefits Package 2024 or N-HBP 2024** means and refers to the bundled package of services required to treat a condition/ailment/ disease that insured families would receive under CMHIS as defined in Clause 4.2 of this Insurance Contract and detailed in Schedule 3A and Schedule 3B of Insurance Contract. All references to N-HBP 2024 shall include both the N-HBP 2024 for CMHIS (GEN) and N-HBP 2024 for CMHIS (EP).

10. **N-HBP 2024 for CMHIS (GEN)** means and refers to the bundled package of services and benefits for Beneficiary Categories 1(AB PM-JAY beneficiaries), 2 and 5 as defined in Clause 4.2 and Schedule 3A of this Insurance Contract.

11. **N-HBP 2024 for CMHIS (EP)** means and refers to the list of services and benefits for Beneficiary Categories 3 and 4 as defined in Clause 4.2 and Schedule 3B of this Insurance Contract.

12. **Beneficiary** means all people who are residents of the state as defined in in Clause 3.2 of the Tender document.

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

14. **Bidder** shall mean any eligible Insurance Company which has submitted its bid in response to theTender released by the State Government.

15. **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 amount 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.

16. **CGHS** means the Central Government Health Scheme, a health care facility scheme providing comprehensive medical care to the Central Government Employees and Pensioners enrolled under the scheme.

17. **CMHIS or the Nagaland Chief Minister Health Insurance Scheme** means the health insurance scheme launched by the Government of Nagaland as set forth in Section 1 of Part 1 of the Tender Document and in Schedule 1 of the Insurance Contract (Part 3 of the Tender Document).

18. **CHC** means a community health centre and refers to a health facility with in-patient beds that is designated as a “community health centre” by the DoHFW, GoN.

19. **Claim** means a claim for treatment under the AB PM-JAY CMHIS that is received by the Insurer from an Empanelled Health Care Provider, either online or through alternate mechanism in absence of internet connectivity.

20. **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 of the Scheme.

21. **Clause** means a clause of this Insurance Contract.

22. **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.

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

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

25. **Fraud** shall mean and include any intentional deception, manipulation of facts and / or documents or misrepresentation made by a person or organization with the knowledge that the deception could result in unauthorized financial or other benefit to herself/himself or some other person or organization. It includes any act that may constitute fraud under any applicable law in India.

26. **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.

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

28. **ICU or Intensive Care Unit** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

29. **Insurance Contract** shall mean this contract between the State Health Agency and the Insurer for the provision of the benefits under the Risk Cover, to the Beneficiaries and setting out the terms and conditions for the implementation of the AB PM-JAY CMHIS.

30. **Insured Person** means those covered and registered under the AB PM-JAY CMHIS Scheme.

31. **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 this Insurance Contract with the State Government.

32. **IRDAI** means the Insurance Regulatory and Development Authority of India established under the Insurance Regulatory and Development Authority Act, 1999.

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

34. **Law/Applicable Law** means any statute, law, ordinance, notification, rule, regulation, judgment, order, decree, byelaw, approval, directive, guideline, policy, requirement or other governmental restriction or any

similar form of decision applicable to the relevant party and as may be in effect on the date of the execution of this Contract and during its subsistence thereof.

35. **Medically Necessary Treatment:** Medically necessary treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which: i) is required for the medical management of the illness or injury suffered by the insured; ii) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity; iii) must have been prescribed by a medical practitioner; iv) must conform to the professional standards widely accepted in international medical practice or by the medical community in India

36. **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.

37. **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.

38. **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 are 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, as per HBPs detailed in Schedule 3of the Insurance Contract.

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

40. **NHA** shall mean the National Health Authority set up by the MoHFW with the primary objective of coordinating the implementation, operation, and management of AB-PMJAY. The NHA will also foster co-ordination and convergence with other similar Schemes being implemented by the Government of India and State Governments.

41. **Out-patient care** means any sort of care provided without admission into the hospital.

42. **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 the Cover, which shall be determined in accordance with the rates provided in this Insurance Contract.

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

44. **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 per Contract entered between SHA and Insurer, unless cancelled earlier in accordance with this Insurance Contract.

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

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

47. **Schedule** means a schedule of this Insurance Contract and all such Schedules shall be deemed to be an integral part of the Insurance Contract.

48. **Scheme** shall mean the AB PM-JAY CMHIS managed and administered by the Government of Nagaland.

49. **Selected Bidder** shall mean the successful bidder which has been transparently selected through a competitive bidding exercise and has agreed to the terms and conditions of the Tender Document and signed the Insurance Contract with the SHA.

50. **Service** Area refers to the entire State of Nagaland covered and included under this Contract for the implementation of AB PM-JAY CMHIS.

51. **State Health Agency** (SHA) refers to the agency/ body set up by the Department of Health and Family Welfare, Government of Nagaland for the purpose of coordinating, administering, and implementing the AB PM-JAY CMHIS in the State of Nagaland.

52. **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 bidders, who has agreed to the terms and conditions of the Insurance Contract and with whom the SHA intends to and sign the Insurance Contract for this Scheme.

53. **Sum Insured** shall mean the sum of the annual cover of Rs. 5,00,000/-on family floater basis, that the insured families would receive under the AB PM-JAY CMHIS. A top up cover of Rs. 15,00,000/- will be extended to beneficiaries belonging to the category CMHIS (EP) i.e., Employees and Pensioners of Govt. of Nagaland.

54. **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care center by a medical practitioner as per HBPs detailed in Schedule 3 of the Insurance Contract.

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

56. **Tender Documents** refers to the Tender Document published on ***14/02/2024*** including (**Part 1 Invitation to Bid – ITB; Part 2: Insurance Contract; and Part 3: Schedules to the Insurance Contract**). Without prejudice, the Tender Documents shall include all Addenda issued by the SHA, any written responses of queries and any other documents made available by the SHA to the Bidders from time to time during the Tendering process including the Contract.

57. **Turn-around Time** means the time taken by the Insurer in completing the task. These tasks include but are not limited to beneficiary verification, processing preauthorization, processing a Claim received from an Empanelled Health Care Provider and in making a Claim Payment including investigating such Claim or rejection of such Claim etc. defined in this Insurance Contract

58. **Material Breach** means breach of any term and condition as enlisted in this contract caused due to any act and/or omission by the Insurer's wilful misconduct and/or negligence.

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

2. AB PM-JAY CMHIS Beneficiaries and Beneficiaries Family Unit

2.1 The Parties hereby agree that for the purpose of this Insurance Contract and any Policy issued pursuant to this Insurance Contract, all the persons that meet the criteria set forth in **Clause 2.2** below shall be eligible to become Beneficiaries under the Scheme.

2.2 For Scheme administration purposes, the population of Nagaland that are eligible for benefits under the AB PM-JAY CMHIS shall be divided into the following categories of Beneficiaries (**Beneficiary Categories**):

2.2.1 ***Beneficiary Category 1: AB PM-JAY beneficiaries*****:** All individuals who are eligible for benefits under the Government of India's Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY). Specifically for the AB PM-JAY Beneficiaries, the AB PM-JAY Beneficiary Family Units, as defined under the deprivation criteria of D1, D2, D3, D4, D5 and D7, Automatically Included category (in rural areas) and broadly defined occupational un-organised workers (in Urban Sector) of the Socio-Economic Caste Census (SECC) database of Nagaland (as updated from time to time) along with the existing Rashtriya Swasthya Bima Yojana (RSBY) Beneficiary Families not figuring in the SECC 2011 Database which are resident in Nagaland and NFSA ration card holder families of Nagaland satisfying the eligibility criteria set forth in Clause 2.2.5 shall be considered as eligible for benefits under the Scheme and be automatically covered under the AB PM-JAY.

2.2.2 ***Beneficiary Category 2: Additional AB-PMJAY beneficiaries***: All additional categories of individuals, like the Building and Construction Workers, who have been included as eligible for benefits under the AB PM-JAY shall be eligible for benefits under the AB PM-JAY CMHIS.

2.2.3 ***Beneficiary Category 3: Employees of the GoN***: All employees of the GoN and other officials who are employees of Public Sector Undertakings, Corporations and Autonomous Bodies entitled for Monthly Medical Allowance and Medical Re-imbursement scheme, and serving Parliamentarians/Legislators.

Beneficiary Category 3 shall be subdivided as follows:

3A. Regular employees of the GoN and other officials at Pay Level 15 and above, and serving Parliamentarians/Legislators.
3B. Regular employees of the GoN at Pay Level 10 to 14
3C. Regular employees of the GoN at Pay Level less than 10

2.2.4 ***Beneficiary Category 4: GoN pensioners***: All individuals who were full-time employees of the GoN including employees of Public Sector Undertakings, Corporations and Autonomous Bodies, who were entitled for Monthly Medical Allowance and Medical Re-imbursement scheme and are now retired and drawing pension from the GoN and ex-parliamentarians/Legislators shall be eligible for benefits under the AB PM-JAY CMHIS.

Beneficiary Category 4 shall be subdivided as follows:

4A. Pensioners of the GoN who retired at Pay Level 15 and above, and ex-Parliamentarians/Legislators
4B. Pensioners of the GoN who retired at Pay Level 10 to 14
4C. Pensioners of the GoN who retired at Pay Level less than 10.

2.2.5 ***Beneficiary Category 5- General population***: All other individuals who do not fall in Beneficiary Categories 1 to 4 above, and who fulfil the criteria set forth in Clause 2.2 shall be eligible for benefits under the AB PM-JAY CMHIS. Beneficiary Category 5 shall be sub-divided into **Beneficiary Category 5a** which shall include all ration card holders with a Nagaland address as per the NFSA database, and **Beneficiary Category 5b** shall include residents who have or produce a valid Permanent Residency Certificate or Indigenous Inhabitant Certificate issued by the designated authorities of the GoN.

2.3 The SHA hereby commits the payment of Premium for the following minimum number of Beneficiary Family Units in each of the 5 categories detailed in Clause 2.2:

Category	Category description	Minimum number of families for which premium will be paid*
Cat 1: AB PM-JAY	AB PM-JAY Beneficiaries	2,59,468
Cat 2: Additional AB PM-JAY	Additional categories who have been extended benefit of AB PM-JAY, e.g., Building and Construction Workers (BoCW)	
Cat 3: GoN regular employees and other officials, and serving Parliamentarians/Legislators	3A. Regular employees and other officials of the GoN of Pay Level 15 and above, and serving Parliamentarians/Legislators	1,029
	3B. Regular employees of the GoN of Pay Level 10 to 14	6,912
	3C. Regular employees of the GoN of Pay Level less than 10	64,184
Cat 4: GoN Pensioners and ex-Parliamentarians/Legislators	4A. Pensioners of the GoN who retired at Pay Level 15 and above and ex-Parliamentarians/Legislators	25,000
	4B. Pensioners of the GoN who retired at Pay Level 10 to 14	
	4C. Pensioners of the GoN who retired at Pay Level less than 10	
Cat 5: General Population	Individuals not falling under any of the Categories 1 to 4	20,000
Total number of Beneficiary Family Units		**3,76,593**

**For any additional families enrolled beyond the minimum committed number of families, the State Government shall pay the Insurer based on the discovered premium price per family. All such premium for the first year for each family shall be calculated on a prorate basis from the date of enrolment.*

2.4 The Insurer hereby agrees that the unit of coverage under the Scheme shall be a family and each family for this Scheme shall be called an **AB PM-JAY CMHIS Beneficiary Family Unit** or the "**BFU**", which will comprise all members in that family. Any addition in the family will be allowed only as per the provisions approved by the State Government.

2.5 The Insurer further agrees that: (i) no entry or exit age restrictions will apply to the members of a BFU; and (ii) no member of a BFU will be required to undergo a pre-insurance health check-up or medical examination before their eligibility as a Beneficiary and all pre-existing illnesses of the beneficiaries will be covered.

2.6 The presence of name in the Beneficiary Identification System Portal (amended from time to time, due to addition of family member, as per Schedule 2) shall be the proof of eligibility of the BFU for the purpose of availing benefits under this Insurance Contract and a Policy issued by the Insurer pursuant to this Insurance Contract.

3. Risk Covers and Sum Insured

The Insurer shall ensure that all Beneficiaries of the Scheme shall have access to cashless and paperless services under the AB PM-JAY CMHIS up to the limit of their annual coverage, package charges on specific procedures and subject to other terms and conditions outlined herein below:

3.1 **Risk Cover** for each BFU shall include hospitalization and treatment expenses coverage including treatment for medical conditions and diseases requiring secondary and tertiary level of medical and surgical care treatment and including defined day care procedures (as applicable) and follow up care along with cost for pre- and post-hospitalisation treatment as detailed in Schedule 3A and Schedule 3B.

3.2 From the point of view of Risk Cover, the benefits under the AB PM-JAY CMHIS shall be divided into two categories: (a) Benefits for the AB PM-JAY and general population beneficiaries hereinafter referred to as the **CMHIS(GEN)**, where "GEN" connotes General population; and (b) Benefits for government employees and pensioners hereinafter referred to as the **CMHIS (EP)** where "EP" connotes Government Employees and Pensioners.
Table below provides details of coverage type for which each beneficiary category is eligible.

Beneficiary category	Population category	Coverage type
Beneficiary Category 1	AB- PMJAY beneficiaries (as defined in Clause 2.2.1 above)	CMHIS(GEN)
Beneficiary Category 2	Additional AB- PMJAY beneficiaries (as defined in Clause 2.2.2 above)	CMHIS(GEN)
Beneficiary Category 3	GoN employees and other officials, and serving Parliamentarians/Legislators (as defined in Clause 2.2.3 above)	CMHIS(EP)
Beneficiary Category 4	GoN pensioners and ex- Parliamentarians/Legislators (as defined in Clause 2.2.4 above)	CMHIS(EP)
Beneficiary Category 5	General population (uncovered households) (as defined in Clause 2.2.5 above)	CMHIS(GEN)

3.3 **Sum Insured for CMHIS (GEN) BFU**: As on the date of commencement of the Policy Cover Period, the AB PM-JAY CMHIS Sum Insured in respect of the Risk Cover for each CMHIS (GEN) BFU shall be **Rs. 5,00,000 (Rupees Five Lakhs Only) per family** per annum on a family floater basis. This shall be called the **Sum Insured for CMHIS (GEN) Beneficiary Family Unit**, which shall be fixed irrespective of the size of the Beneficiary Family Unit.

3.4 **Sum Insured for CMHIS (EP) Beneficiary Family Unit**: As on the date of commencement of the Policy Cover Period, the AB PM-JAY CMHIS Sum Insured in respect of the Risk Cover for each CMHIS (EP) Beneficiary Family Unit shall be **Rs. 5,00,000 (Rupees Five Lakhs Only) with an additional top up cover of Rs. 15,00,000 (Rupees Fifteen Lakhs Only) per family** per annum. This shall be called the **Sum Insured for the CMHIS (EP) Beneficiary Family Unit**, which shall be fixed irrespective of the size of the Beneficiary Family Unit.

3.5 **Risk cover to be provided on a family floater basis**: The Insurer shall ensure that the Scheme's Risk Cover shall be provided to each BFU on a family floater basis covering all the members of the BFU including Senior Citizens, i.e., the Sum Insured shall be available to any or all members of such BFU for one or more Claims during each Policy Cover Period. The SHA shall reserve the right to add new family members or delete existing family members as provided in Clause 2.6.

3.6 **All pre-existing conditions/diseases to be covered**: The Insurer shall ensure that the Policy covers all pre-existing conditions/diseases from the first day of the start of Policy, only subject to the exclusions given in Schedule 4.

3.7 **Defined day-care treatments to be included in the Policy:** Coverage of health services related to surgical nature for defined procedures shall also be provided on a day care basis. The Insurer shall provide coverage for the defined day care treatments, procedures and medical treatments as given in Schedule 3A and Schedule 3B, including all its sub-schedules.

3.8 **Pre and Post Hospitalisation expenses to be covered**:

3.8.1 For Coverage under N-HBP 2024 for CMHIS(GEN)/PM-JAY

The Insurer shall ensure that expenses incurred for consultation, diagnostic tests, and medicines 3(three) days before the admission of the patient in the same hospital and cost of diagnostic tests and medicines up to 15 (fifteen) days of the discharge from the hospital for the same ailment/ surgery as detailed in N-HBP 2024 Schedule 3A and Schedule 3C are covered under the Policy.

3.8.2 For Coverage under N-HBP 2024 for CMHIS(EP)
The Insurer shall ensure that expenses incurred for consultation, diagnostic tests, and medicines 3(three) days before the admission of the patient in the same hospital and as detailed in N-HBP 2024 Schedule 3B and Schedule 3C are covered under the Policy.
Note: For medical cases, any drugs prescribed for post hospitalization can be booked on actuals (refer to Schedule 1 shared), however for surgical cases any drugs/consumables/investigations can be booked as post hospitalization drugs/consumables/investigations capped at Rs.10,000 in addition to the fixed surgical package list shared.

4. Benefits Package and Rates

4.1 The Health Benefit Package for Nagaland shall be called the N-HBP 2024. The N-HBP 2024 has two parts: N-HBP 2024 for CMHIS (GEN) and N-HBP 2024 for CMHIS (EP) as defined in Clause 4.2 of the Insurance Contract.

4.2 The Insurer shall provide cashless benefits within this Scheme under the Risk Cover to all AB PM-JAY CMHIS Beneficiaries up to the limit of their annual coverage as per agreed upon packages and package rates specific to different categories, namely CMHIS (GEN) and CMHIS (EP); which shall include:

a. Hospitalization expense benefits;
b. Day care treatment benefits (as applicable);
c. Follow-up care benefits;
d. Pre- and post-hospitalization expense benefits; and
e. New-born child/ children benefit

4.3 **N-HBP** 2024 **for CMHIS(GEN):** The N-HBP 2024 for the Beneficiary Categories that are eligible for CMHIS(GEN) cover shall cover and include:

4.3.1 **Procedures**: The Scheme will cover approximately 1950 in-patient procedures across 27 major clinical specialties. The procedures will include both surgical and medical procedures and limited day-care packages, as listed in Schedule 3A of this Insurance Contract, subject only to the exclusions to the Policy listed under Schedule 4. The list may undergo revisions, additions and deletions as the Scheme progresses, based on the feedback and suggestions received from stakeholders.

4.3.2 **Bundled package costs**: The package cost for the procedures referred to in Clause 4.3.1 shall be all inclusive cost which is payable for a particular procedure (including medical management cases), the cost of Implants, high end drugs and diagnostics may be additional in case of few specific procedures.

4.3.3 For the purpose of Hospitalization expenses as package rates shall include all the costs associated with the treatment, amongst other things:
Registration charges.
Bed charges
Nursing and boarding charges.
Surgeons, Anaesthetists, Medical Practitioner, Consultants fees etc.
Anaesthesia, Blood Transfusion, Oxygen, O.T. Charges, Cost of Surgical Appliances etc.
Medicines and drugs.
Cost of prosthetic devices, implants etc (as per Schedules 3A and 3B).
Pathology and radiology tests: Medical procedures include basic Radiological imaging and diagnostic tests such as X-ray, USG, Haematology, pathology etc. However, High end radiological diagnostic and

High-end histopathology (Biopsies) and advanced serology investigations packages can be booked as a separate add-on procedure if required. Surgical packages are all inclusive and do not permit addition of other diagnostic packages.
Food to patient, wherever food is provided to the patient by the hospital.
Pre and Post Hospitalization expenses: Expenses incurred for consultation, diagnostic tests, and medicines 3(three) days prior to admission of the patient in the same hospital and cost of diagnostic tests and medicines up to 15 (fifteen) days after discharge from the hospital for the same ailment / surgery.
Any other expenses related to the treatment of the patient in the hospital.

4.4 **N-HBP** 2024 **for CMHIS(EP):** The N-HBP 2024 for the Beneficiary Categories that are eligible for CMHIS(EP) shall be as follows:

4.4.1 Benefit for CMHIS (EP) shall be as per the CGHS package construct.

4.4.2 Beneficiary Categories that are eligible for CMHIS(EP) cover shall be entitled to in-patient care with differential room entitlement as per employee Pay Level or Pay Level at which the employee retired as specified in Clause 4.4.3.

4.4.3 For the purposes of room entitlement as provided in Clause 4.4.2, employees of GoN shall be entitled to treatment as per the room entitlement given in the table below:

Employee classification as per Pay Level	Room entitlement	Maximum Room Rate (Per day)
Pay Level 15 and above	Private ward	4500
Pay Level 10-14	Semi-private ward	3000
Pay Level 9 and below	General Ward	1500
All levels	Day Care (6-8 hours)	500

a) Room rent is applicable only where prescribed treatment package rates are not available. Room rent includes charges for occupation of bed, diet for patient, charges for electricity and water supply, linen charges, nursing charges and routine up keeping.
b) For patients availing bundled health benefit packages (surgical packages), no separate room rent will be admissible if the patient is treated in ICU/ICCU.
c) Private ward, semi-private ward, and general ward are as per the definitions given by CGHS. Entitlement to rooms and exceptions in case of non-availability of entitled category accommodation, admission to higher or lower category of accommodation, etc., shall be as per extant CGHS guideline.

4.4.4 For the purposes of room entitlement as provided in Clause 4.4.1, all pensioners of GoN shall be entitled to avail of care with room upgrade as per the room entitlement given in Clause 1.7.2.1 above based on the employee classification level at which they retired from service with the GoN.

4.4.5 The Insurer shall ensure that all beneficiaries under Beneficiary Category 3: all employees and other officials of GoN, and serving parliamentarians/Legislators shall be allowed to avail of care with room upgrade per their room entitlement provisions set forth in Clause 4.4.3.

4.4.6 The Insurer shall ensure that all beneficiaries under Category 4: GoN pensioners and ex-parliamentarians/Legislators shall be allowed to avail of care with room upgrade as per their room entitlement provisions set forth in Clause 4.4.4 based on the employee classification level at which they retired from service with the GoN.

4.4.7 The benefits under the CMHIS (EP) shall be organized on a cashless basis at empanelled hospitals.

4.4.8 Treatment of Beneficiaries eligible for CMHIS (EP) in CMHIS(EP) empanelled hospitals shall follow the following construct as per prescribed rates detailed out in N-HBP 2024 for CMHIS(EP) in Schedule 3B:

a) The prescribed package rates are for semi-private ward. If the beneficiary is entitled for general ward there will be a decrease of 10% in the rates. For private ward entitlement there will be an increase of 15%. However, the rates shall be the same for investigation irrespective of entitlement.

b) Package rate includes all the expenses for in-patient treatment, and specific daycare procedures. Beneficiaries are permitted by the competent authority or for treatment under emergency from the time of admission to the time of discharge, including (but not limited to):

- Registration charges
- Admission charges
- Accommodation charges
- Diet charges
- Operation charges
- Injection charges
- Dressing charges
- Doctor consultant charges
- ICU/ICCU charges
- Monitoring charges
- Transfusion charges
- Anesthesia charges
- Operation theatre charges
- Procedural charges
- Surgeon fee
- Surgical disposables cost
- Medicines cost
- Physiotherapy charges
- Nursing charges
- Cost of Investigation

c) For implants, stents, grafts, consumables, drugs, not specifically mentioned in the NHBP 2024 for CMHIS (EP) list, the NPPA (National Pharmaceutical Pricing Authority) ceiling rates shall be applicable. If no prescribed ceiling rates are available, the cost shall be paid as per actual. If the beneficiary insists on high end implants which is beyond the package rate, the additional cost beyond the package rate will be borne by the patient provided a written consent is obtained from the concerned patient.

d) Post hospitalization charges up to 15 days covering drugs/consumables/investigations shall be paid separately as per prescribed rate limit as mentioned in Schedule 3B.

e) Schedule 3A: NHBP 2024 for CMHIS (GEN) Schedule 3A may be accessed at : https://cmhis.nagaland.gov.in/docs/N-HBP%202024%20for%20CMHIS%20(GEN).pdf

f) Schedule 3B: NHBP 2024 for CMHIS (EP) Schedule 3B may be accessed at: https://cmhis.nagaland.gov.in/docs/N-HBP%202024%20for%20CMHIS%20(EP).pdf

4.4.9 For CMHIS (EP) beneficiaries accessing treatment at any of the GOI hospitals ,i.e., all AIIMS hospitals, NEIGRIHMS, RIMS, Imphal which are empanelled under Central Government Health Scheme (CGHS) , prevalent CGHS rates applicable for that city across India with room category as per their room entitlement as set forth in the Table under Clause 1.8.2.1 above will be applicable. For the sake of clarity, no other incentives referred to elsewhere in this document shall be applicable to such GOI hospital. However, if these hospitals are empanelled specifically under CMHIS(EP), all applicable incentives shall be applicable to the hospitals.

4.4.10 In line with the Ministry of Health and Family Welfare (MoHFW) Agreement with Tata Memorial Hospital (TMH/TMC), Mumbai wherein CGHS beneficiaries and their dependents are charged as per the rates in force and amended from time to time for various treatment as per Tata Memorial Centre, CMHIS (EP) beneficiaries can avail treatment at TMH, Mumbai at their prevalent rates, given in Schedule 3E.

4.4.11 CMHIS(EP) beneficiaries can avail treatment in non-empanelled hospitals in case of emergencies provided there are no CMHIS(EP) empanelled hospitals in the city/town or when Specific procedures not available in any of the empaneled hospitals with approval of the State Medical Committee. Beneficiaries shall avail reimbursement for the treatment undertaken as per actuals or the applicable rates under N-HBP 2024 for CMHIS(EP), whichever is lower. Claim submission and processing shall be through a separate portal developed specifically for this purpose.

4.5 The Insurer shall provide cashless benefits as per the Benefit Packages furnished in Schedule 3: 'N-HBP 2024 and Packages Rates' and its sub-schedules subject to exclusions set forth in Schedule 4: 'Exclusions to the Policy', except for cases that fall under clause 4.4.11.

4.6 The Insurer shall ensure pre-authorisation of pre-defined cases within the prescribed turn-around time for availing select treatment in any empanelled hospitals.

4.7 Except for exclusions listed in Schedule 4, treatment/procedures will also be allowed, in addition to the procedures listed in Schedules 3A and 3B, of up to the limit of Insurance Cover **(called 'Unspecified Procedure')** to all AB PM-JAY CMHIS Beneficiaries within the overall limit of Rs. 5,00,000 for CMHIS (GEN) and with an additional top up cover of Rs. 15,00,000 for CMHIS (EP). Operations pertaining to Unspecified Procedure are to be governed as per Unspecified Package Guidelines provided under Schedule 3C.

4.8 The Insurer shall reimburse claims of Empanelled Health Care Provider under the Scheme based on N-HBP 2024 Package Rates determined as follows:

4.8.1 If the package rate for a medical treatment or surgical procedure requiring Hospitalization or Day Care Treatment (as applicable) is fixed in Schedule 3 (including Schedules 3A & 3B), then the Package Rate so fixed shall apply for the Policy Cover Period.

4.8.2 If the package rate for a surgical procedure requiring Hospitalization or Day Care Treatment (as applicable) is not listed in Schedule 3 (including Schedules 3A & 3B), then the Insurer may pre-authorise an appropriate amount based on rates for similar procedures defined in Schedule 3 (including Schedules 3A & 3B) or based on other applicable national or state health insurance Schemes such as CGHS. In case of medical care, the rate will be calculated on per day basis as specified in Schedule 3 (including Schedules 3A & 3B) except for special inputs like high end medicines and radiological diagnostic , high-end histopathology (Biopsies) and advanced serology investigations packages or some other special inputs existing in the N-HBP 2024 (or are released by the SHA from time to time) which can be clubbed with medical packages.

4.8.3 All AB PM-JAY CMHIS beneficiaries shall have the option to use other sources of funding over and above AB PM-JAY CMHIS wallet (if required) for availing healthcare services as provided in Schedule 5.

4.8.4 In case a Beneficiary is required to undertake multiple surgical procedures in one OT session, then the procedure with highest rate shall be considered as the primary package and reimbursed at 100%, thereupon the 2nd surgical procedure and any follow procedures thereafter shall be reimbursed at 50% of package rate.

4.8.5 Surgical and Medical packages together or multiple Medical packages will not be allowed to be availed at the same time (except for certain add on procedures as defined in Schedule 3A and Schedule 3B).

In exceptional circumstances, hospital may raise a request for such pre-auth which will be decided by SHA with the help of concerned medical specialist.

4.8.6 Certain packages as mentioned in Schedule 3A and Schedule 3B will only be reserved for Public EHCPs as decided by the SHA. The SHA may permit availing of these packages in Private EHCPs only after a referral from a Public EHCP is made.

4.8.7 Incentivization will be provided to AB PM-JAY CMHIS empanelled hospitals based on the guidelines provided in Schedule 3D which will be over and above the rates defined in Schedule 3A and 3B**.**

4.9 For the purpose of Day Care Treatment expenses shall include, amongst other things:

a. Registration charges.
b. Surgeons, anaesthetists, Medical Practitioners, consultants' fees, etc.
c. Anaesthesia, blood transfusion, oxygen, operation theatre charges, cost of surgical appliances, etc.
d. Medicines and drugs.
e. Cost of prosthetic devices, implants, organs, etc.(as per Schedules 3A and Schedules 3B).
f. Pathology and radiology tests: Medical procedures include basic Radiological imaging and diagnostic tests such as X-ray, USG, Haematology, pathology etc. However, High end radiological diagnostic and High-end histopathology (Biopsies) and advanced serology investigations packages can be booked as a separate add-on procedure if required. Surgical packages are all inclusive and do not permit addition of other diagnostic packages.
g. Pre and Post Hospitalization expenses: Expenses incurred for consultation, diagnostic tests, and medicines 3 (three) days prior to admission of the patient in the same hospital and cost of diagnostic tests and medicines up to 15 (fifteen) days after discharge from the hospital for the same ailment / surgery.
h. Any other expenses related to the Day Care Treatment provided to the Beneficiary by an Empanelled Health Care Provider.

4.10 **Revision/Stratification of Package Rates during Term of the Insurance Contract**: The SHA may, following due diligence and based on the incidence of diseases or reported medical conditions or on its own, if deemed necessary, suggest revision of HBP under the following circumstances:

4.10.1 to add packages which are frequently being booked under Unspecified and do not fall under exclusion as per Policy, then

i. If Packages are added and cost of added package is below Rs. 1,00,000 (Rupees one Lakh only) then addition is binding on the Insurer without any additional financial implication on the SHA, in case the procedures were otherwise allowed in unspecified package. In this case added package rates shall be deemed to have been included in **Schedule 3A and Schedule 3B** with effect from the date on which the SHA informs the Insurer in writing.

ii. If Packages are added and cost of added package is above Rs. 1,00,000 (Rupees one lakh only) and in cases the cost of package is less than Rs 1,00,000 but it was earlier excluded from the N-HBP 2024, then the Insurer shall make the claims payment of such packages and the SHA will make quarterly payment for such claims as per the actual additional expenditure by the Insurance Company.

4.10.2 The SHA shall have the right to increase the cost of any/ all packages during the existence of a Policy Period which the Insurer shall be bound to agree, subject to the following conditions:
The Insurer shall process and pay such claims with the base package amount and the increased cost together as a single claim processing transaction in TMS. NHPS shall make an advance deposit amount of ₹1,00,00,000.00 (One Crore Only) as corpus funds from which the applicable additional cost of all claims shall be paid out. All other claims processing and payment terms shall remain the same. The corpus funds shall be governed by the following terms and conditions:
a) NHPS shall deposit the corpus amount to the Insurer at a bank account specified by the Insurer.

b) At the end of each month, Insurer shall submit a statement of utilisation of the corpus funds accompanied by detailed claims report.
c) NHPS shall replenish the corpus amount at the end of the month or if the utilisation reaches 80% of the corpus, whichever is earlier.
d) Any unutilised amount shall be refunded to NHPS at the end of the policy period interest free.

4.10.3 There shall be no financial implication on any Party if certain Packages are dropped/or cost is reduced from the existing Package list. No change in premium or payment to the Insurer shall be made in case of changes in reservation policy.

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

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

4.13 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 total of Risk Cover for a Beneficiary Family Unit.

4.14 Benefits under the AB PM-JAY CMHIS shall be available to AB PM-JAY CMHIS Beneficiaries only through Empanelled Health Care Providers, subject to:
a. The benefits under the AB PM-JAY CMHIS Risk Cover shall only be available to a Beneficiary through an EHCP after Aadhaar based identification as far as possible as per SHA defined Guidelines on beneficiary identification and enrolment. In case Aadhaar is not available then other defined Government recognised ID will be used for this purpose. State Government shall share with the insurance company within 7 days of signing the agreement a list of defined Government IDs.
b. The benefits under the CMHIS (GEN) and CMHIS (EP) Cover shall, subject to the available Sum Insured, be available to the Beneficiary on a cashless and paperless basis at any EHCP.
c. Specialized tertiary level services shall be available and offered only by the EHCP empanelled for that service. Not all EHCPs can offer all tertiary level services unless they are specifically designated by the SHA for offering such tertiary level services.

4.15 Rewarding Healthy Behaviour:
With a view to address the drivers of preventable rehospitalization/repeat hospitalizations leading to spiralling cost of Public Health-insurance and as a step towards Value-based insurance design (VBID), the Insurer shall incentivize beneficiaries to work towards better health. The rewards in form of health coupons/any other form mutually decided by state government and the Insurer shall be given to members families, participating in digital/physical health assessment, organized by state / insurer or any appointed agency. Any financial implications to the Insurer under this initiative shall not be part of the claim utilisation calculations against Premium and shall be funded through the Insurer's CSR Component.

5. Identification of Beneficiary Family Units

5.1 Principles and policies

5.1.1 All eligible Beneficiaries of AB PM-JAY CMHIS shall be identified and registered in the AB PM-JAY CMHIS Master Beneficiary Data enrolled under AB PM-JAY CMHIS as per the eligibility criteria set forth in Clause 3 and as the provisions of Schedule 2 of this Insurance Contract.

5.2 Roles and specific obligations of the Insurer

5.2.1 The Insurer shall be responsible only for online verification and approval of AB PM-JAY CMHIS e-card requests generated by either the EHCPs or other government or non-government agencies engaged

directly by the SHA at its own cost. The Insurer shall provide all such verifications and approvals as per the AB PM-JAY CMHIS guidelines and also the performance standards, timelines, turn-around-times and subject to penalty deductions, if applicable, provided in Schedule 11B - Performance KPIs.

5.2.2 The Insurer shall have the responsibility of approving e-card requests for all those Beneficiaries who meet the AB PM-JAY CMHIS eligibility criteria set forth in Clause 3 and have provided documentary evidences as per Clause 4 of Schedule 2 substantiating their eligibility of benefits under the AB PM-JAY CMHIS.

5.2.3 However, for all e-card requests that do not meet the eligibility criteria as set forth in Clause 2, or there are doubts related to the veracity of the documentary evidence submitted, the Insurer's responsibility shall be strictly limited to only recommending such cases for rejection to the SHA. The Insurer shall have no right to reject any AB PM-JAY CMHIS e-card request; and all decisions related to rejection of e-card requests shall rest solely with the SHA based on SHA's due diligence.

5.3 Responsibilities of the SHA

5.3.1 The SHA shall be responsible for

a. Generating awareness about enrolment, organising enrolment drives either directly or through independent agencies.
b. Providing the Insurer with appropriate level of access rights to the Beneficiary Identification System (BIS) portal on which all AB PM-JAY CMHIS e-card requests shall be generated and verification and approval exercise will take place.
c. Timely intervention and decision on all e-card rejection requests forwarded on the BIS portal by the Insurer as per the provisions of Clause 5.2.3 or by any other card verification agency that the SHA at its sole discretion and at its own cost may deploy.

6. Period of Insurance Contract and Policy, Policy Cover Period

6.1 Term of the Insurance Contract with the Insurer

6.1.1 **Duration of the contract**: The Insurer shall be contracted for the first Policy Period as indicated in Clause 6.2, with the contract having a provision for annual renewals at the end of each Policy Year for upto a maximum of 3(three) consecutive Policy years, subject to satisfactory performance on key performance parameters at the end of each Policy Period.

6.1.2 The **negotiated** and mutually agreed premium for a beneficiary family unit as provided in Clause 8 shall remain valid for all three Policy Periods under this Insurance contract.

6.1.3 On **expiry** of the Policy period indicated Clause 6.2.1, the IC will be obliged to extend the policy upto a period of 3 (three) months at the existing terms and conditions on a pro rata basis, if the First Party desires so on account of administrative purposes.
Thereafter, any extension beyond the said period can be done only on mutually agreed terms and conditions and the Second Party shall have the right not to extend the Policy Period.
Any extended Policy Period will be considered as a separate Policy Period, however Premium payment will be prorated for the period of extension. The prorated premium for the extended period will be paid in 1 (one) instalment. The modalities for refund of premium if any shall as per Clause 7.2

6.1.4 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.

6.2 Policy Cover Period

6.2.1 In respect of each policy, the base Policy Cover Period shall be for a period of 12 (twelve) months from the date of commencement of each such Policy Period as mentioned in the tables under this Clause 6.2.1. However, the subsequent policy period shall aligned with the financial year as follows:

Table 1: For PM-JAY /CMHIS(Gen)

Policy Period	Policy Start Date and Time	Policy End Date and Time
1	1st April 2024 at 0000 hours	31st March 2025 at 2359 hours
2	1st April 2025 at 0000 hours	31st March 2026 at 2359 hours

6.2.2 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.

6.3 Policy Cover Period for the Beneficiary Family Unit

6.3.1 During the first Policy Cover Period for Nagaland, the Policy Cover shall commence as per the schedule provided in the table under Clause 6.2.1 above. However, the Policy period for all families that are enrolled after the start date of the first policy period shall begin on the date of their enrolment to end date of policy.

6.3.2 The end date of the Policy Cover for each Beneficiary Family Unit of Nagaland shall be as per Clause 6.2.1 or the date on which the available Sum Insured in respect of that Cover becomes zero.

6.4 Cancellation of Policy Cover

6.4.1 Upon early termination of the Insurance Contract between the SHA 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 Clause 18 and all its sub-clauses of this Insurance Contract.

7. Premium, Premium Payment and other Payments

7.1 Premium and Payment of Premium

7.1.1 The SHA shall pay the Insurer a Premium on a family floater basis as per the Premium rate schedule provided in the table under this clause 7.1.1:

Beneficiary Type	Category	Premium Per Annum Per Beneficiary Family Unit	Top-Up Premium per Beneficiary Family Unit (as applicable after Premium discovery)
CMHIS (GEN)	Cat 1: AB PM-JAY	Rs. 1,950/-	Not applicable
	Cat 2: Additional AB PM-JAY		
	Cat 5: General Population		
CMHIS (EP)	Cat 3: GoN regular employees and other officials	Rs.3,590/-	Rs. 270/-
	Cat 4: GoN Pensioners		

7.1.2 The total Premium to be paid by the SHA to the Insurer shall be the higher of:

a. Premium for the minimum number of committed Beneficiary Family Units as provided in the table in Clause 2.3 multiplied by the premium per Beneficiary Family Units for each category as provided in the table in Clause7.1.1.

OR

b. Premium for the actual number of enrolled Beneficiary Family Units, as registered on the Beneficiary Identification System Portal of the Scheme, multiplied by the premium per Beneficiary Family Unit for each category as provided in the table in Clause 7.1.1.

Provided that, for this option in Clause 7.1.2 b, the Premium per Beneficiary Family Unit shall be prorated from the date on which each such additional Beneficiary Family Unit was registered on the Beneficiary Identification System Portal of the Scheme.

7.1.3 The payment of the premium to the Insurer by the SHA will be done as per the following schedule annually:

S. No.	Instalment 1 (Upon Issuance of the Policy)	Instalment 2 (After completion of 2nd Quarter of the Policy Cover Period)	Instalment 3 (After completion of 10 months of the Policy Cover Period)
i.	45% of the agreed annual Premium	45% of the agreed annual Premium	10% of the agreed annual Premium

7.1.4 **Submission of the Invoice by the Insurer:** The Insurer shall submit separate invoices for each Beneficiary Category as per Clause 2.3.

a. **First Instalment of the Premium** - The Insurer, upon the issue of the Policy, shall raise separate invoices for each Beneficiary Category for the first instalment of the Premium as per Clause 7.1.2 and Clause 7.1.3, subject to the provisions of Clause 7.1.7.

b. **Second instalment of the Premium**: The Insurer upon the completion of 5 months shall raise separate invoices for each Beneficiary Category for the second instalment of the Premium payable for the Beneficiary Family Units as per Clause 7.1.2 and Clause 7.1.3, subject to the provisions of Clause 7.1.7

c. **Third Instalment of the Premium**: Upon completion of 9(nine) months of the Policy Period, the Insurer shall submit a self-certified Claim Settlement Report of the first 9(nine) months of the policy period along with the separate invoices for each Beneficiary Category for the last instalment of the Premium payable for the Beneficiary Family Units as per Clause 7.1.2 and Clause 7.1.3, subject to the provisions of Clause 7.1.7.

7.1.5 **Processing and** payment **of Invoices for Beneficiary Category 1 and Beneficiary Category 2:** The SHA shall process and pay all invoices for Beneficiary Category 1 and Beneficiary Category 2 as per provisions of Schedule 9, subject to deductions against penalties if any, as set forth in Schedule 11.

7.1.6 **Processing and payment of Invoices for Beneficiary Category 3, Beneficiary Category 4 and Beneficiary Category 5:** The SHA shall process and pay all invoices for Beneficiary Category 3, Beneficiary Category 4 and Beneficiary Category 5 shall be paid within 21(twenty-one) days of receiving the invoice, subject to deductions against penalties if any, as set forth in Schedule 11.

7.1.7 The first instalment of the premium shall be based on the minimum number of committed Beneficiary Family Units as provided in the table in Clause 3.3. However, for the second and third instalments of the Premium, the total Premium payable shall be as per the provisions of Clause 7.1.2.

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

7.2.1 At the end of each Policy Period, and subject to the provisions of Clause 7.2.3, the Insurer shall submit a statement as per Schedule 12 duly certified by its Appointed Actuary stating the Insurer's average Claim Ratio for the entire Term of this Insurance Contract covering all Policy Periods therein.

7.2.2 The SHA reserves the right to undertake its due diligence and verification of the statement submitted by the Insurer in Clause 7.2.1 above. Differences, if any, in the Claim Ratio submitted by the Insurer and the Claim Ratio calculated by the SHA as a part of its verification, shall be mutually resolved, failing which the parties shall have the right to seek remedies under Clause 44 of the Insurance Contract.

7.2.3 If this Insurance Contract is terminated earlier by the SHA, date of termination of Policy shall be considered as Term for Policy Cover Period and stated for Insurer's average claim Ratio. After its due diligence as per the provisions of Clause 7.2.3 of this Insurance Contract, the SHA shall issue a letter/email communication indicating 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 7.2.4.

7.2.4 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 SHA as per timeline mentioned in Schedule 11C Payment Related KPIs. The surplus amount to be refunded shall be calculated after a defined administrative cost is adjusted which is given as follows:

i. Administrative cost allowed at 10% if claim ratio less than 65%.
ii. Administrative cost allowed at 12% if claim ratio between 66% - 75%.
iii. Administrative cost allowed at 15% if claim ratio between 76% - 85%.

7.2.5 If the Insurer fails to refund the Premium within 90-day period and/ or the default interest thereon, the SHA shall be entitled to recover such amount along with applicable Penalty as a debt due from the Insurer, subject to the provisions of Clause 44.

7.2.6 However, Payment of Premium by SHA and Refund of Premium by the Insurer are two separate activities. Payment of Premium shall be as per Clause 7.1 and Refund of Premium by Insurer shall be as per Clause 7.2. Under no circumstances, any party shall claim to corelate these two activities.

7.3 Taxes

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

a. pay any statutory levies / tax assessed or levied by any competent tax authority on the Insurer or on the State Health Agency for or on account of any act or omission on the part of Insurer; or

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

7.4 Premium All Inclusive

7.4.1 Except as expressly permitted in Clause 7.1.2, the Insurer shall have no right to claim any additional amount from the State Health Agency in respect of:
a. the risk cover provided to each eligible Beneficiary Family Unit; or
b. the performance of any of its obligations under this Insurance Contract; or
c. any costs or expenses that it incurs in respect thereof.

7.4.2 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 Policy.

8. Cashless Access of Services

8.1 All AB PM-JAY CMHIS 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.

8.2 The Insurer shall reimburse EHCP as per the package cost specified in Schedule 3A and Schedule 3B for specified packages or as pre-authorised amount in case of unspecified packages.

9. Pre-authorisation of Procedures

9.1 All procedures in Schedule 3A and Schedule 3B 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 for all Procedures irrespective of the pre-authorisation status in Schedule 3A and Schedule 3B.

9.2 Subject to the provisions of Clause 9.1, the Insurer will not allow any EHCP, under any circumstance whatsoever, to undertake any such earmarked procedure without pre-authorisation unless under emergency. In case of an emergency approval, the process defined as per the AB PM-JAY CMHIS guidelines will have to be followed.

9.3 The Insurer shall ensure that all EHCPs submit preauthorisation request on the Scheme portal and the Insurer shall process all such preauthorisation requests as per Scheme Guidelines and within the Turn-Around-Time specified in Schedule 11B. In case of any queries, the appropriate provisions in the Scheme's portal can be exercised.

9.4 In cases of any delay in raising preauthorisation by the EHCP, the EHCP shall provide the justification for delay along with the request for preauthorisation.

9.5 The Insurer shall ensure that in all cases pre-authorisation request related decisions are communicated to the EHCP as per TAT mentioned in Schedule 11B of this Insurance Contract. If there is no response from the Insurer within prescribed TAT of EHCP filing the pre-authorisation request, the request of the EHCP shall be deemed to be automatically authorised and shall affect the performance KPIs of the Insurer mentioned in Schedule 11B of this Insurance Contract.

9.6 The Insurer shall not be liable to honour any claims from the EHCP for procedures featuring in Schedule 3A and Schedule 3B, for which pre-authorisation is mandated in Schedule 3A and Schedule 3B and the EHCP does not have a pre-authorisation, unless EHCPs comply with the provisions of Clause 9.4.

9.7 Reimbursement of all claims for procedures listed under **Schedule 3 and all its sub-schedules** shall be as per the financial limits prescribed for each such procedure, subject to incentives if applicable as per Schedule 3D and other provisions of this Insurance Contract.

9.8 The Insurer should check that the preauthorisation request is accompanied by the minimum documentation required for processing the preauthorisation.

9.9 The Insurer will guarantee payment only after receipt of preauthorisation request on the Transaction Management System Portal of the Scheme along with necessary medical details. The Insurer shall process all such preauthorisation requests as per the timeline indicated in Schedule 11B.

9.10 In case the medical data provided is not sufficient for the medical team of the authorisation department of the Insurer to process the preauthorisation, the Insurer may seek further clarification/ information from the EHCP before denying the authorisation.

9.11 The Insurer shall have to submit a report to the SHA explaining reasons for denial of every such pre-authorisation request.

9.12 The Insurer shall provide authorisation only for the necessary treatment cost of the ailment covered and mentioned in the preauthorisation request from the EHCP. The entry on the AB PM-JAY CMHIS portal for claim amount blocking as well at discharge would record the authorisation number as well as package amount agreed upon by the EHCP and the Insurer.

9.13 In case the balance sum available is less than the specified amount for the Package, claim processing and payment shall be as per the provisions specified in Schedule 5.

9.14 The Insurer will not be liable to make payment in case the information provided during preauthorisation request and subsequent documents during authorisation is found to be incorrect or not fully disclosed.

9.15 In cases where the 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 must be paid by the Insurer from the Policy which was operating during the period in which the beneficiary was admitted.

9.16 Regarding Claims Adjudication, Insurer shall ensure adherence to guidelines issued and updated from time to time by SHA.

10. Portability of Benefits

10.1 **For Beneficiary Categories 1,2 and 5**: The Insurer shall ensure that the benefits of AB PM-JAY CMHIS will be portable across the country and all Beneficiaries of CMHIS(GEN) in Beneficiary Categories 1, 2, and 5 of the Scheme get access to benefits under the Scheme in all AB PM-JAY empanelled hospitals across the country. However, all CMHIS(GEN) Beneficiaries availing services outside Nagaland as part of portability features, shall be only be eligible for the benefit package of the state where the treatment is sought, and N-HBP 2024 shall not apply in all such cases.

10.2 **For Beneficiary Categories 3 and 4**: The Insurer shall ensure that the benefits of AB PM-JAY CMHIS will be portable across the country and all Beneficiaries of CMHIS (EP) in Beneficiary Categories 3 and 4 shall be able to access services as per the provisions of Clause 5.4 of the Insurance Contract.

10.3 The Insurer is required to honour claims from any empanelled hospital under the Scheme within India and will settle claims within 30 (thirty) days of the receipt of such claims from the EHCPs.

10.4 Detailed guidelines of portability are provided at **Schedule 10**.

11. Claims Adjudication

11.1 Claim Payments and Turn-around Time

The Insurer shall, subject to the penalty provisions set forth in Schedule 11 and its sub-schedules, and other provisions under this Insurance Contract wherever applicable, comply with the following procedure regarding the processing of Claims received from the EHCP:

11.1.1 The Insurer shall require the EHCPs to submit their Claims electronically as early as possible but not later than 7 (seven) days after discharge of a AB PM-JAY CMHIS patient in the defined format to be prescribed by the SHA.

11.1.2 If the EHCP fails to submit the claims within 7 (seven) days as set forth in Clause 11.1.1 above but within 45(Forty-Five) days, specific approvals from the SHA will be required to allow the claim to be processed, in line with guidelines and orders issued by the SHA from time to time. However, in case of Public EHCPs this time may be relaxed as defined by the SHA from time to time.

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

11.1.4 If the Insurer rejects a Claim, the Insurer shall issue an electronic (e)-notification of rejection to the EHCP stating details of the Claim summary; reasons for rejection; and details of the District Grievance Nodal Officer.

11.1.5 The Insurer shall ensure that for each rejected claim as per Clause 11.1.3 and Clause 11.1.4, e-notification of rejection is issued to the SHA and the EHCP within a turn-around time of 15 (fifteen) days from receipt of such a Claim. This turn-around time for portability claims shall be 30 (thirty) days for all Portability Claims. The Insurer should inform the EHCP of its right to seek redressal for any Claim related grievance before the District Grievance Redressal Committee in its e-notification of rejection.

11.1.6 If a Claim is rejected because the EHCP 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.

11.1.7 The Insurer shall be responsible for settling all claims as per timelines provided in Schedule 11B**.**

11.1.8 The Insurer shall make the full Claim Payment without deduction of tax, for all PHCs, CHCs, District Hospitals and other government sponsored hospitals in Nagaland, subject to compliance of Income Tax Act, 1961 and its Allied Rules. In case of private healthcare providers in Nagaland, the Insurer shall make the full Claim Payment without deduction of tax, provided the EHCP submits a tax exemption certificate to the Insurer within 7 (seven) days of signing the Provider Service Agreement with the SHA, failing which, the Insurer shall make the Claim Payment after deducting tax at the applicable rate.

11.1.9 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 it shall be the liability of the Insurer to pay such Claim in full by the Insurer subject to the available Sum Insured and the claims being eligible for payment as per the provisions of AB PM-JAY CMHIS and the

provisions of this Insurance Contract. For the avoidance of doubt, the Insurer shall not reject any claim from an EHCP solely on the ground that the patient was discharged after the end of such Policy Cover Period and the Policy is not renewed.

11.1.10 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.

11.1.11 The process specified in Clauses 11.1.2 to 11.1.10 above in relation to Claim Payment or investigation of the Claim shall be completed such that the Turn-around Time shall be completed as per the Turn Around Time specified in Clause 11.1.7.

11.1.12 If delay by the SHA in release of Premium to the Insurer results in delay of Claim Payment by the Insurer to the EHCP beyond laid down TATs, then the same shall not be considered towards calculation of penalties under Schedule 11B.

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

11.1.14 The Insurer shall make Claim Payments to each EHCP against Claims received through The Transaction Management System Portal of the Scheme to such Empanelled Health Care Provider's designated bank account.

11.1.15 The Insurer hereby agrees that it shall undertake all Claims audits/investigations only by qualified and experienced Medical Practitioners appointed by it 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.

11.1.16 The Insurer shall ensure that none of its medical staff shall impart advice 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.

11.1.17 The Insurer shall submit monthly details of:

a. all Claims that are under investigation to the District Nodal Officer of the State Health Agency for its review.
b. every Claim that is pending beyond the Turn Around Time to the State Health Agency, along with its reasons for delay in processing such Claim; and
c. details of applicable penalty as per KPIs mentioned under Schedules 11A, 11B, and 11C.

11.1.18 The Insurer may collect at its own cost, complete Claim papers from the EHCP, if required for audit purposes. This shall not have any bearing on the Claim Payments to such EHCPs.

11.1.19 In case the Insurer hires one or more Third Party Administrator (TPA), it shall ensure that the TPA does not approve or reject any Claim 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.

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

11.1.21 The overall responsibility of the execution of this Insurance Contract will rest solely and completely with the Insurer, irrespective of whether it engages a TPA or not.

11.1.22 With regard to submission of claims, claims processing, handling of claim queries, and all other related details, Insurer shall adhere to prevalent Claims Adjudication guideline issued by the SHA from time to time.

11.2 Right of Appeal and Reopening of Claims

11.2.1 The EHCP shall have a right of appeal against a rejection of a Claim by the Insurer, if the EHCP feels that the Claim is payable. Such decision of the Insurer may be appealed by filing a grievance with the District Grievance Nodal Officer (DGNO) within 15 (fifteen) days of rejection of claim, in accordance with Clause 27 of this Insurance Contract. The SHA may relax these timelines for public hospitals.

11.2.2 The Insurer and/or DGNO or the District Grievance Redressal Committee (DGRC), as the case may be, may re-open the Claim, if the Empanelled Health Care Provider submits the proper and relevant Claim documents that substantiates their right to re-open such claims.

11.3 No Contributions

11.3.1 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.

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

(i) its liability to make a Claim Payment shall not be waived or discharged in part or in full based on a rateable or any other proportion of the expenses incurred and that are covered by the benefits under the Covers.
(ii) it shall be required to make the full Claim Payment in respect of the benefits provided under this Insurance Contract and the relevant Policy; and
(iii) if the total expenses incurred by the Beneficiary exceeds the available Sum Insured under the Covers, then the Insurer shall make payment to the extent of the available Sum Insured in respect of the benefits provided under this Insurance Contract and the relevant Policy and for the remaining payment, the guidelines for Co-payment as set forth in Schedule 5 shall apply.

12. Fraud Control and Management

12.1 The Insurer should have the capability of developing a comprehensive fraud control system for the Scheme which shall at the minimum include regular monitoring, data analytics, e-cards audit, medical audit, field investigation, hospital audit, corrective action etc. It shall comply with the provisions of Anti-Fraud Guidelines and Advisories as issued by the SHA from time to time.

12.2 For all trigger alerts related to possible fraud at the level of EHCPs, the Insurer shall take the lead in immediate investigation of all such cases in close coordination with and under constant supervision of the SHA.

12.3 Investigations pursuant to any such alert shall be concluded by the Insurer within 07 (seven) 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 SHA.

12.4 The SHA shall take all such decision within the provisions of the Insurance Contract, Anti-Fraud Guidelines, Recovery Guidelines and Advisories laid by the SHA from time to time. All such decisions of the SHA shall be founded on the Principles of Natural Justice and as per Applicable Laws.

12.5 The Insurer shall be responsible for monitoring and controlling the implementation of the Scheme in the State in accordance with Clause 16.

12.6 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 SHA shall be to:

a. 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 any entity that has undertaken or participated in a Fraudulent Activity; and/or
b. take disciplinary action against the Empanelled Healthcare provider that has made a fraudulent Claim or undertaken or participated in any unethical practices, including but not limited to issuing show cause notice, levying penalties as per provisions or refer for suspension or de-empanelment to the State Empanelment Committee.
c. terminate the services agreement with the TPA or other intermediary appointed by the Insurer; and/or provided that the Insurer keeps the SHA informed of actions taken by it along with details thereof.
d. The State Health Agency shall have the right to conduct a random audit of any or all cases in which the Insurer has exercised such remedies against an Empanelled Health Care Provider and/or any Beneficiary.

12.7 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.

13. Service beyond Service Area

13.1 To ensure true portability of AB PM-JAY, State Governments participating in the Scheme are deemed to be in arrangement with ALL other States, through NHA, that are implementing AB PM-JAY for allowing sharing of network hospitals, transfer of payment of claims & transaction data arising in areas beyond the service area. This corresponds to Beneficiary Categories 1 and 2 of the AB PM-JAY CMHIS who are eligible for CMHIS(GEN) Benefits.

13.2 The deemed arrangement between states through the NHA referred to in Clause 13.1 above, shall extend to AB PM-JAY CMHIS Beneficiary Category 5 (General Population) who are also eligible for CMHIS(GEN) Benefits.

13.3 The Insurer has to ensure that this benefit of portability shall also be available for Beneficiary Category 3 and Beneficiary Category 4 who are eligible for CMHIS (EP) Benefits should they chose to seek services outside Nagaland at all hospitals outside the state empanelled under CMHIS (EP).

13.4 The Insurer shall hereby further ensure that CMHIS(EP) beneficiaries, in addition to portability benefits under Clause 13.3, shall access GOI hospitals empanelled under CGHS across the country, including, but not limited to, all AIIMS hospitals, NEIGRIHMS, RIMS, Imphal.

14. Monitoring and Control

14.1 Scope of Monitoring

14.1.1 Monitoring under AB PM-JAY CMHIS shall include supervision and monitoring of all the activities undertaken by the Insurer and ensuring that the Insurer complies with all the provisions of the Insurance Contract signed with the SHA and all contracts and sub-contracts/ agreements issued by the Insurer pursuant to the Insurance Contract with the SHA for implementation of the Scheme.

14.1.2 Monitoring shall include but not be limited to:

a. Overall performance and conduct of the Insurer
b. Claims management process
c. Grievance redressal process
d. Fraud control process
e. Any other aspect/ activity of the Insurer related to the implementation of the Scheme

14.2 Monitoring Activities to be undertaken by the Insurer

14.2.1 General Monitoring Obligations

Under the AB PM-JAY CMHIS, the Insurer shall monitor the entire process of Scheme implementation on an ongoing basis to ensure that it meets all its obligations under its Insurance Contract with the SHA. 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 PM-JAY CMHIS beneficiaries under the provisions of the Scheme;
c. Ensure monitoring of processes for timely processing, management, and payment of all claims of the EHCPs;
d. Ensure monitoring of processes/transactions/entities for fraud control;
e. Ensure fulfilment of minimum threshold levels as per the agreed Key Performance Indicators (KPIs) laid down in Schedules 11A to 11D; and
f. Ensure compliance from all its sub-contractors, vendors and intermediaries hired/ contracted by the Insurer under the Scheme for the fulfilment of its obligations.

14.3 Monitoring Activities to be undertaken by the SHA

14.3.1 Audits by the State Health Agency

a. The SHA shall have the right but not the obligation to undertake random or planned audits of any kind related to the scope of services provided by the Insurer to ensure compliance Insurer's compliance to the scheme guidelines and the terms of the contract.

14.3.2 Spot Checks by the State Health Agency

a. The SHA shall have the right to undertake spot checks of State office of the Insurer and the premises of EHCPs without any prior intimation.

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

14.3.3 Performance Review and Monitoring Meetings

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

b. Whereas the SHA 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 relevant item.

c. The SHA shall ensure that all meetings shall be documented, and minutes shared with all concerned parties.

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

14.4 Key Performance Indicators for the Insurer

14.4.1 The Insurer hereby agrees that the SHA shall monitor its performance based on 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 Schedules 11A to 11D.

14.4.2 At the end of every 12 (twelve) months, if there is a renewal of the Term of this Insurance Contract, the SHA shall have the right to amend the KPIs, which if amended, shall be applicable pre-emptively on the Insurer and the Insurer shall be obliged to abide by the same.

14.5 Measuring Performance and Penalties

14.5.1 The SHA shall monitor the performance of the Insurer as per timelines and KPI threshold levels provided in Schedules 11A to 11D.

14.5.2 The SHA shall review Indicator performance results every month or quarter as per the frequency indicated for each indicator in Schedules 11A to 11D and the Insurer shall provide reasons for variances in performance, if any.

14.5.3 KPI related penalties are provided in the KPI tables in Schedules 11A to 11D and imposition of penalties shall be as specified in such Schedules.

14.5.4 The Insurer shall, in line with KPIs mentioned in Schedules 11A to 11D, pay the SHA all penalties imposed by the SHA on the Insurer within 15 (fifteen) days of receipt of the **Penalty Notice** from the SHA. The SHA shall ensure that Penalty Notice contains all the details regarding penalties being imposed.

14.5.5 Penalty Notice, if applicable, shall be shared by the SHA with the Insurer in each quarter and calculation of penalties shall be as detailed in Schedules 11A to 11D.

14.5.6 If the Insurer wishes to contest the penalties levied by the SHA, it may represent to the SHA along with necessary documentary proof within 7 (seven) days of receipt of such a Penalty Notice.

14.5.7 The SHA may examine the evidence and facts and arrive at a final penalty amount/decision and shall convey the same to Insurer withing 7 (seven) days of the receipt of such a representation from the Insurer.

14.5.8 Failure to pay penalty within the timeline provided in the Penalty Notice or elsewhere in this Insurance Contract, if applicable, will invite penal interest on the penalties as specified in Schedule 11C and the Insurer shall be obliged to pay the Penalties with such penal interest.

14.5.9 If the Insurer fails to pay Penalty within 90-day period and/ or the default interest thereon or such timeframe as stated in the Penalty Notice, whichever is earlier, the SHA shall be entitled to recover such amount along with applicable interest, if any, as a debt due from the Insurer, subject to the provisions of Clause 44 Dispute Resolution of this Insurance Contract.

14.5.10 Also, based on the review, the SHA shall have the right to issue rectification orders demanding the performance to be brought up to the levels desired as per the AB PM-JAY CMHIS Guidelines.

14.5.11 In the event of delay due to IT system downtime, KPI penalties shall not be applicable.

14.5.12 Along with monitoring of KPIs, SHA may issue rectification orders to Insurer. 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).

14.5.13 At the end of the rectification period, the Insurer shall submit an Action Taken Report with evidence of rectifications done to the SHA.

14.5.14 If the SHA 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 SHA and the Insurer.

14.5.15 The SHA, as a policy holder, reserves the right to approach the IRDAI for necessary action in case the Insurer persistently fails to meet contractual obligations. Such instances of default may relate to - as not meeting baseline KPIs, not paying penalties in timely manner or failure to return premium etc.

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

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

15.2 For the purpose of hiring an outsourced agency or service provider the Insurer shall enter into a Service Level Agreement with the concerned agencies or service providers and within 14 (fourteen) days and submit a redacted copy of such Agreements to the SHA.

15.3 The Insurer shall ensure that in all such cases 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 material breach of this Insurance Contract.

15.4 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.

15.5 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.

16. Reporting Requirements

16.1 The Insurer shall submit all reports mandated by the SHA and within the timelines prescribed by the SHA.

16.2 All reports shall be uploaded by the Insurer online on the SHA web portal along with separate email and physical copy.

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

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

17. Grievance Redressal

17.1 The SHA shall set up a robust and strong grievance redressal mechanism with Grievance Redressal Committees at different levels within the state of Nagaland to attend to the grievances of various stakeholders at different levels.

17.2 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 also record the information in pre-agreed format of any complaint / grievance received by oral, written or any other form of communication as per the guidelines.

17.3 The Insurer shall unconditionally adhere to such Grievance Redressal Guidelines issued by the SHA from time to and time.

18. Term and Termination

18.1 Term

18.1.1 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. The expiration of the Policy Cover Period under each Policy issued under this Insurance Contract; and
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 SHA, including for refund of any Premium for any of the previous Policy Cover Periods.

18.1.2 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 State Health Agency within 45 (forty five) days of the date of expiration of the Policy Cover Period for that Policy.

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

18.2 Conditions for Termination of the Agreement

Without prejudice to any other rights or remedies which the Parties may have under this Insurance Contract, upon occurrence of one Party's Default ("**Defaulted Party**") as per the provisions of Clause 18, the other Party shall be entitled to terminate this Insurance Contract by issuing a Termination Notice to the defaulted Party; provided that before issuing the Termination Notice, the concerned Party shall by a notice inform the *Defaulted Party* of its intention to issue such Termination Notice (**Preliminary Termination Notice**) and grant 30 (thirty) days to the *Defaulted Party* to make a representation, and may after the expiry of such 30 (thirty) days, whether or not it is in receipt of such representation, issue the Termination Notice (**Final termination Notice**).

SHA will provide pro rata premium for the period for which the Insurer has provided the policy within 30 (thirty) days of effective date of termination and fulfilment of obligations of Insurer. In case excess premium with respect to pro rata policy has been already received by the Insurer, then the Insurer will need to refund the excess premium excluding the premium due for the pro rata period within 30 (thirty) days of the end of the Policy Period.

18.3 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 15 (fifteen) 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 force majeure notice as per Clause 30.

18.4 Consequences of Termination

Upon termination of this Insurance Contract, the Insurer shall:

a. Continue to provide the benefits to the Beneficiaries until the Termination Date.

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

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

Where:

TC is the sum to be paid by the Insurer to the State Health 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 State Health Agency to the Insurer for the Policy Cover Period in which the Termination Date occurs.

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

UT is the unexpired term of the Policy for that 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 State Health Agency exclusive of all applicable taxes and duties. The Insurer shall bear and pay all applicable taxes and duties in respect of such amount.

c. The sum to be paid calculation under Clause 18.4 c shall be calculated separately for each premium as per the categories in Clause 7.1.

d. 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.

e. The Insurer undertakes that it shall discharge its liabilities in respect of all such Claims raised within 45 (forty-five) days of the Termination Date.

18.5 Migration of Policies Post Termination

18.5.1 At least 120 (one hundred and twenty) days prior to the expiration of this Insurance Contract or the Termination Date, the SHA 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**).

18.5.2 Once the SHA has issued such a Migration Request:

a. The SHA shall have the right to identify the New Insurer to whom the Policies will be migrated up to 30 (thirty) days prior to the expiration date or the Termination Date.
b. The SHA shall also have the right to withdraw the Migration Request at any time prior to the 30 (thirty) days period immediately preceding the expiration date or the Termination Date. If the SHA chooses to withdraw the Migration Request, then the remaining provisions of this Clause 18.5.2 shall not apply from the date of such withdrawal and this Insurance Contract shall terminate forthwith upon the withdrawal of the Migration Request. The reasons for withdrawal of Migration Request shall be placed on record by the SHA.

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

18.5.4 Within 7 (seven) 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.

18.5.5 The Insurer shall not be entitled to:
a. 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
b. 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
c. charge the SHA, 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.

18.5.6 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: (a) the date on which the New Insurer assumes all the risks under the Policies; and (b) the date of withdrawal of the Migration Request (the **Migration Termination Date**).

18.6 Hand-Over Obligations

Without prejudice to the provisions of Clause 18.5, 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 PM-JAY CMHIS in favour of the State Health Agency and/or to the New Insurer, provided that the Insurer has received a written notice to this effect at least 30 (thirty) 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.
c. For closure of the contract, the full and final settlement would be subject to the following conditions:
   i. –Submission of an invoice with details of claim ratio calculation and accordingly calculating the amount to be returned to SHA or claimed for SHA as per the final instalment
   ii. -Certification that all dues of EHCP have been settled
   iii. -Certification of handover of all data as per Clause 18.6.

19. Force Majeure

19.1 Definition of Force Majeure Event

A Force Majeure Event shall mean the occurrence in the State of Nagaland 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 19.1 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 19.1; 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 Nagaland 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 19.1; 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 19.1 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 19.1; 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.

19.2 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.

19.3 Claims for Relief

19.3.1 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**).

19.3.2 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 (seven) 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 19.3 of this Insurance Contract.

19.3.3 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.

19.3.4 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 (fifteen) 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 17.

19.3.5 Subject to the Affected Party having complied with its obligations under Clause 19, 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.

19.4 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.

19.5 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.

19.6 Termination upon Subsistence of Force Majeure Event

If a Force Majeure Event continues for a period of 4 (four) weeks or more within a continuous period of 365 (three hundred and sixty five) days, either Party may terminate this Insurance Contract by giving the other Party 90 (ninety) days' written notice.

20. Assignment

20.1 **Assignment by Insurer:** 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.

20.2 Assignment by Beneficiaries or Empanelled Health Care Providers

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

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

of any third party.

Without limiting the foregoing, the Parties acknowledge that the public Empanelled Health Care Providers in the Service Area that are under the management of Rogi Kalyan Samitis may assign all or part of their right to receive Claims Payments from the Insurer in favour of the Government of Nagaland or any other department, organization or public body that is under the ownership and/or control of the Government of Nagaland.

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 Nagaland, the Insurer shall pay all or part of the Claims Payments to the person(s) so notified.

21. Confidentiality of Information and Data Protection

21.1 Insurer will treat any and all such information which has come to the knowledge of the Insurer that may relate but not be limited to the AB PM-JAY CMHIS Scheme, Disclosing Party's business, operations, financials, services, facilities, processes, methodologies, technologies, intellectual property, trade secrets, this agreement and/or its contents, research and development, trade names, Personal Data, Sensitive Personal Data, methods and procedures of operation, business or marketing plans, licensed document know-how, ideas, concepts, designs, drawings, flow charts, diagrams, quality manuals, checklists, guidelines, processes, formulae, source code materials, specifications, programs, software packages/ codes, clients and suppliers, partners, principals, employees, consultants and authorized agents and any information which is of a manifestly confidential nature (including the AB PM-JAY CMHIS Scheme) , that is supplied by Disclosing Party to the Insurer or otherwise acquired/ accessed by the Insurer during the course of dealings between the Parties or otherwise in connection with the scope of this Agreement.

21.2 "Personal Data" shall mean any data / information that relates to a natural person which, directly or indirectly, in combination with other information available or likely to be available with, is capable of identifying such natural person and

21.3 "Sensitive Personal Data" shall mean personal data revealing, related to, or constituting, as may be applicable— (i) passwords; (ii) financial data; (iii) health data; (iv) official identifier; (v) sex life; (vi) sexual orientation; (vii) biometric data; (viii) genetic data; (ix) transgender status; (x) intersex status; (xi) caste or tribe; (xii) religious or political belief or affiliation; or (xiii) any other category of data as per applicable laws of India as amended from time to time.

21.4 The Term confidential information also mean 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 and/or the applicable laws.

21.5 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 and/or specifically permitted in the agreement.

21.6 The obligation of confidentiality with respect to Confidential Information will not apply to any information:

- If the information is or becomes publicly known and available other than as a result of prior authorized disclosure
- If the Insurer is legally compelled by applicable law, by any court, governmental agency, or regulatory authority or subpoena or discovery request in pending litigation, but only if, to the extent lawful, the Insurer gives prompt written notice of that fact to SHA prior to disclosure so that the SHA may request a protective order or other remedy, the Insurer may disclose only such portion of the Confidential Information which it is legally obligated to disclose.

21.7 **Obligation to Maintain Confidentiality:** Insurer agrees to retain the Confidential Information in strict confidence, to protect the security, integrity, and confidentiality of such information and to not permit unauthorized access to or unauthorized use, disclosure, publication, or dissemination of Confidential Information except in conformity with this Insurance Contract.

21.8 Confidential Information provided by the SHA is and will remain the sole and exclusive property of the SHA and will not be disclosed or revealed by Insurer except (i) to other employees of the Insurer who have a need to know such information and agree to be bound by the terms of this Contract (ii) to any government or regulatory authority or (iii) with the SHA's express prior written consent.

21.9 Upon termination of this Insurance Contract, the Insurer will ensure that all Confidential Information including all documents, memoranda, notes and other writings or electronic records prepared by the Insurer and its employees for this engagement are either returned to the SHA or retained as per applicable regulations.

21.10 The Insurer shall at no time, even after end of the Term or Termination of this Insurance Contract, be permitted to disclose Confidential Information, except to the extent that such Confidential Information is excluded from the obligations of confidentiality under this Contract pursuant to Clause 21.2 above. The onus to prove that the exclusion is applicable is on the Insurer.

21.11 As prerequisite to signing of this Insurance Contract, Insurer shall sign Non-Disclosure Agreement (provided in Schedule 14) and Individual Confidentiality Undertaking (provided in Schedule 15)

22. Intellectual Property Rights

22.1 Each party will be the owners of their intellectual property rights (IPR) involved in this Scheme and will not have any right over the IPR of the other party.

22.2 Both parties agree that for the purpose of fulfilling the conditions under this Insurance Contract they may allow the other party to only use their IPR only for the Term of this Insurance Contract. However, after the end of the contract no parties will have any right over the IPR of other party.

22.3 The SHA shall have a right in perpetuity to use such newly created IPR, which may not be limited to processes, products, specifications, reports, drawings, and any other documents produced leveraging any data which it has got access to during the performance and completion of services under this Insurance Contract and for the purposes of inter-alia use of such services under this Insurance Contract. The Insurer undertakes to disclose all such Intellectual Property Rights, to the best of its knowledge and understanding, arising in performance of the services of this Insurance Contract to the SHA.

23. Severability

If for any reason whatsoever any provision of this Insurance Contract is or becomes invalid, illegal or unenforceable or is declared by any court of competent jurisdiction or any other instrumentality to be invalid, illegal or unenforceable; the validity, legality or enforceability of the remaining provisions shall not be affected in any manner, and the Parties shall negotiate in good faith with a view to agreeing upon one or more provisions which may be substituted for such invalid, unenforceable or illegal provisions, as nearly as is practicable.

24. 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 registered post or by fax or email(the case of fax or email, original shall be sent by registered post).

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

To: **State Health Agency**
Attn: Mr. / Ms. _____
E-Mail: _____
Phone: _____
Fax: _____

25. Governing Law and Jurisdiction

25.1 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.

25.2 The courts in Nagaland shall have the exclusive jurisdiction over any disputes arising under, out of or in connection with this Insurance Contract.

26. Publicity

26.1 The Insurer shall not use the trademarks and /or IPR of SHA and/or anything related to AB PM-JAY CMHIS Scheme without the prior written consent of SHA and/or any Competent Authority who is authorised to give such permission.

26.2 The Insurer shall not publish or permit to be published either along or in conjunction with any other person any press release, information, article, photograph, illustration, or any other material of whatever kind relating to this Agreement or the business of the Parties or relating to AB PM-JAY CMHIS Scheme without prior reference to and approval in writing from SHA for purposes other than those covered under scope of this Insurance Contract.

27. Dispute Resolution

Save where expressly stated to the contrary in this Insurance Contract, any dispute or difference whatsoever arising between the Parties to this Contract out of or relating to the construction, meaning, scope, operation or effect of this Contract or the validity of the breach or termination of this Insurance Contract (a "**Dispute**") shall be determined in accordance with the procedure set out in this Clause.

27.1 Notice of Dispute and Manner of Dispute Resolution

27.1.1 Either Party may notify the other Party in writing of a Dispute (a "**Dispute Notice**"). The Parties shall attempt to resolve the Dispute amicably in accordance with the amicable resolution procedure set forth in Clause 25.2.

27.1.2 The Parties agree to use their best efforts for resolving all Disputes arising under or in respect of this Insurance Contract promptly, equitably and in good faith and further agree to provide each

other with reasonable access during normal business hours to all non-privileged records, information and data pertaining to any Dispute.

27.2 Amicable Resolution

27.2.1 In the event of any Dispute between the Parties, either Party may require such Dispute to be referred to [Governing Board of SHA] and the [Chairman of the Board of Directors]/ [governing body] of the Insurer for amicable settlement. Upon such reference, the said persons shall meet no later than 7 (seven) days from the date of reference to discuss and attempt to amicably resolve the Dispute.

27.2.2 If the Dispute is not amicably settled within 15 (fifteen) days of the meeting for amicable resolution between the parties; either Party may refer the Dispute to arbitration in accordance with the provisions of Clause 27.3.

27.3 Arbitration

27.3.1 Any Dispute which is not resolved amicably by amicable resolution procedure under Clause 27.2 shall be finally decided by reference to arbitration by a Board of Arbitrators appointed in accordance with Clause 27.3.2. The provisions of the Arbitration and Conciliation Act, 1996 and Rules thereunder will be applicable, and the award made there under shall be final and binding upon the parties hereto, subject to legal remedies available under the law. Such differences shall be deemed to be a submission to arbitration under the Indian Arbitration and Conciliation Act, 1996, or of any modifications, Rules, or re-enactments thereof. The seat and venue of such Arbitration proceedings will be held at Kohima, Nagaland (State) India. Any legal dispute will come under the sole and exclusive jurisdiction of the state if Nagaland, India. The language of arbitration proceedings shall be English.

27.3.2 The Board of arbitrators shall consist of 3 (three) arbitrators, with each Party appointing one arbitrator and the third arbitrator being appointed by the two arbitrators so appointed. If the parties cannot agree on the appointment of the Arbitrator within a period of one month from the notification by one party to the other of existence of such dispute, then the Arbitrator shall be appointed by the Kohima bench of the Gauhati High Court, India

27.3.3 The Arbitrator shall make a reasoned award (the “Award”). Such award shall be implemented by the Parties concerned within such time as directed by the Arbitrator in such Award.

27.3.4 The Insurer and the SHA agree that an Award may be enforced against the Insurer and/or the SHA, as the case may be, and their respective assets wherever situated as stated in Arbitration Award. Both the Parties to bear their own cost pertaining to the Arbitration Proceedings.

27.4 Performance Pending Disputes

This Insurance Contract and the rights and obligations of the Parties shall remain in full force and effect, pending written settlement in any amicable settlement proceedings or the Award in any arbitration proceedings hereunder, unless this Insurance Contract has been terminated; or expressly provided otherwise in this Insurance Contract.

28. Entire Agreement

This Insurance Contract and the Schedules together constitute a complete and exclusive statement of the terms of the agreement between the Parties on the subject hereof, and no amendment or modification hereto shall be valid and effective unless such modification or amendment is agreed to in writing by the Parties and duly executed by persons especially empowered in this behalf by the respective Parties. All prior written or oral understandings, offers or other communications of every kind pertaining to this Insurance Contract are abrogated and withdrawn.

29. Exclusions

AB PM-JAY CMHIS 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:

(a) Condition that does not require hospitalization and can be treated under Outpatient Care, unless featuring in the NHBP 2024.
(b) 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.
(c) Any dental treatment or surgery which is corrective, prosthetic, cosmetic procedure, filling of tooth cavity, root canal including wear and tear of teeth, periodontal diseases, dental implants etc. are excluded. Exception to the above would-be treatment needs arising from trauma / injury, neoplasia / tumour / cyst requiring hospitalisation for bone treatment.
(d) Any assisted reproductive techniques, or infertility related procedures, unless featuring in the NHBP 2024.
(e) Vaccination and immunization
(f) Surgeries related to ageing face & body, laser procedures for tattoo removals, augmentation surgeries and other purely cosmetic procedures such as fat grafting, neck lift, aesthetic rhinoplasty etc.
(g) Circumcision for children less than 2 years of age shall be excluded (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident).
(h) Persistent Vegetative State: a condition in which a medical patient is completely unresponsive to psychological and physical stimuli and displays no sign of higher brain function, being kept alive only by medical intervention.