15 -ാം കേരള നിയമസഭ

14 -ാം സമ്മേളനം

നക്ഷത്ര ചിഹ്നം ഇല്ലാത്ത ചോദ്യം നം. 2609 **06-10-2025 - ൽ മറുപടിയ്ക്ക്**

മെഡിസെപ് പദ്ധതിയുടെ രണ്ടാംഘട്ട നടപടികൾ

ചോദ്യം		ഉത്തരം	
ശ്രീ. കുറുക്കോളി മൊയ്തീൻ		**ശ്രീ കെ എൻ ബാലഗോപാൽ (ധനകാര്യ വകുപ്പ് മന്ത്രി)**	
(എ)	സംസ്ഥാന സർക്കാർ ജീവനക്കാർക്കും അധ്യാപകർക്കും നടപ്പിലാക്കിയ ആദ്യഘട്ട മെഡിസെപ് പദ്ധതിയുമായി ബന്ധപ്പെട്ട് ഇൻഷുറൻസ് കമ്പനിയുമായി ഒപ്പിട്ടിട്ടുള്ള ധാരണാപത്രത്തിന്റെ പകർപ്പ് ലഭ്യമാക്കാമോ;	(എ)	മെഡിസെപ് പദ്ധതി നടത്തിപ്പിനായി സർക്കാർ ഓറിയന്റൽ ഇൻഷ്വറൻസ് കമ്പനിയുമായി 27.06.2022-ൽ ഒപ്പു വച്ച ധാരണാപത്രത്തിന്റെ പകർപ്പ് അനുബന്ധമായി ചേർക്കുന്നു.
(ബി)	പ്രസ്തുത പദ്ധതിയുടെ രണ്ടാം ഘട്ടം നടപ്പിലാക്കുന്നതിന് തിരഞ്ഞെടുക്കപ്പെട്ട ഇൻഷുറൻസ് കമ്പനി ഏതാണെന്നും പ്രസ്തുത കമ്പനിയുമായി ഒപ്പിട്ട ധാരണാപത്രത്തിലെ വ്യവസ്ഥകൾ എന്തൊക്കെയാണ് എന്നും അറിയിക്കാമോ;	(ബി)	നിലവിലെ പാക്കേജുകൾ കാലാനുസൃതമായി പരിഷ്കരിക്കുന്നതിനും, നൂതനമായ പാക്കേജുകൾ ഉൾപ്പെടുത്തുന്നതിനുമായി ഡോ. ശ്രീറാം. വി. ഐ.എ.എസ് ചെയർമാനായി രൂപീകരിച്ച മെഡിക്കൽ എക്സ്പെർട്ട് കമ്മിറ്റി **സമർപ്പിച്ച** അന്തിമ റിപ്പോർട്ട് അംഗീകരിച്ച കൊണ്ട് ഗുണഭോക്താക്കൾക്ക് കൂടുതൽ ഉപയോഗപ്രദമാകുന്ന രീതിയിൽ പദ്ധതിയെ പരിഷ്കരിച്ച് രണ്ടാംഘട്ടം ആരംഭിക്കുന്നതിന് 14.08.2025 തീയതിയിലെ സ.ഉ.(പി)നം.102/2025/ധന പ്രകാരം ഉത്തരവാകുകയും തുടർനടപടികൾ സ്വീകരിച്ചു വരികയും ചെയ്യുന്നു. നടപടിക്രമങ്ങൾ പാലിച്ച് ഇൻഷുറൻസ് കമ്പനിയെ തെരെഞ്ഞെടുക്കുന്നതിനുള്ള പ്രവർത്തനങ്ങൾ ത്വരിത ഗതിയിൽ പുരോഗമിച്ചു വരുന്നു.
(സി)	മെഡിസെപ് പദ്ധതിയുടെ ആദ്യഘട്ടത്തിൽ നിന്ന് രണ്ടാം ഘട്ടത്തിലേക്കെത്തുമ്പോൾ വ്യവസ്ഥകളിലും ഗുണഭോക്താക്കൾക്ക് ലഭ്യമാകുന്ന ആനുകൂല്യങ്ങളിലും ഉണ്ടാകുന്ന മാറ്റങ്ങൾ എന്തൊക്കെയാണ് എന്ന് അറിയിക്കാമോ;	(സി)	നിലവിലെ പാക്കേജുകൾ കാലാനുസൃതമായി പരിഷ്കരിക്കുന്നതിനും, പാക്കേജുകൾ ഉൾപ്പെടുത്തുന്നതിനുമായി ഡോ. ശ്രീറാം വി. ഐ.എ.എസ്. ചെയർമാനായി രൂപീകരിച്ച മെഡിക്കൽ എക്സ്പെർട്ട് കമ്മിറ്റി സമർപ്പിച്ച റിപ്പോർട്ട് അംഗീകരിച്ച് 14/08/2025 യിലെ സ.ഉ.(പി)നം.102/2025/ധന. പ്രകാരം രണ്ടാം ഘട്ടം ആരംഭിക്കുന്നതിനു അനുമതി

നൽകിയിട്ടുണ്ട്. രണ്ടാം ഘട്ടത്തിൽ അടിസ്ഥാന ഇൻഷുറൻസ് പരിരക്ഷ (Basic Sum Insured) 3 ലക്ഷത്തിൽ നിന്നും 5 ലക്ഷമായി ഉയർത്തിയിട്ടുണ്ട്. 41 സ്പെഷ്യാലിറ്റ് ചികിത്സകൾക്കായി 2100 -ലധികം ചികിത്സാ പ്രക്രിയകൾ അടിസ്ഥാന ചികിത്സാ പാക്കേജിൽ ഉൾപ്പെടുത്തിയിരിക്കുന്നു. HBP 2022 revised അടിസ്ഥാനമാക്കിയുള്ള ചികിത്സാ പാക്കേജുകളാണ് ഉൾപ്പെടുത്തിയിട്ടുള്ളത് ഹെൽത്ത് ബെനിഫിറ്റ് പാക്കേജ് (HBP) 2022 revised Tier 1 city നിരക്കിന്റെ ഒന്നര ഇരട്ടി വരെ വർദ്ധനവ് പ്രൈവറ്റ് ആശുപത്രികളിലും സർക്കാർ ആശുപത്രികളിലും ബാധകമാക്കിയിട്ടുണ്ട്. മുട്ടുമാറ്റിവയ്ക്കൽ, ഇടുപ്പെല്ല് മാറ്റിവയ്ക്കൽ ശസ്ത്രക്രിയകൾ അടിസ്ഥാന പരിരക്ഷയിൽ ഉൾപ്പെടുത്തിയിട്ടുണ്ട്.

ഗുരുതര/അവയവമാറ്റ ചികിത്സകൾക്കായി ഇൻഷുറൻസ് കമ്പനി 2 വർഷത്തേയ്ക്കായി 40 കോടി രൂപയുടെ കോർപ്പസ് ഫണ്ട് നീക്കി വയ്ക്കേണ്ടതാണ്. അടിസ്ഥാന ഇൻഷുറൻസ് പരിരക്ഷയുടെ 1% വരെ മുറി വാടക (5000/- day) സർക്കാർ ആശുപത്രികളിൽ പേ വാർഡ് വാടക പ്രതിദിനം 2000/- രൂപ വരെ. ഇ.എസ്.ഐ. ആനുകൂല്യം ലഭ്യമാകാത്ത പൊതുമേഖലാ സ്ഥാപനങ്ങൾ, ബോർഡുകൾ, കോർപ്പറേഷനുകൾ, സ്വയംഭരണ സ്ഥാപനങ്ങൾ, സഹകരണ മേഖലയിലെ ജീവനക്കാരെയും പെൻഷൻകാരെയും പദ്ധതിയുടെ ഭാഗമാക്കുന്നതാണ്. ആശുപത്രികളെ പദ്ധതിയിൽ എംപാനൽ ചെയ്യുന്നതിനുള്ള പുതുക്കിയ മാനദണ്ഡങ്ങൾ നിശ്ചയിച്ചിട്ടുണ്ട്. SCTIMST, JIPMER പോലെയുള്ള നാഷണൽ ഇൻസ്റ്റിറ്റ്യൂഷനുകൾ എംപാനൽ ചെയ്യണമെന്നും, ഏതെങ്കിലും കാരണവശാൽ, SCTIMST എംപാനൽ ചെയ്തില്ലായെങ്കിൽ പ്രസ്തുത ആശുപത്രിയിലെ എല്ലാ ചികിത്സകൾക്കും പാക്കേജ് നിരക്ക് പ്രകാരമുള്ള തുക ഇൻഷുറൻസ് കമ്പനി റീ-ഇംപേഴ്സ് ചെയ്ത് നൽകേണ്ടതാണ്. നോൺ എംപാനൽഡ് ആശുപത്രികളിലെ അടിയന്തര സാഹചര്യങ്ങളിലെ ചികിത്സകൾക്ക് റീ-ഇംപേഴ്സ്മെന്റ് അനുവദിക്കുന്ന വ്യവസ്ഥയിൽ നിലവിലുള്ള 3 ചികിത്സകൾ

			കൂടാതെ 10 ചികിത്സകൾ കൂടി ഉൾപ്പെടുത്തിയിട്ടുണ്ട്. തുടർച്ചയായി ചികിത്സ തേടേണ്ട ഡേ-കെയർ പ്രൊസീജിയറുകളായ ഡയാലിസിസ്, കീമോതെറാപ്പി എന്നിവയ്ക്ക് ഇൻഷ്വറൻസ് പോർട്ടലിൽ ഒരു One time registration അനുവദിക്കണമെന്നും, ഒരേ സമയം സർജിക്കൽ, മെഡിക്കൽ പാക്കേജുകൾ ക്ലബ് ചെയ്ത് അംഗീകാരം നൽകണമെന്നും വ്യവസ്ഥ ചെയ്തിട്ടുണ്ട്. പരാതി പരിഹാര സംവിധാനം കൂടുതൽ ശക്തിപ്പെടുത്തുന്നതിനുള്ള നടപടികൾ സ്വീകരിച്ചിട്ടുണ്ട്. ഗുണഭോക്താക്കളുടെ വിവരങ്ങൾ വേഗത്തിൽ ലഭ്യമാക്കുന്നതിനായ മെഡിസെപ് കാർഡിൽ ഒരു QR code സംവിധാനം ഉൾപ്പെടുത്തുവാനുള്ള നിർദ്ദേശം ഉണ്ട്. കരാറിൽ നിന്നും വ്യതിചലിക്കുന്ന ആശുപത്രികൾക്കെതിരെ കർശന നടപടി സ്വീകരിക്കുന്ന തരത്തിലുള്ള ഒരു SOP (Standard Operating Procedure) ഇൻഷ്വറൻസ് കമ്പനി തയാറാക്കേണ്ടതാണ്. കൂടാതെ, അധിക ബിൽ ഈടാക്കുക തുടങ്ങിയ സ്വകാര്യ ആശുപത്രിയിൽ നിന്നുള്ള ചൂഷണങ്ങൾ നിയന്ത്രിക്കുന്നതിനായി ക്ലിനിക്കൽ എസ്റ്റാബ്ലിഷ്മെന്റ് അതോറിറ്റിയുടെ സേവനം കൂടി ഉപയോഗപ്പെടുത്തുന്നതാണ്.
(ഡി)	മെഡിസെപ്പിന്റെ രണ്ടാംഘട്ടത്തിൽ സേവനം ലഭ്യമാക്കുന്ന ആശുപത്രികളുടെ ലിസ്റ്റ് ജില്ലതിരിച്ച് ലഭ്യമാക്കാമോ;	(ഡി)	14/08/2025 യിലെ സ.ഉ.(പി)നം.102/2025/ധന. പ്രകാരം മെഡിസെപ് പദ്ധതിയുടെ രണ്ടാം ഘട്ടം ആരംഭിക്കുന്നതിനു അനുമതി നൽകിയിട്ടുണ്ട്. രണ്ടാംഘട്ടം നടപ്പിലാക്കുന്നതിന് തെരെഞ്ഞെടുത്ത ഇൻഷുറൻസ് കമ്പനിയാണ് ആശുപത്രികളെ എംപാനൽ ചെയ്യുന്നത്. ഇൻഷുറൻസ് കമ്പനിയെ തെരെഞ്ഞെടുക്കുന്നതിനുള്ള നടപടികൾ ത്വരിത ഗതിയിൽ പുരോഗമിച്ചു വരുന്നു.
(ഇ)	മെഡിസെപ്പിലൂടെ ജീവനക്കാർക്കും അധ്യാപകർക്കും എല്ലാവിധ അസുഖങ്ങൾക്കും പണം അടയ്ക്കാതെ ചികിത്സ ലഭ്യമാകുമോ എന്നറിയിക്കാമോ;	(ഇ)	മെഡിസെപ് പദ്ധതിയിൽ ഉൾപ്പെടുന്ന ചികിത്സാ പാക്കേജുകൾക്ക് പദ്ധതിയിൽ എംപാനൽ ചെയ്തിട്ടുള്ള ആശുപത്രികളിൽ നടത്തുന്ന ചികിത്സകൾക്കാണ് ഗുണ ഭോക്താക്കൾക്ക് ക്യാഷ്ലെസ്സ് ആനുകൂല്യം ലഭ്യമാകുന്നത്.മെഡിസെപ്പിന്റെ രണ്ടാം ഘട്ടത്തിൽ എമ്പാനൽ ചെയ്യുന്ന ആശുപത്രിയിലെ എല്ലാ വിഭാഗങ്ങളെയും എമ്പാനൽ ചെയ്യണമെന്ന വ്യവസ്ഥ ഉൾപ്പെടുത്തിയിട്ടുണ്ട്. മെഡിസെപ് പരിരക്ഷ ലഭ്യമാകുന്നത് കിടത്തി ചികിത്സക്കും തിമിരം,

			ഡയാലിസിസ്, കീമോതെറാപ്പി തുടങ്ങിയ ഡേ-കെയർ പ്രോസീജറുകൾക്കുമാണ്.
(എഫ്)	ഒരു കുടുംബത്തിൽ ഒന്നിലധികം പേർ സർക്കാർ ജീവനക്കാരായിട്ടുണ്ടെങ്കിൽ അവരെല്ലാവരും മെഡിസെപ്പിന്റെ ഭാഗ അടയ്ക്കേണ്ടതുണ്ടോ എന്നും ഒരു കുടുംബത്തിൽ നിന്നും ഒന്നിലധികം പേർ മെഡിസെപ് പ്രീമിയം അടയ്ക്കുന്നുണ്ട് എങ്കിൽ അവർക്ക് എന്തെങ്കിലും പ്രത്യേക അധിക ആനുകൂല്യം ലഭിക്കുമോ എന്നും വ്യക്തമാക്കാമോ;	(എഫ്)	ഒരു കുടുംബത്തിൽ ഒന്നിലധികം പേർ സർക്കാർ ജീവനക്കാരായിട്ടുണ്ടെങ്കിൽ അവരെല്ലാവരും മെഡിസെപ് പ്രീമിയം അടക്കേണ്ടതാണ്. ഓരോരുത്തർക്കും 3 ലക്ഷം രൂപയുടെ പ്രത്യേകം പ്രത്യേകം ഇൻഷുറൻസ് പരിരക്ഷ ലഭ്യമാകുന്നതാണ്.
(ജി)	മറ്റേതെങ്കിലും ആരോഗ്യ ഇൻഷുറൻസ് പദ്ധതിയിൽ ചേരാൻ താല്പര്യപ്പെടുന്ന സർക്കാർ ജീവനക്കാരെയും അധ്യാപകരെയും മെഡിസെപ്പ് പദ്ധതിയിൽ നിന്ന് ഒഴിവാക്കുന്നതിന് ഉള്ള തടസ്സം എന്താണ് എന്ന് വിശദമാക്കാമോ?	(ജി)	11,49,719 പ്രാഥമിക ഗുണഭോക്താക്കളും അവരുടെ ആശ്രിതരായ 19,52,494 പേരും ചേർന്ന് ആകെ 31,02,213 പേർ നിലവിൽ മെഡിസെപ് പദ്ധതിയിൽ അംഗങ്ങളായിട്ടുള്ള മെഡിസെപ്പിന്റെ ഒന്നാം ഘട്ടത്തിൽ 01.08.2025 വരെയുള്ള കണക്ക് പ്രകാരം 10,89,791 ക്ലെയിമുകൾക്ക് 1964,74,23,535/- രൂപയുടെ അടിസ്ഥാന ഇൻഷുറൻസ് പരിരക്ഷ ലഭ്യമാക്കിയിട്ടുണ്ട്. ഗുരുതര/ അവയവമാറ്റ ചികിത്സകൾക്കായി 72.88 കോടി രൂപയും റീ-ഇംപേഴ്സ്മെന്റ് ഇനത്തിൽ 10.51 കോടി രൂപയും ഇൻഷുറൻസ് കമ്പനി അനുവദിച്ചിട്ടുണ്ട്. ഇത്തരത്തിൽ ഒന്നാം ഘട്ടം വിജയകരമായി പൂർത്തിയാക്കിയ സാഹചര്യത്തിൽ കൂടുതൽ മെച്ചപ്പെട്ട രീതിയിൽ രണ്ടാം ഘട്ടം ആരംഭിക്കുന്നതിനുള്ള നടപടികൾ ദ്രുതഗതിയിൽ നടന്നുവരുന്നു. ഏകദേശം 30 ലക്ഷത്തിൽ അധികം പേർ ഗുണഭോക്താക്കൾ ആയിട്ടുള്ള മെഡിസെപ് പദ്ധതിയിൽ പ്രായം, നിലവിലെ അസുഖം, waiting period, ആശ്രിതരുടെ എണ്ണവും പ്രായവും ഒന്നും കണക്കിലെടുക്കാതെ എല്ലാവർക്കും ഒരേ നിരക്കിലും കുറഞ്ഞ നിരക്കിലുമുള്ള പ്രീമിയമാണ് നിശ്ചയിച്ചിട്ടുള്ളത്. പദ്ധതിയിൽ നിന്നും ഗുണഭോക്താക്കളെ ഒഴിവാക്കുന്നത് പ്രീമിയം നിരക്ക് ഉയരാൻ ഇടയാക്കും എന്നതിനാലും സംസ്ഥാനത്തെ എല്ലാ സർക്കാർ ജീവനക്കാർക്കും പെൻഷൻകാർക്കും നിർബന്ധിതാടിസ്ഥാനത്തിൽ നടപ്പിലാക്കിയ പദ്ധതിയായതിനാലും സർക്കാർ ജീവനക്കാരേയും പെൻഷൻകാരെയും പദ്ധതിയിൽ നിന്നും ഒഴിവാക്കാൻ നിർവാഹമില്ല.

സെക്ഷൻ ഓഫീസർ

MEDISEP

MEDICAL INSURANCE FOR STATE EMPLOYEES AND PENSIONERS

Memorandum of Understanding
dated 27.06.2022
between
The Finance Department, Government of Kerala
and
The Oriental Insurance Company Limited

ओरिएण्टल इंश्योरेंस

Oriental insurance

കേരളം केरल KERALA

DM 077340

Insurance Contract
for the implementation of
Medical Insurance Scheme for State Employees and Pensioners (MEDISEP)

This Agreement for the implementation of MEDISEP for providing the MEDISEP Cover (the **Insurance Contract**) is made at Thiruvananthapuram on 27/06/2022

BETWEEN

(1) **The Finance Department, Government of Kerala** represented by the Additional Chief Secretary/Officer on Special Duty(Finance-Resources), having his principal office at Government Secretariat (hereinafter referred to as the **Authority** which expression shall, unless repugnant to the context or meaning thereof, be deemed to mean and include its successors and permitted assigns);

AND

(2) The **Oriental Insurance Company Ltd.**, an insurance company registered with the Insurance Regulatory & Development Authority of India having registration number 556 and having its registered office at A-25/27, ASAF ALI ROAD, NEW DELHI – 110002(hereinafter referred to as the **Insurer**, which expression shall, unless repugnant to the context or meaning thereof, be deemed to mean and include its successors and permitted assigns).

The Authority and the Insurer shall collectively be referred to as the **Parties** and individually as the **Party**.

MOHAMMED Y. SAFIRULLA K.
Additional Chief Secretary
Special Duty
Finance (Resources) Dept.
Government Secretariat
Thiruvananthapuram

रेमा देवी वी
REMA DEVI V.
मुख्य क्षेत्रीय प्रबंधक
Chief Regional Manager

KERALA GOVT. SECRETARIAT FINANCE DEPARTMENT

THE ORIENTAL INSURANCE COMPANY LTD. R.O. COCHIN

NO 2022 DATE
VALUE OF RS
SOLD TO

M.A. KUNJU BEEVI
HIGH COURT VENDOR

DISTRICT STAMP DEPOT
22 JUN 2022
ERNAKULAM

WHEREAS

A.The Medical Insurance Scheme for State Employees and Pensioners (the **MEDISEP**) is intended to provide comprehensive health insurance coverage to all serving employees of the Government who are covered under the existing Kerala Government Servants Medical Attendant Rules [KGSMA Rules, 1960] and pensioners. This includes newly recruited, employees and their family, part time contingent employees, part time teachers, teaching, non-teaching staff of aided schools and colleges and their family and pensioners and their spouses and family pensioners on compulsory basis, and All India Service officers serving in the State who are covered under the existing Kerala Government Servants Medical Attendant Rules [(KGSMA) Rules, 1960] on optional basis. It is estimated that approximately 5 lakh State Government Employees and 5 lakh pensioners and their dependents will be beneficiaries of the scheme. In addition to the above-mentioned categories, employees and pensioners of the universities which receive Grant-in-Aid from the State Government and Local Self Government Institutions and the directly recruited personal staff of the Chief Minister, Ministers, Leader of Opposition and Chief Whip etc. and personal staff pensioners/family pensioners shall also be considered as beneficiary for this scheme.

B. The scheme envisages cashless treatment facility to beneficiaries through an insurance company and a network of empanelled hospitals according to the criteria specified by the Government. The benefit package of the scheme would include a basic benefit package which will provide coverage for catastrophic, secondary and tertiary care procedures, emergency (the beneficiaries is admitted due to road traffic accidents resulting in injuries of specified severity to nearest hospital by emergency caregivers where procedures listed are carried out limited to the package cost mentioned against such procedures for the category which the hospital belongs to had it been empanelled, Cardiac Arrest and stroke where the patient is moved by caregivers to a non-empanelled hospital subject otherwise to the terms and conditions of the scheme) and trauma care, and day care procedures. The Medical Expert Committee constituted by the Finance Department recommended a Basic Benefit Package and Additional Benefit Package for catastrophic procedures including transplant surgeries. The scheme will also cover all pre-existing diseases of the beneficiaries from the inception of the scheme. However, Outpatient Treatment will not be covered under this scheme.

C. On 22/01/2021 the Authority commenced a bidding process by issuing tender documents (the **Tender Documents**), inviting insurance companies to submit their bids for the implementation of the MEDISEP. Pursuant to the Tender Documents, the bidders submitted their bids on 06/02/2021 for the implementation of the MEDISEP.

D. Following a process of evaluation of technical and financial bids submitted by bidders, the Authority accepted the Bid of the Insurer for the implementation of the MEDISEP. The Authority issued a notification of award dated 06/08/2021 (the **NOA**) and requested the Insurer to execute this Insurance Contract. The Insurer accepted the NOA on 13/08/2021.

E. The Insurer represents and warrants that it has the experience, capability and know-how required for carrying on health insurance business and has agreed to provide health insurance services and provision of the Risk Cover (*defined below*) to the Beneficiary Family Units (*defined below*) eligible under the MEDISEP for the implementation of the MEDISEP.

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

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

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

G. The Government of Kerala have accorded administrative sanction vide G.O(P) No. 01/2022/Fin dated 01/01/2022 to entrust the Insurance Contract to Oriental Insurance Company Ltd. and to enter into agreement between the parties.(Annexure I).Sanction has been accorded for implementing the scheme w.e.f.01.07.2022 vide GO(P)No.70/2022/Fin dated 23.06.2022(Annexure II).

NOW THEREFORE IT IS AGREED AMONGST THE PARTIES AS FOLLOWS:

1. Definitions and Interpretations

Definitions

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

Additional Coverage means the additional sum assured for specified diseases.

Annexure means an annexure to this Insurance Contract

Appellate Authority shall mean the authority designated by the Authority 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 Authority and the Insurer.

Authority means Additional Chief Secretary/Officer on Special Duty (Finance-Resources), Finance Department, and Government of Kerala.

Beneficiaries means All Serving employees of the Government including newly recruited, and their family who are covered under the existing Kerala Government Servants Medical Attendant Rules [KGSMA Rules, 1960], part time contingent employees, part time teachers, teaching, non-teaching staff of aided schools and colleges and their family and pensioners and their spouses and family pensioners on compulsory basis, and all All India Service officers serving in the State of Kerala who are covered under the existing Kerala Government Servants Medical Attendant Rules [KGSMA Rules, 1960] on optional basis . In addition to the above-mentioned categories, employees and pensioners of the Universities which receive Grant-in-Aid from the Government and Local Self Government Institutions and the directly recruited personal staff of the Chief Minister, Ministers, Leader of Opposition and Chief Whip etc. and personal staff pensioners/ family pensioners shall also be considered as beneficiary for this scheme. Notwithstanding the above, the Authority have the discretion to include or exclude any categories of beneficiaries to/from the coverage of the scheme at any stage of the scheme.

Benefit Package refers to the package of benefits that the insured families would receive under the MEDISEP.

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 Tender Document and all subsequent submissions made by the Bidder as requested by the Authority for the purposes of evaluating the bid.

Bidder shall mean any eligible Insurance Company which has submitted its bid in response to the Tender released by the Government of Kerala.

Cashless facility means a facility provided to the employee/pensioner by the insurance company, to make payments of treatment costs directly to the Empanelled Healthcare Provider in respect of treatment undergone in a network provider, to the extent of approval given where such treatment is in accordance with the policy terms and conditions.

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

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

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

Clause means a clause of this Insurance Contract.

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Catastrophic illness means severe illness requiring prolonged hospitalization for recovery. These illnesses (speciality and super speciality) involve high costs for treatment and may incapacitate the person from working, creating a financial hardship.

Day Care Centre means any registered institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and is under supervision of a registered and qualified medical practitioner and must comply with all minimum criterion.

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.

Day one means the date on which the scheme will come into force.

Dependant means those who are dependent on the employee for their livelihood.

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Empanelled Health Care Provider (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 in accordance with terms of this Contract for the provision of health services to the Beneficiaries.

Enrolment means registration of beneficiaries to the scheme.
Enrolment Period means the period given for the registration of the beneficiaries to the scheme.

Family means all or any of the following relatives of an insured person, namely:

A. In the case of an insured employee:

(i) legal spouse of the employee (who do not have the eligibility to enrol in this

scheme).

(ii) minor or adopted child/children dependent upon the insured, till they get employed,

married or attained the age of 25 years whichever is earlier.

(iii) Physically / Mentally challenged children of the employee without any age restriction on the grounds of benchmark disability(certificate should be produced as specified in the scheme).

(iv) Dependent parents of the employee.

B. In the case of insured pensioner:

Legal spouse (who do not have the eligibility to enrol in this scheme) and physically/mentally challenged children of the pensioner without any age restriction on the grounds of benchmark disability. (Certificate should be produced as specified in the scheme).

C. In the case of insured family pensioner.

Physically/mentally challenged children of the pensioner without any age restriction on the grounds of benchmark disability (certificate should be produced as specified in the scheme).

Government means Government of Kerala.

Hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Kerala Clinical Establishments (Registration and Regulation) Act 2018, having the standards and benchmarks for hospitalisation that provides network prescribed by Insurance Regulatory and Development Authority of India.

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, for MEDISEP.

Hospitalization means any Medical Treatment or Surgical Procedure which requires the Beneficiary to stay at the

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premises of an Empanelled Health Care Provider for 24 hours or more including day care treatment as defined above.

Identity Cards means card issued by the Insurer / TPA which would contain Unique Insurance Identification/**MEDISEP** Number along with Permanent Employee Number (PEN) / Pension Payment Order Number (PPO)/ AADHAR and all relevant details of MEDISEP members which will be used at the provider network to access health insurance benefits.

Insured Person means the member who has insured under the scheme.

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

Insurance Contract shall mean this contract between the Authority 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 MEDISEP.

Insurer means the successful bidder which has been selected pursuant to this bidding process and has agreed to the terms and conditions of the Tender Document and has signed the Insurance Contract with the Government.

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

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

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

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

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

Medical Board means standing medical board constituted by the Director of Health Services, Government of Kerala consisting of not less than 3 members.

Medical insurance policy is a contract between an insurer and the Government in which the insurer agrees to provide specified health insurance cover to the employees and pensioners and their dependents at a particular "premium".

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

New-born Benefit means the benefit given to the new-born child/children along with the insured mother.

New-born baby means baby born during the Policy Period.

Package Rate means the fixed maximum charges for a Medical Treatment or Surgical Procedure or for any Follow-up Care that will be paid by the Insurer under Cover, which shall be determined in accordance with the rates provided in this Contract and Pre/Post hospitalisation cost are a part of the package rate.

Party means either the Insurer or the Authority and **Parties** means both the Insurer and the Authority.

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Policy Cover Period shall mean 36 calendar months from the date of start of the Policy Cover or lesser period as stipulated by Authority from time to time, unless cancelled earlier in accordance with this Insurance Contract.

Period of Contract means three years from the date of signing of MOU +3months.

Period of Insurance means three years from the date of signing of MOU between the Government of Kerala and the Insurer.

Pre–existing diseases is a medical condition/disease that existed before the commencement of the insurance coverage obtained from the health insurance policy.

Pre-hospitalization/Post hospitalisation Medical Expenses means the medical expenses that shall form part of the package incurred after finalization after agreed procedure (limited to 15 days prior to date of admission) in the same hospital where the medical treatment or surgical procedure is carried out and consultation expenses, medicines, laboratory tests, related to the procedure carried out in the same hospital during admission limited to 15 days after the date of discharge. The final package cost is inclusive of pre and post hospitalisation expenses. There shall be no reimbursement of any expenses, medical/laboratory charges/treatments incurred as pre/post hospitalisation over and above the package rates.

Premium means the aggregate sum agreed by the Parties as the annual premium to be paid by the Authority to the Insurer for each Beneficiary Family Unit that is eligible for the scheme, as consideration for providing the Cover to such Beneficiary Family Unit under this Insurance Contract. The Premium of the employee shall be deducted from their salary in monthly instalments and the premium of the pensioner shall be met from their pension entitlement.

Policy plan period means the three-year period from the date of implementation of the scheme.

Provider Network means hospitals or health care providers enlisted by an insurer, to provide medical services to an insured by cashless facility.

Risk Cover shall mean an annual risk cover as defined covering inpatient care and day care surgeries (as applicable) for treatment of diseases and medical conditions through a network of Empanelled Health Care Providers (EHCP) for the eligible MEDISEP Beneficiary Family Units.

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

State Nodal Cell means the implementation and monitoring mechanism for MEDISEP under the Authority.

Sum Assured means the total benefit coverage provided by the insurer.

Schedule means a schedule of this Insurance Contract.

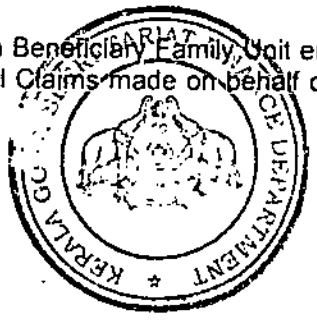
Scheme shall mean the MEDISEP (Medical Insurance Scheme for State Employees and Pensioners) managed and administered by Finance Department, Government of Kerala.

Selected Bidder shall mean the successful bidder which has been selected in the bid exercise and has agreed to the terms and conditions of the Tender Document and has signed the Insurance Contract with the State Government.

Service Area refers to the entire MEDISEP covered and included under this Contract for the implementation of MEDISEP.

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

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



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

Tender Documents refers to Request for Proposal released on 22.01.2021 (E-tender No.2021_FIN_407935_1 dated 22.01.2021) including all amendments, modifications issued by the Authority in writing pursuant to the release of the Tender Document.

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

(i) is required for the medical management of the illness, disease or injury suffered by the Beneficiary;
(ii) does not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;
(iii) Has been prescribed by a Medical Practitioner; and conforms with the standard treatment guidelines under the Clinical Establishment Act prescribed by the State Government / Government of India.
(iv) Conforms to the professional standards widely accepted in international medical practice or by the medical community in India.

Turn-around Time means the time taken by the Insurer in processing a Claim received from an Empanelled Health Care Provider along with all requisite details /documents of the hospitalisation and in making a Claim Payment including investigating such Claim or rejection of such Claim.

1.1 Interpretation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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PART I

TERMS AND CONDITIONS OF INSURANCE

2. MEDISEP Beneficiaries and Beneficiary Family Unit

a. The Parties agree that for the purpose of this Insurance Contract and any Policy issued pursuant to this Insurance Contract, and all the persons who are eligible for the scheme as per database provided by the Authority

b. Unit of coverage under the Scheme shall be a family of employee or pensioner and each family for this Scheme shall be called a MEDISEP Beneficiary Family Unit, which will comprise all members in that family.

All MEDISEP Beneficiary Family Units, as defined: **A.** In the case of an insured employee :(i) legal spouse of the employee (who do not have the eligibility to enrol in this scheme). ii) Minor or adopted child/children dependent upon the insured, till they get employed, married or attained the age of 25 years whichever is earlier. (iii) Physically challenged/mentally challenged children of the employee without any age restriction on the grounds of ***Bench Mark Disability***.(certificate should be produced as specified in the scheme). iv) Dependent parents of the employee. **B.** In the case of insured pensioner: Legal Spouse (who do not have the eligibility to enrol in this scheme) and physically challenged/mentally challenged children of the pensioner without any age restriction on the grounds of ***Bench Mark Disability***. (certificate should be produced as specified in the scheme). **C.** In the case of insured family pensioner Physically challenged/mentally challenged children of the pensioner without any age restriction on the grounds of ***Bench Mark Disability***. (certificate should be produced as specified in the scheme). These categories are considered as eligible for benefits under the Scheme and be automatically covered under the Scheme.

(i) Addition to the family is allowed in following contingencies during the policy. (1) Marriage of the beneficiary (requiring inclusion of spouse's name) (2) Children born during policy period. (ii) Deletion from Family is allowed in following contingencies (1) Death of covered beneficiary (2) Divorce of the spouse. (3) Member becoming ineligible (on condition of dependency).

The insurer agrees to a two month additional period from the inception of the policy date for finalisation of the database by the Authority. This period will be used by the authority to make rectifications / additions to the individual enrolment database.

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

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

The Insurer agrees to issue Identity Card to the beneficiaries based on the database shared by the "Authority" and the card would include Unique Insurance Identification/MEDISEP Number along with Permanent Employee Number (PEN)/PPO number/ AADHAR (if available) and all relevant details of MEDISEP members. This card would be used at the Empanelled Health Care Provider to access health insurance benefits.

3. Risk Covers and Sum Insured

3.1 Risk Cover and Sum Insured

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

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

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As on the date of commencement of the Policy Cover Period, the MEDISEP Sum Insured in respect of the Risk Cover for each MEDISEP Beneficiary Family Unit shall be;

1. **Basic Benefit Package Coverage** :This caters to the benefit package list mentioned in Schedule I in which medical, surgical and day care procedures will be covered up to a sum of Rs. 3 lakh per annum for a block period of three years. Out of the annual coverage of three lakhs, Rs.1.5 lakh are fixed in nature and Rs.1.5 lakh can be availed on a floater basis each year. The first component of Rs.1.5 lakh is fixed for each year and will lapse at the end of each year. The floater component, if not exhausted, can be carried over to the subsequent years of the policy.

2. **Additional Package Coverage** : In addition to the Basic Benefit Package coverage mentioned above, all procedures mentioned in the Schedule I will be covered by the policy.

3. **Corpus fund for Catastrophic illnesses** : An additional sum of not less than Rs.35 crore for three years shall be provided by the Insurer as a corpus fund for providing coverage to Additional Packages enlisted under Schedule I. The corpus fund can also be used for reimbursement of expenses to insurance company, in case there is any new catastrophic illness and a treatment package for the same, which is not listed in the benefit package, but recommended for inclusion after detailed review by the Health Department.

The sum insured for the above three categories will be per family per annum on family floater basis. This shall be called the **Sum Insured**, which shall be fixed irrespective of the size of the MEDISEP Beneficiary Family Unit.

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

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

Medical pre-hospitalisation/post hospitalisation expenses are medical expenses that shall form part of the package incurred after finalisation of the agreed procedure (limited to 15 days prior to the date of admission) in the same hospital where the medical treatment or surgical procedure is carried out and consultation expenses, medicines, laboratory tests , related to the procedure carried out in the same hospital during admission limited to 15 days after the date of discharge. The final package cost is inclusive of pre and post hospitalisation expenses. There shall be no reimbursement of no expenses, medical/laboratory charges / treatment incurred as pre/post hospitalisation over and above package rates.

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

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

3.2 Benefit Package: MEDISEP Cover

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

(i) Hospitalization expense benefits
(ii) Day care treatment benefits (as applicable)
(iii) Pre and post hospitalization expense benefits as defined above in 3.1
(iv) New-born child/ children benefit

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The details of benefit package and list of exclusions are furnished in Schedule I and Schedule IX respectively. For availing select treatment in any empanelled hospitals, preauthorisation is required to be taken for defined under schedule I and "Unspecified procedures".

There shall be no reimbursement of any expenditure incurred other than as defined below:

Road Traffic Accident resulting in injuries of specified severity (cases where due to emergency the beneficiary is admitted to nearest hospital by emergency care givers where procedures listed are carried out limited to the package cost mentioned against such procedures for the category which the hospital belong to had it been empanelled), Cardiac Arrest and Stroke where the patient is moved by caregivers to a non empanelled hospital, subject otherwise to the terms and conditions of the scheme.

If any particular unspecified procedure recurs more than hundred times the first three months after the commencement of the scheme, the same shall be considered and included as a procedure.

The Insurer shall reimburse claims of public and private health care providers under the MEDISEP based on Package Rates determined as follows:

(i) If the package rate for a medical treatment or surgical procedure requiring Hospitalization or Day Care Treatment (as applicable) is fixed in Schedule I, then the Package Rate so fixed shall apply for the Policy Cover Period.

(ii) If the treatment cost is more than the benefit coverage amount available with the beneficiary families then the remaining treatment cost will be borne by the MEDISEP Beneficiary family as per the package rates defined in this document. Beneficiary will need to be clearly communicated in advance about the additional payment. The insurance company should fix the average length of stay for all procedures, and accordingly the total room rent charges would be calculated subject to the rates specified in Schedule III. Any charge over and above the ceiling rates prescribed would have to be borne by the beneficiary.

In case, if MEDISEP Beneficiary is required to undertake multiple surgical treatment, then the highest package rate shall be taken at 100%, thereupon the 2nd treatment package shall be taken as 50% of package rate and 3rd treatment package shall be at 25% of the package rate.
Surgical and Medical packages will not be allowed to be availed at the same time.

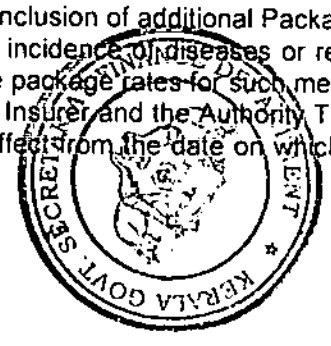
For the purpose of Hospitalization expenses as package rates shall include all the costs associated with the treatment, amongst other things:

(i) Registration charges.
(ii) Bed charges (General/ Semi private/ Private room).
(iii) Nursing and boarding charges.
(iv) Surgeons, Anaesthetists, Medical Practitioner, Consultants fees etc.
(v) Anaesthesia, Blood Transfusion, Oxygen, O.T. Charges, Cost of Surgical Appliances etc.
(vi) Medicines and drugs.
(vii) Cost of prosthetic devices, implants etc.
(viii) Pathology and radiology tests: radiology to include but not be limited to X-ray, MRI, CT Scan, etc.
(ix) Diagnosis and Tests, etc
(x) Pre and Post Hospitalisation expenses: Expenses incurred for consultation, diagnostic tests and medicines before the admission of the patient in the same hospital and cost of diagnostic tests and medicines and up to 15 days of the discharge from the hospital for the same ailment/ surgery.
(xi) Any other expenses related to the treatment of the patient in the hospital.

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

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

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



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

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

However, if the balance in the sum insured available for a beneficiary family unit is not sufficient in case at the admission package rates for some medical treatment or surgical procedures may exceed the available Sum Insured, it would enable MEDISEP beneficiaries to avail treatment of such medical conditions or surgical procedures on their own cost / expenses at the package rate rather than on an open-ended or fee for service basis. But in case there is no balance sum insured for the beneficiary family, they will have to avail treatment of such medical conditions or surgical procedures on their own cost / expenses at the hospital rates.

3.3 Benefits Available only through Empanelled Health Care Providers

a. The benefits under the MEDISEP Risk Cover shall only be available to a MEDISEP Beneficiary through an EHCP after Aadhaar based identification as far as possible. In case Aadhaar is not available then Voters ID/ Ration card and in the case of minor children, birth certificate will be used for this purpose.In case of pensioners having no valid id proofs , the identification certificates issued from the treasury along with the medisep identity cards will be used for identification purpose.

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

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

4. Identification of MEDISEP Beneficiary Family Units

a. The beneficiaries will be identified using the MEDISEP Identity card issued by the insurer based on the database provided by the Authority which can be used as reference while availing benefits.
OR
b. The beneficiaries will be identified by using Aadhar produced by the beneficiary at the point of contact.

5. Empanelment of Health Care Providers

a. All public hospitals providing secondary and tertiary care, government hospitals and super speciality institutions including the Regional Cancer Center (RCC), Malabar Cancer Center (MCC), Cochin Cancer Center (CCC) and Sree Chitra Thirunal Institute of Medical Sciences and Technology (SCTIMST), shall be included in the provider network.

Private healthcare providers (both for profit and non-profit) which provide hospitalization and/or day care services (as applicable) would be eligible for empanelment under MEDISEP, subject to their meeting of certain requirements (empanelment criteria) in the areas of infrastructure, manpower, equipment (IT, help desk etc.) and services (for e.g. liaison officers to facilitate beneficiary management) offered, which can be seen at **Schedule II** of this document.

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

c. The Insurer shall be responsible for empanelment and periodic renewal of empanelment of health care providers for offering services under the MEDISEP. The insurance company shall ensure the availability of a minimum of five hospitals in category one (excluding government hospitals) in each district of the State and the availability of a minimum 25 network hospitals (excluding government hospitals) in the areas under each cluster of districts indicated at Schedule II. In category 2, (excluding government hospitals) the insurance company should ensure a minimum of five hospitals for each speciality group of the benefit package in each cluster. In category 3, (excluding government hospitals) the insurance company shall ensure a minimum of two hospitals for transplant

surgeries mentioned in additional benefit package in each cluster. The insurance company can empanel all specialities or a group of specialities depending on availability of each specialities in a network hospital. A network hospital can be empanelled for all three categories or for any one of the three categories specified above.

d. The insurer agrees to consider empanelment of new hospitals upon request by the authority from time to time, provided the hospitals agree the package rates specified as per the MEDISEP.

e. In case the insurer fails to fulfill the hospital empanelment criteria in category three (organ transplant), the expenditure incurred by the beneficiary on such procedures in non-empaneled hospitals may be reimbursed by the insurer as per the package rate specified under MEDISEP.

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

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

6. Agreement with Empanelled Health Care Providers

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

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

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

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

(e) As a part of the Agreement, the Insurer shall ensure that each EHCP has within its premises the IT infrastructure (hardware and software) required for the MEDISEP Scheme.

7. De-empanelment of Health Care Providers

a. The Authority, either on its own or through Insurer, shall suspend or de-empanel an EHCP from the MEDISEP, as per the guidelines mentioned in **Schedule II**

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

8. Issuance of Policies

(a) For the purpose of issuance of a policy, all eligible beneficiary family units of MEDISEP shall be covered under **four policies**. The Insurer shall issue the Policies before the commencement of the Policy Cover Period.

The first Policy Cover Period under the Policy for MEDISEP shall commence from the date 01/07/2022
The terms and conditions set out in each Policy issued by the Insurer to the Authority shall at a minimum include:

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

(b) In the event of any discrepancy, ambiguity or contradiction between the terms and conditions set out in the Insurance Contract and a Policy issued for MEDISEP by the Insurer, the terms of the Insurance Contract shall prevail

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for the purpose of determining the Insurer's obligations and liabilities to the Authority and the MEDISEP Beneficiaries.

9. Period of Insurance Contract and Policy

9.1 Term of the Insurance Contract with the Insurer

This Insurance Contract shall be for a period of maximum of 36 months with starting date_01.07.2022

9.2 Policy Cover Period

In respect of each policy, the Policy Cover Period shall be for a period of 36 months from the date of commencement of such Policy Cover Period with yearly renewal without any changes in policy terms and conditions, subject to receipt of premium. Provided that upon early termination of this Insurance Contract, the Policy Cover Period for the MEDISEP shall terminate on the date of such termination, wherein the premium shall be paid on pro-rata basis after due adjustment of any recoveries on account of termination.

For the avoidance of doubt, the expiration of the risk cover for any Beneficiary Family Unit in the MEDISEP during the Policy Cover Period shall not result in the termination of the Policy Cover Period.

9.3 Policy Cover Period for the MEDISEP Beneficiary Family Unit

During the first Policy Cover Period for a MEDISEP, the policy cover shall commence **from 00:00 hours of 01.07.2022.**

The end date of the policy cover for MEDISEP be 36 months from the date of start of the Policy Cover or the date on which the available Sum Insured in respect of that Cover becomes zero.

9.4 Cancellation of Policy Cover

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

For implications and protocols related to early termination, refer to **Clause 25**.

10 Premium and Premium Payment

10.1 Payment of Premium

The Authority will pay the insurance premium on behalf of the employees/pensioners to the Insurance Company. For the first year the premium will be initially calculated based on the number of beneficiaries in position covered under the Scheme as on date of implementation. Of this amount, 25 % will be paid as the first instalment on signing the agreement and prior to commencement of the Scheme. During the implementation, the actual premium will be arrived at based on the number of identity cards issued .The remaining 75% will be calculated as per the premium amount based on the number of identity cards issued and will be paid in three equal instalments after the successful completion of three months.
In case of newly recruited employees ,who joined the service during the policy period and unverified pensioners whose premium is deducted for the scheme but is not remitted to the Insurance Company in that quarter, an advance will be paid to Insurance Company based on the anticipated number of new recruitments and unverified pensioners. This shall be reconciled with the actual number and shall be settled before the payment of last quarter of each year.
In the case of death of a beneficiary/s prior to the commencement of the scheme and not identified while transferring database to the insurer the advance premium paid to the insurance company shall be refunded to /adjusted to the Authority within three months on submission of necessary documents.
The payment schedule will be as follows:

2nd instalment due on – 25th day of the third month
3rd instalment due on - 25th day of the 6th month

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4th instalment due on - 25th day of the 9th month

In the event of non-payment of instalments within 15 days of the due dates as per the above payment schedule shall, till the time of invocation of the cancellation clause, attract interest on the amount due @1/2% per month, if the cover is required to continue during the period of default.

The same payment schedule will be continued during the second and third year. For these years the total annual premium will be calculated on the basis of number of identity cards **or certificates of Pay Drawing Officers issued under the** Scheme as on date .The payment of premium will be based on the data made available by the department.

The Authority shall make the payment to the Insurance Company through Electronic Fund Transfer.

The insurer shall raise an invoice on the Government as per the following schedule:

2nd instalment–5th day of the third month
3rd instalment - 5th day of the 6th month
4th instalment - 5th day of the 9th month

10.2 Taxes

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

a. pay any service tax assessed or levied by any competent tax authority on the Insurer or on the Authority for or on account of any act or omission on the part of Insurer; or
b. on account of the Insurer's failure to file tax returns as required by applicable Laws or comply with reporting or filing requirements under applicable Laws relating to service tax; or
c. arising directly or indirectly from or incurred by reason of any misrepresentation by or on behalf of the Insurer to any competent tax authority in respect of the service tax.

10.3 Premium All Inclusive

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

a. the risk cover provided to each eligible Beneficiary Family Unit; or
b. the performance of any of its obligations under this Insurance Contract; or
c. any costs or expenses that it incurs in respect thereof.

10.4 No Separate Fees, Charges or Premium

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

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

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

The Insurer undertakes and agrees that it shall not:

(i)file an application with the IRDA for approval of the revision, modification or amendment of the Premium for or the terms and conditions of or for the withdrawal of any or all of the Covers; or
(ii)revise, modify, amend or withdraw any or all of the Covers, **whether with or without the IRDA's approval** under the Health Insurance Regulations, at any time during the Term of this Insurance Contract.

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

11. Cashless Access of Services

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

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

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

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

e.The Insurer shall support the administration of EHCP that will be responsible for the implementation of the MEDISEP on the use of the Hospital IT infrastructure for making Claims electronically and providing Cashless Access Services.

f.The EHCP shall establish the identity of the member of a MEDISEP Beneficiary Family Unit by MEDISEP Identity Card (No person shall be denied the benefit in the absence of MEDISEP Identity card through use of alternate Government ID and ensure:

(i) That the patient is admitted for a covered procedure and package for such an intervention is available.
(ii) MEDISEP Beneficiary has balance in her/ his MEDISEP Cover amount.
(iii) Provisional entry shall be made on the server using the MEDISEP ID of the patient. It has to be ensured that no procedure is carried out unless preauthorisation is approved.
(iv) At the time of discharge, the final entry shall be made on the patient account after completion of Aadhaar Card Identification Systems verification or any other recognised system of identification adopted by the Authority of MEDISEP Beneficiary Family Unit to complete the transaction.

12. Pre-authorisation of Procedures

(a) All procedures in **Schedule I** that are earmarked for pre-authorisation shall be subject to mandatory pre-authorisation.

(b) Insurer will not allow any EHCP shall, under any circumstances whatsoever, to undertake any such earmarked procedure without pre-authorisation unless under emergency. Process for emergency approval will be followed as per guidelines laid down under MEDISEP

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

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

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

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

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

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

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

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

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

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

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

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

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

(p) The entry on the MEDISEP portal for preauthorisation approval as well at discharge would record the authorisation number as well as package amount agreed upon by the EHCP and the Insurer.

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

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

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

Detailed guidelines for hospital transactions including pre authorisation should be furnished by the insurer to the Authority , before the commencement of the scheme.

13. Claims Management

13.1 Claim Payments and Turn-around Time

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

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

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

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

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

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

(f) The Insurer shall make the full Claim Payment without deduction of tax, for public hospitals. For private healthcare providers the Insurer shall make the full Claim Payment without deduction of tax, if the Empanelled Health Care Provider submits a tax exemption certificate to the Insurer within 7 days after signing the agreement with the Insurer making a Claim. If the Empanelled Health Care Provider fails to submit a tax exemption certificate to the Insurer, then the Insurer shall make the Claim Payment after deducting tax at the applicable rate.

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

(h) 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.

(i) The process specified in paragraphs (b) to (d) above in relation to Claim Payment or investigation of the Claim shall be completed such that the Turn-around Time shall be no longer than 15 working days.
(j) The counting of days for the purpose of this Clause shall start from the date of receipt of complete set of documents of the Claim.

(k) Claim payments in respect of Pre-Authorized amounts shall be made electronically to the EHCP as early as possible but not later than 15 working days, provided all claim documents are received by the Insurer as per MoU with the hospital.

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

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

(m) The Insurer shall submit details of:

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

(ii) every Claim that is pending beyond 15 working days of receipt of complete set of claim documents to the Authority, along with its reasons for delay in processing such Claim; and

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

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

Guidelines for submission of claims, claims processing, handling of claim queries, and all other related details should be furnished by the insurer, before the commencement of the scheme.

13.2 Right of Appeal and Reopening of Claims

The Empanelled Health Care Provider shall have a right of appeal against the rejection of a Claim by the Insurer, if the Empanelled Health Care Provider feels that the Claim is payable. Such decision of the Insurer may be appealed by filing a complaint with the Grievance Redressal Committees in accordance with **Clause 24** of this Insurance Contract.

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

13.3 No Contributions

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.

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

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

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

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

14. No Duty of Disclosure

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

Prior to commencement of each Policy Cover Period, the Authority undertakes to prepare the Beneficiary Database as correctly as possible. The Insurer acknowledges that, notwithstanding such efforts being made by the Authority, the information in the Beneficiary Database may not be accurate or correct and that the Beneficiary Database may contain errors or mistakes, which shall be rectified within two months of the commencement of the scheme.

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

The Insurer represents, warrants and undertakes that it has completed its own due diligence and is relying on its own judgment in assessing the risks and responsibilities that it will be undertaking by entering into this Insurance Contract and in providing the Covers to the enrolled Beneficiary Family Units and in assessing the adequacy of the Premium for providing the Covers for the Beneficiary Family Units.

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

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

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

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

15. Fraud Control and Management

a. The insurer is expected to develop a comprehensive fraud control system for the scheme. For an indicative (not exhaustive) list of fraud triggers that may be automatically and on a real-time basis be tracked please refer to **Schedule III**. The Insurer shall have capacities and track the indicative (not exhaustive) triggers and it can add more triggers to the list.
b. For all trigger alerts related to possible fraud at the level of EHCPs, the Insurer shall take the lead in immediate investigation of the case in close coordination and under constant supervision of the Authority.
c. Investigations pursuant to any such alert shall be concluded within 15 days and all final decision related to outcome of the Investigation and consequent penal action, if the fraud is proven, shall vest solely with the Authority.
d. The Authority shall take all such decision within the provisions of the Insurance Contract and be founded on the Principles of Natural Justice.
e. The Authority shall on an ongoing basis measure the effectiveness of anti-fraud measures in the Scheme through a set of indicators. For a list of such indicative (not exhaustive) indicators, refer to **Schedule IV**.
f. The Insurer shall be responsible for monitoring and controlling the implementation of the MEDISEP in the State in accordance with **Clause 24**.

g. In the event of a fraudulent Claim being made or a false statement or declaration being made or used in support of a fraudulent Claim or any fraudulent means or device being used by any Empanelled Health Care Provider or 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 Authority shall be to:

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

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

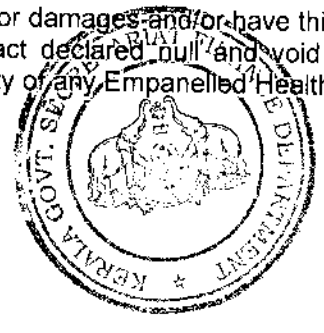
(iii) terminate the services agreement with the intermediary appointed by the Insurer; and/or

Provided that the Insurer has issued a notice to the Authority of its proposed exercise of any of these remedies; and such notice is accompanied by reasonable documentary evidence of such fraudulent activity. An indicative list of fraudulent triggers has been set out in **Schedule III**.

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

(i) The Insurer hereby releases and waives all rights or entitlements to:

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.



16 Representations and warranties of the Insurer

16.1 Representations and Warranties

The Insurer represents, warrants and undertakes that:

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

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

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

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

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

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

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

e. In **the financial year prior to the submission of its Bid, the Insurer has maintained its solvency ratio in full compliance with the requirements of the IRDA Solvency Regulations.**

f. The Insurer has complied with and shall continue to comply with all Laws, including but not limited to the rules or regulations issued by the IRDA in connection with the conduct of its business and the MEDISEP Guidelines issued by the Authority from time to time.

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

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

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

h. The Insurer shall not later deny issuance of a Policy or payment of a Claim on the grounds that: (i) the Premium is found financially unviable; or
(ii) the assumptions taken by the Insurer and/or its Appointed Actuary have been breached; or (iii) the Insurer's underwriting policy has been breached.

i. Without prejudice to Clause 16.1 (e) above, the Insurer is and shall continue to be capable of meeting its liabilities to make Claim Payments, servicing the Covers being provided by it under this Insurance Contract and has and shall continue to have sufficient infrastructure, trained manpower and resources to perform its obligations under this Insurance Contract.

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

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

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

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16.2 Continuity and Repetition of Representations and Warranties

The Insurer agrees that each of the representations and warranties set out in Clause 16.1 are continuing and shall be deemed to repeat for each day of the Term.

16.3 Information regarding Breach of Representations and Warranties

The Insurer represents, warrants and undertakes that it shall promptly, and in any event within 15 days, inform the Authority in writing of the occurrence of a breach or of obtaining knowledge of a potential breach of any of the representations and warranties made by it in Clause 16.1 at any time during the continuance of the Term.

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PART II
PROJECT OFFICE

17. Project Office and District Offices

The Insurer shall establish a Project Office at a convenient place at Thiruvananthapuram for coordination with the Authority on a regular basis within 15 days of signing of the contract. The insurer shall have district coordinators for coordinating the insurance activities at the district level with the Authority's district level administration. The details of the State and district coordinators of the insurance company shall be shared with the Authority for effective coordination of services.

18. Capacity Building Interventions

a The insurer shall prepare a training plan and share with Authority within 15 days of signing of the contract. The Insurer shall, at a minimum, conduct the following training and make them part of training plan. The insurer shall provide training to the key staff of all empanelled health care providers about the scheme profile list of covered procedures and prices, pre-authorisation procedures and requirements, IT training for making online Claims and ensuring proper installation and functioning of the Hospital IT Infrastructure for each Empanelled Health Care Provider before the commencement of the scheme.

b If a particular EHCP frequently submit incomplete documents or incorrect information in claims or in its request for authorisation as part of the preauthorisation procedure, then the insurer shall undertake a follow up training for such EHCP.

c The cost of all capacity building interventions associated with the implementation of the capacity building programme shall be borne by the insurer.

19. Other Obligations

19.1 Insurer's Obligations before start of the policy.

The Insurer shall mandatorily complete the following activities before the start of policy.

a. Sign contract with the empanelled hospitals and provide the service agreement with EHCP along with list of EHCP with speciality departments.

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

c. State office is set up and functional and district coordinators are in place.

d. Insurer shall provide the guidelines for transaction management, preauthorization and claims management process.

e. Establish the 24*7 Call center for the MEDISEP Scheme.

f. The insurer will publish a detailed manual for the "MEDISEP" which shall include operational guidelines and details of the scheme in consultation with Authority, with provision to update and modify the same. The insurer shall follow the guidelines and instructions given in the manual while implementing the scheme. All guidelines and relevant information regarding MEDISEP shall be also made available on the official website of the scheme. The details shall consist of

(i) Details about MEDISEP;
(ii) Process for utilizing the Covers under MEDISEP;
(iii) Pre-Authorization Process
(iv) List of Exclusions;
(v) Start and end date of the Policy Cover Period.
(vi) List of the Empanelled Health Care Providers along with addresses and contact details;

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(vii) The names and details of the District Coordinator of the Insurer in that district;

(viii)Toll-free number of the call centre;
(ix) Process of claims management
(x) Process for filing complaints or grievances;
(xi) All other details required for smooth usage of the MEDISEP.

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

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

19.2 Insurer's other obligations

a. Insurer shall enrol the beneficiaries as and when the Authority furnish the data during the policy period.as per the following criteria
   i) New beneficiaries in respect of new appointments to be covered on the first day of the subsequent month of furnishing the data
   ii) New born and newly married spouse to be covered from day one.
iii) On receipt of intimation regarding serving employees retiring during the course of the policy period, the insurer shall effect necessary changes to record inclusion as a pensioner with effect from the date of retirement.
b. There shall be no refund under the policy other than that mentioned in the clause 25.5

19.3 Authority's Obligations

The Authority shall mandatorily complete the following activities before the start of the policy .

a. Provide the Beneficiary Database in the format prescribed by the MEDISEP Guidelines to the insurer at least 30 days prior to the commencement of the Policy Cover Period.
b. Set up Grievance Redressal Committees as detailed out in clause 24 of this contract document.

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PART III

OTHER OBLIGATIONS REGARDING IMPLEMENTATION OF MEDISEP

20. Plan for provision of services in the absence of internet connectivity

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

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

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

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

21. Software and Management Information System

The insurer shall develop a dedicated information technology platform by means of suitable web portal and data base & management information system for supporting the implementation of MEDISEP and provide real time access to State Nodal Cell for monitoring the scheme performance. The information technology platform is expected to include the following parameters.

i. Database of beneficiaries.
ii. Database of Enrolment.
iii. Package details in the network hospitals.
iv. E- Health database: This database will maintain the patient details along with the diagnosis and treatment details. This Database will also be linked to the Enrolment Database & Claims Transaction Database to form the Central Database.
v. E- Pre-authorization: The Hospital will require a Pre-Authorization e-form to be filled before going in for the treatment.
vi. Claim processing and settlement Data Base: The claims processing database should include claim intimation, scrutiny of claims and status update and upon verification, settlement of claims.
vii. Management Information System(MIS)Reporting: Real-time reporting on performance and monitoring indicators.
viii. Accounting system: Payment Reconciliation.
ix. Third Party Integration: This will include (a) Electronic clearance of bills with payment gateway (b) SMS Gateway.

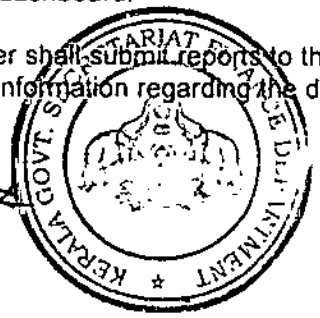
The web portal for MEDISEP shall provide information on the scheme details, List of empanelled and de-empanelled Hospitals, claims status, grievance redressal mechanisms, and other relevant information about the scheme. The insurer shall be responsible for ensuring the regular backup of data in collaboration with the State Nodal Cell.

The Authority shall have the access to the IT platform developed by the insurer for the implementation of the scheme. The shared information of beneficiaries and claims should be used only for the said purpose. The insurer should strictly maintain the confidentiality of any form of data or information shared by the Authority and protect information created, disclosed or acquired in the context of the client and health service provider relationship.

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

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

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



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

All data generated by the Insurer in relation to the implementation and management of the Scheme and/or in performing its obligations under the Insurance Contract shall be the property of the Authority. The Insurer undertakes to handover all such information and data to the Authority within 45 days of the expiration or cancellation of the Policy and on the expiration or early termination of the Insurance Contract/ or settlement of all dues to and from the insurer.

22.Monitoring and Control

22.1 Scope of Monitoring

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

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

22.2 Monitoring Activities to be undertaken by the Insurer

22.2.1 General Monitoring Obligations

Under the MEDISEP, the Insurer shall monitor the entire process of implementation of the Scheme on an ongoing basis to ensure that it meets its obligations under its Insurance Contract with the Authority. Towards this obligation the Insurer shall undertake, **but not be limited** to, the following tasks:
Ensure compliance to all the terms, conditions and provisions of the Scheme.

Ensure monitoring of processes for seamless access to cashless health care services by the MEDISEP beneficiaries under the provisions of the Scheme.

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

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

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

22.2.2 Medical Audit

(a) Scope

The scope of medical audit under the Scheme shall focus on ensuring comprehensiveness of medical records and shall include but not be limited to:

Completeness of the medical records file.
Evidence of patient history and current illness.
Operation report (if surgery is done).
Patient progress notes from admission to discharge.
Pathology and radiology reports.

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

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Methodology

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

The indicative process of conducting medical audits is set out below and based on this the Insurer shall submit its detailed audit methodology to the Authority for approval:

The auditor shall check the data before meeting the EHCP authorities.

The audit should preferably be conducted in the presence of the EHCP's physician/ treating doctor.

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

Personnel

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

Frequency and Sample

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

22.2.3 Hospital Audit

The Insurer will conduct hospital audit for every single EHCP visited by it as a part of the medical audit as described in **Clause 22.2.2** above.

Hospital audit shall be conducted as per the format prescribed in **Schedule VII.**

Hospital audit will focus on compliance to EHCP's obligations like operational help desk, appropriate signage of the Scheme prominently displayed, etc. details of which are captured.

22.3 Monitoring Activities to be undertaken by the Authority

22.3.1 Audits by the Authority

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

b. Direct audits: In addition to the audit of the audits undertaken by the Insurer referred in **Clause 22.3.1.a**, the Authority shall have the right to undertake direct audits on a regular basis conducted either directly by it or through its authorized representatives/ agencies including appointed third parties. Direct audits shall include:

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

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

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

- Evidence of rigorous review of claims.

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

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

22.3.2 Spot Checks by the Authority

a. The Authority shall have the right to undertake spot checks of State Project office of the Scheme at Trivandrum and the premises of the EHCP without any prior intimation.
b. The spot checks shall be random and will be at the sole discretion of the Authority.

22.3.3 Performance Review and Monitoring Meetings

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

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

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

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

22.4 Key Performance Indicators for the Insurer(KPI)

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

22.5 Measuring Performance

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

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

All penalties imposed by the Authority on the Insurer shall have to be paid by the Insurer within 60 days of such demand and in case of any dispute, within 45 days of disposal of such appeal.

Based on the review the Authority shall have the right to issue rectification orders demanding the performance to be brought up to the levels desired as per the MEDISEP Guidelines.

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).

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

If the Authority 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 Authority and the Insurer.

22.6 Penalties

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

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

Grievance Redressal: It is mandated that all orders of the grievance redressal committee is carried out within 30 days unless stayed by the next higher level. Any failure to comply with the direction of the Grievance Redressal Committee at any level will meet with a penalty of Rs. 25,000/- per decision for the first month and 50,000/- per month thereafter during which the decision remains un-complied. The amount shall be paid by the insurance company to the Authority.

Apart from the above, in the event of noncompliance of guidelines and agreement leading to disruption of the project will attract a penalty subject to a maximum of 75% of estimated annual project cost.

23. Reporting Requirements

The Insurer shall submit the following reports as per the schedule provided in the table below:

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

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

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

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

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

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PART IV

COORDINATION AND GRIEVANCE REDRESSAL

24. Grievance Redressal

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

Under the Grievance Redressal Mechanism of MEDISEP, set of three tier Grievance Redressal Committees have been set up to attend to the grievances of various stakeholders at different levels.
If any dispute arises between the parties namely insurer & beneficiary, insurer & empanelled hospital and beneficiary & empanelled hospital and during the policy plan period or thereafter, in connection with the validity, interpretation, implementation or alleged breach of any provision of the scheme etc, it will be settled in the following way.

1.District Level Grievance Redressal Committee (DGRC)

A Grievance Redressal committee shall be set up in each District for redressing of grievance of beneficiaries/Network provider by the Insurer. The committee will constitute following members:

i) District Collector/Representative(Convener)
ii) District Medical Officer
iii) Representative of Insurer
iv) Finance Officer of District Collectorate

The Committee will resolve the Grievance within 30 days from the date of receiving the application. The aggrieved, if not satisfied with the decision of the committee, can approach to the State Level Committee.

2.State Level Grievance Redressal Committee (SLGRC)

A State Level GRC consisting of the following members shall be set up to examine the grievances which could not be solved in the DGRC.

i) Additional Secretary (Finance Health Insurance Department)(Convenor)
ii) Additional Secretary (Health & Family Welfare Department)
iii) Additional Director of Health Services, Medical
iv) Joint Director of Medical Education
v) Representative of Insurer

The Committee will resolve the Grievance within 30 days from the date of receiving the application. The aggrieved, if not satisfied with the decision of the committee, can approach the Appellate Authority for arbitration.

3.Appellate Authority

The appellate authority will consist of the following members

i) Additional Chief Secretary/Principal Secretary (Finance Department)(Convenor)
ii) Additional Chief Secretary/Principal Secretary (Health & Family Welfare Department)
iii) Director of Health Services
iv) Director of Medical Education

The decision of the appellate authority will be final &binding on all the parties.

In case of disputes arising between the Government of Kerala and the Insurer, in respect of the validity, interpretation, implementation or alleged breach of any provision of the scheme etc, can be directly taken up with the appellate authority for resolution. The civil courts situated in Thiruvananthapuram, Kerala shall have exclusive jurisdiction of any disputes which remain unresolved by any of the above procedure.

25.Term and Termination

25.1 Term

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

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

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 Authority within 45 days of the date of expiration of the Policy Cover Period for that Policy.

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

25.2 Termination by the Authority

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

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

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

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

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

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

The Insurer has been adjudged as bankrupt or become insolvent; or Any petition for winding up of the Insurer has been admitted and liquidator or provisional liquidator has been appointed or the Insurer has been ordered to be wound up by Court of competent jurisdiction, except for the purpose of amalgamation or reconstruction with the prior consent of the Authority, provided that, as part of such or reconstruction and the amalgamated or reconstructed entity has unconditionally assumed all surviving obligations of the Insurer under the Insurance Contract; or The Insurer has abandoned the Project Office(s) of the MEDISEP and is non-contactable; or Intentional or unintentional act of undisputedly proven fraud committed by the Insurer.

Performance against KPI is below the threshold specified in schedule VI for two consecutive quarters.

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

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

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

25.3 Authority Event of Default

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

b. Upon the occurrence of a Authority Event of Default (non-payment of instalment as per clause10.1), the Insurer may, without prejudice to any other right it may have under this Insurance Contract, in law or at equity, issue a Preliminary Termination Notice to the Authority. If the Authority fails to remedy or rectify the Authority Event of Default stated in the Preliminary Termination Notice issued by the Insurer within 30 days of receipt of the Preliminary Termination Notice, the Insurer will be entitled to terminate this Insurance Contract by issuing a Final Termination Notice.

25.4 Termination Date

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

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

2. Authority Event of Default, shall be the date falling 90 Business Days from the date of the Final Termination Notice issued by the Insurer; and

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

25.5 Consequences of Termination

Upon termination of this Insurance Contract, the Insurer shall:

a. Continue to provide the benefits in respect of the Covers to the Beneficiaries until the Termination Date.
b. Pay to the Authority 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:

TC = P x N x UT/365

Where:

TC is the sum to be paid by the Insurer to the Authority on the Termination Date ;

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

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

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

Refund, if any, shall be only for those family units who have not made any claim under the scheme. Such payment shall be made by the Insurer to the Authority exclusive of all applicable taxes and duties. The Insurer shall bear and pay all applicable taxes and duties in respect of such amount.

The balance in the amount paid in advance to the insurance company based on the anticipated number of new recruitments and unverified pensioners shall be refunded to the Authority after adjusting with the premium of actual numbers.

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

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

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

25.6 Hand-Over Obligations

Without prejudice to the provisions of **Clause 26.6**, on expiration of the Term or on the Termination Date, the Insurer shall:

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

(b) hand-over, transfer and assign all rights and title to and all intellectual property rights in all data, information and reports in favour of the Authority 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;

26. Force Majeure

26.1 Definition of Force Majeure Event

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

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

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

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

but regardless of the extent to which the conditions in the first paragraph of this Clause 26.1 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

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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 26.1; 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 Kerala unless the loss, damage or delay was directly caused by an event that affected a intermediary of the Insurer and that, if it had happened to the Insurer hereunder, would have come within the definition of Force Majeure Event under Clause 26.1; 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 26.1 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 26.1; 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.

26.2 Limitation on the Definition of Force Majeure Event

Any event that would otherwise constitute a Force Majeure Event pursuant to Clause 26.1 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.

26.3 Claims for Relief

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

b. The Affected Party shall not be entitled to any relief for or in respect of a Force Majeure Event unless it has notified the other Party in writing of the occurrence of the Force Majeure Event as soon as reasonably practicable and in any event within 7 days after the Affected Party knew, or ought reasonably to have known, of the occurrence of the Force Majeure Event and it has complied with the requirements of Clause 26.3 of this Insurance Contract.

c. Each Force Majeure Notice shall:

(i) fully describe the Force Majeure Event;

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

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

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

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

If Parties are unable to arrive at a mutual agreement on the occurrence of a Force Majeure Event or the mitigation measures to be taken by the Affected Party within 15 days of receipt of the Force Majeure Notice, then the other Party shall have a right to refer such dispute to grievance redressal in accordance with Clause 24.

e. Subject to the Affected Party having complied with its obligations under Clause 26.3, the Affected Party shall be excused from the performance of the obligations that is affected by such Force Majeure Event for the duration of such Force Majeure Event and the Affected Party shall not be in breach of this Insurance Contract for such failure to perform for such duration; provided however that no payment obligations (including Claim Payments) shall be excused by the occurrence of a Force Majeure Event.

26.4 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.

26.5 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.

26.6 Termination upon Subsistence of Force Majeure Event

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

27. ASSIGNMENT

27.1 Assignment by Insurer

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

27.2 Assignment by Authority

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

27.3 Effect of Assignment

If this Insurance Contract or any Policy or any rights, obligations or liabilities arising under this Insurance Contract or such Policy are assigned or transferred in accordance with this Clause 27, then this Insurance Contract and such Policy shall be fully binding upon, inure to the benefit of and be enforceable by the Parties hereto and their respective successors and permitted assigns.

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

27.4 Assignment by Beneficiaries or Empanelled Health Care Providers

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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.

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

28. Confidentiality of Information and Data Protection

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

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

29. Intellectual Property Rights

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

30. Entire Agreement

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

31. Relationship

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

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

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

32. Variation or Amendment

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

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b. Notwithstanding anything to the contrary in Clause 32(a) above, the Insurer agrees the Authority shall be free to issue MEDISEP Guidelines from time to time and the Insurer shall comply with all such MEDISEP Guidelines issued during the Term, whether or not the provisions or terms of such MEDISEP Guidelines have the effect of varying or amending the terms of this Insurance Contract.

33. Severability

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

34. Notices

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

To: Insurer
Attn:. The Oriental Insurance Company Ltd.
Regional Office , Metro Palace
North Railway Station Road
Ernakulam , Cochin-682018

E-Mail: medisep@orientalinsurance.co.in_
Phone: 0484- 2579100/2579101/2579102/2579107/2579136
Fax: 0484-2397381/2392450

To: Authority
Attn: Mr. / Ms. Additional Chief secretary/Principal Secretary
E-Mail: financehealthinsurance @gmail.com
Phone: 04712517486
Fax: 04712326990

35. No waiver

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

36. Special provisions relating to the outcome of WA 615/2019 and subsequent appeals relating to the case.

a. OICL shall not incur any legal or financial liability arising out of the orders in WA No. 615 of 2021. If the cancellation of this agreement is necessitated due to award in WA No.615/2021 or subsequent legal disputes by the parties to the Writ Petition, it may be noted that once the scheme is implemented and the premium paid, whether in instalment or otherwise, refund of premium, if any, will be done only after necessary adjustment of all incurred claims and expenses.

b. Liability in excess of the Premium Instalment paid would not fall within the scope of this agreement. Further no extraneous liability shall devolve on the Oriental Insurance company vis-a –vis such agreement or cancellation thereof

37. Governing Law and Jurisdiction

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

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

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

SIGNED, SEALED and DELIVERED

For and on behalf of
Governor of Kerala

Represented by

MOHAMMED Y SAFIRULLA. K. I.A.S.
Officer on Special Duty
Finance (Resources) Dept.
Government Secretariat
Thiruvananthapuram

SECRETARIAT FINANCE DEPARTMENT KERALA GOVT.

In the presence of:

(1) T. Sivakumar T. Sivakumar

(2) SHIBU.

SIGNED, SEALED and DELIVERED

For and on behalf of
Oriental Insurance Company Ltd.

THE ORIENTAL INSURANCE COMPANY LTD. R.O. COCHIN

Represented by

रमा देवी वी
REMA DEVI V.
मुख्य क्षेत्रीय प्रबंधक
Chief Regional Manager

In the presence of:

(1) (NIMIMOL)

(2) (JANAKI SUBRAMANIAN)