Queries received via email/letters before 17:00 hrs. on 13th July 2022

The queries raised and the clarifications sought by the representatives of the Bidders and the corresponding responses are set out below:

Sl No.	**Extract**	**Questions**	**Response**
1		The Authority has provided us district wise numbers of SECC families along with Meghalaya Health Scheme Households beneficiary details. These details are really helpful in calculating risk exposure and burning cost for the product. In addition to the beneficiary details, if it is possible for the Authority to share claim information of the hospitalization occurred during last tenures of MHIS and AB-PMJAY under above mentioned heads to calculate a fair and reasonable premium.	The required information on Claims Utilisation is given in Annexure 1 & Annexure 2. All efforts have been made to provide the latest Claims Data, data is provided until 30.06.2022. NTMS Hospital List is not available with the State Nodal Agency.
		Please share following data: a. District wise monthly claim count and amount on basis of different Claim Status of last five years. (for e.g. Paid, Outstanding, Rejected etc.) b. Hospital wise utilization at least for top 100 hospitals. Public and private hospitals wise claims count and amount. c. Utilization of Specialties covering number of claims received and amount paid under each specialty. d. Monthly claims (amount and count) under COVID during phase IV of scheme. e. Hospital wise claims count and amount for claims in hospitals outside of Meghalaya f. Utilization of Unspecified package covering amount and count of claims.	
		District wise & procedure wise (medical management (GW & ICU) & surgical cases) number and amount of claims reported, settled & outstanding claims details under MHIS & ABPMJAY for the past three years may be provided for premium calculation	

		Claims data of NTMS cases with details of NTMS hospitals	
		Please provide cover wise claim amount bifurcation (Hospitalisation / Day Care / OPD Diagnostics / Cardiac and Preventive OPD / Child Care / Maternity) for claims where multiple covers were triggered.	
		The Claims Data for the extension period ending on 31.7.2022	
		Claims Dump for the entire policy period.	
		Please provide month on month/public-private/OPD-IPD/ packagewise claims data for last 3 years	
		Kindly provide the month-wise claim count and amount (with breakup into claim paid and outstanding), premium and number of beneficiary families covered for the extension period of the current policy MHIS Phase IV (i.e. for months February 2022 till June 2022), with clear mention of the date up till which the data is provided.	
2		Details of Number of family units covered on monthly basis according to BIS Enrollment dashboard for previous tenures of MHIS and AB-PMJAY.	a. The number of beneficiaries and household registered during the policy period (s) of MHIS 4 is given in Annexure 3, Annexure 3A and Annexure 3B. b. The insurer implementing MHIS-PMJAY shall have access to the Beneficiary Database. c. The existing MHIS 4-PMJAY beneficiaries shall not need to undertake any registration process. The MHIS 5-PMJAY Insurance Coverage is automatically available for such beneficiaries.
		Age wise distribution of families.	
		Will BIS data be shared with implementing agency? How many families have been identified and enrolled for the scheme?	
		Kindly provide us the numbers of Total Beneficiaries Verified and Total Families Verified till date.	
		Will all the existing beneficiaries covered under scheme be transferred to new scheme. What were the number of beneficiary families during last five years of scheme.	
3		When did MHIS phase IV started? What was the premium rate and how many beneficiary families were covered during phase IV of scheme. Please share the bifurcation of categories of families covered/added/deleted during phase IV.	MHIS Phase IV commenced on 1st Feb 2019. The Premium rate for MHIS IV is ₹ 1630/- per household. The bifurcation of household categories can be seen in Annexure 4.

4		What was the premium rate per family for last five years of scheme and who was the implementing agency.	a. The premium for the MHIS 4 policy period (3 Policy Periods) is ₹ 1630 per household. b. The premium for MHIS 3 was ₹ 911 (one policy period) and MHIS 3 Extension Period (3 months) the premium was ₹ 1702. c. Premium paid for each policy of MHIS IV for the last 3 years - ₹ 128,48,57,280/- per year. d. There is no pending premium from the State, e. Details of District Wise Policy Period and Premium is given in Annexure 4.
		What was the premium paid during last policies? Is there any pending premium due on SNA for last policy years?	
		Details of district wise policy period of existing scheme, Premium per family may be provided.	
		Referring to clause 8 subclause D "PREMIUM AND PREMIUM PAYMENT" penalty provision on delay of premium; Shall insurer be paid this penalty of 1%/week and how this penalty will be paid to insurer?	As per Clause 8 C d., Insurer shall be paid 1% per week for delay pf premium payment by either the State or Central Govt. Penal interest shall be paid by way of adjusting in future payable share of premium.
5		Hospital Empanelment – Increase/decrease in list of number of hospitals empaneled (private and public both) as compared to last years.	List of all Empanelled Hospitals in MHIS 4-PMJAY is given in Schedule 6 of Volume II of the Tender Documents.
6		List of EHCP suspended till date and reason for the same.	No empanelled hospital was suspended or de-empanelled during the implementation of MHIS 4 until 15.07.2022.
		Number of hospitals de-empanelled during previous scheme.	
7		Can beneficiary avail treatment in private ward or higher category by paying the difference amount w.r.t the scheme package, or such type of cases shall be rejected.	Yes.
		Package rates are defined in Insurance contract but which HBP is applicable during MHIS and will there be any change in Package rate during the policy implementation.	HBP 2022 and State Specific Packages. The list of all Medical and Surgical Package is given in Schedule 3 of Volume II of the Tender Documents.
		Any change in term condition & Package rate as compared to last year	Yes. The rates have been revised, the number of packages revised from 2362 packages to 2264 packages and 3311 Procedures.
	Determination of Package Rates for Utilization of Covers :Upon the final fixation of the Package Rates, the packages rates applicable for CHCs and PHCs will be reduced by a flat rate of 30%.	Clarify whether the same applies to the "Unspecified Medical Management" per day package in cases of CHCs and PHCs.	Yes.

8		What would be the ceiling limit applicable during Phase V of scheme?	Question not Clear
9		Is the Aadhar card authentication compulsory in all IPD and OPD cases?	Aadhar Card Authentication is not compulsory.
10		What is the basis of Family Identification to avoid duplication?	The SNA through the Registration Process endeavours to avoid any duplication during the registration Process. The insurer is required to go through Schedule 11 of Volume II of the Tender Documents.
11		Referring to page no. 13 point no. E of Tender Document (RFP) please clarify -Are government servants included in the scheme as a beneficiary family? How many number of beneficiaries would be there who do not get reimbursements?	a. The premium shall be paid on 688551 Households (341808 {excluding 10% for Govt Employee from MHIS/State Households} and 346743 PMJAY households).b. Further since the commencement of MHIS, an assumption of 10% has been made through recommendations made by an external consultant and vetted by the Government, based on the numbers of actual government employees. No Database is available at present.
		Further referring to the "Note" under the table of beneficiaries on page no. 14 of Tender document (RFP) please clarify on "It shall be assumed that 10% of the MHIS categories in the Beneficiary Family Units in the Beneficiary Database qualify as families with one or more government employees for which premium shall not be calculated" – What number of beneficiary shall be taken into consideration for the calculation of premium and filling of Financial bid?	
	MHIS 5 is intended to benefit all persons that are residents in all the districts of the State of Meghalaya,including all families belonging to the SECC category of families but not including families that include one or more members that are government servants. However, any member of a government servant family who is not eligible for any reimbursement benefits should be provided with the benefit coverage under MHIS 5.	Provide data/details of government servant families who are not eligible for reimbursement benefits but would get coverage under MHIS-V.	
	It shall be assumed that 10% of the total Beneficiary Family Units in the Beneficiary Database qualify as families with one or more government employees for which premium shall not be calculated	Clarify the logic behind such assumptions and provide data/details available against the same.	

12		Name of the TPA & TPA fees% (Expiring Year) & name of expiring insurer	No TPA was utilised by the Insurance Company in the expiring year.
		Kindly share the level of loadings for TPA and ME. Also are there any fixed/variable expenses.	
		As per page no. 39, 'If the Insurer appoints a TPA to undertake Claims processing, the Insurer shall ensure that the TPA appointed by it shall at all times have: a. adequate infrastructure and trained personnel for undertaking Policy and Claims facilitation services in accordance with the terms of the Insurance Contract;'Whether scheme to be administered through a TPA only or the Insurance Company can handle with the in house facility as insurer has its own in-house infrastructure for processing the claim. Kindly confirm.	Appointment/Engagement of TPA is not mandated, if the Insurer has its own in-house claims processing facilities. Bidders may refer to Clause 29 b of Volume II of the Tender Documents with regard to engagement of TPAs.
13		Member enrolment criteria &Process	The Member Enrolment Criteria and the Process of beneficiary Identification is given in Schedule 11 of Volume II of the Tender Documents.
		Health card issuance process	
14		The highlights of a) the difference between the proposed scheme vs the currently running scheme's OPD cover details – overall Sum Insured limit for OPD cover and further limits for maternity benefit, child care benefit, cardiac and diabetes preventive OPD care benefit, OPD Diagnostic benefit and Follow-up care benefit. b) the changes in the proposed scheme vis-à-vis the currently running scheme with regards to the coverages and package rates c) the changes (if any) with regards to the coverages in the proposed tender vis-à-vis the tender document floated in April 2022. d) the changes (if any) in the package rates in the proposed scheme vis-à-vis the tender document floated in April 2022.	a) The sum insured during MHIS 4 - PMJAY was 5,00,000 per household, however the overall sum insured is proposed at 5,30,000 per household for MHIS 5- PMJAY. b) 2264 packages (3311 procedures) are listed at Volume II of the insurance contract. MHIS 4 - PMJAY was utilising the HBP 1.0 packages of PMJAY along with state specific packages while MHIS 5 - PMJAY will utilise the HBP 2022 package list along with state specific packages. c) Bidders are to kindly consider the tender documents released on 5th July 2022 and not the one floated in April 2022. The major points of differences between MHIS 4-PMJAY and MHIS 5-PMJAY is given in the presentation as uploaded on 18.07.2022.
15		Administrative cost involved for IT integration	No Administrative Cost involved for IT integration.
16		Mid-term addition & deletion process	Question not Clear

17		Current limit for the OPD benefit is -30,000, please confirm OPD limit in expiring policy	No Specific OPD cover is outgoing policy, the OPD benefit is available through the sum insured of ₹ 5,00,000/- where the OPD benefits are limited similar to the benefits given in Clause 3 B (iii), (iv), (v), (vi) and (vii) of Volume II of the Tender Document.
18	OPD Diagnostic benefit :The NHA or the State Nodal Agency may issue MHIS Guidelines and/or a MHIS Operational Manual from time to time to govern such approval. Thereafter, the Insurer shall only be required to honour Claims made under this benefit in compliance with such MHIS Guidelines and/or MHIS Operational Manual.	* Provide Operational Manual and Process Flow for OPD approval.* We understand that the OPD diagnostic benefits would be applicable for cases wherein the treating physician has conducted detailed evaluation & thereby documented the primary diagnosis & clinical indications for recommending such investigation. These benefits are not allowed for cases wherein the beneficiaries voluntarily opt for preventive health check-ups. Suggest if otherwise.	Process flow for OPD Diagnostic Benefits is given in Schedule 5 of Volume II of the Tender Document. Any Beneficiary can undertake any OPD diagnostic benefits services in any EHCP after the recommendation of the treating doctor/physician subjected to the process given in Schedule 5. All OPD benefits including Maternity Care, Child Care, Cardiac and Diabetes Preventive Care, OPD Diagnostic and Follow-up Care have their own set of limits as given in Clause 3 B of Volume ii of the Tender Document. The terms for utilisation of these benefits is also given in Annex 1 of Schedule 3 of Volume II of the Tender Document. OPD Diagnostic Benefits are not allowed for cases wherein the beneficiaries voluntarily opt for preventive health check-ups.
	SUM INSURED FOR BENEFICIARIES: as on the date of commencement of risk cover for such Beneficiary Family Unit under Clause 7 e) or Clause 7 f), as applicable, shall be ₹ 5,30,000; which would be an insurance cover of ₹ 5,00,000 and and an additional cover of ₹ 30,000 for Maternity benefit, Child Care benefit, Cardiac and Diabetic Preventive Care benefit, OPD Diagnostic and Follow-up care benefit as given in Clause 3B (iii), 3B (iv), 3B (v), 3B (vi) and 3 (vii); the utilisation of the benefits under the ₹ 30,000/- cover is defined under Annex 1 of Schedule 3 of the Insurance Contract; and	Clarify whether any sub-limit is applicable against the said OPD benefits as per the subcategory.	
	SUM INSURED FOR MHIS CATEGORY BENEFICIARIES: as on the date of commencement of risk cover for such Beneficiary Family Unit under Clause 7 e) or Clause 7 f), as applicable, shall be ₹ 5,00,000, including OPD benefits specified under Clause 3B iii, 3B iv, 3B v and 3B iv;	Clarify whether any sub-limit is applicable for said benefit under these subcategories.	
19	Health Benefit packages: Cardiac and diabetes preventive care	Provide period gap between visits to be covered under Cardiac and diabetes preventive care packages.	No gap between visits. Benefit/Visit depends on the recommendation of the treating doctor/physician subjected only to the limits as

	CARDIAC AND DIABETES PREVENTIVE OPD CARE: Provides cover for payment of expenses incurred by a Beneficiary for cardiac and diabetes preventive care provided by an Empanelled Health Care Provider, subject only to the Exclusions given in Schedule 1. This benefit is limited to three OPD consultations per beneficiary in each Policy Cover Period.	We understand that benefit under this clause will be limited as per the package rate mentioned in schedule 3 of insurance contract. Please confirm.	given in Clause 3 B (v). The bidders may refer to the relevant clause for the package's utilisation and limits.
	Health Benefit packages: Cardiac and diabetes preventive care	Clarify the package's inclusions and adjudication criteria to evaluate the medical admissibility.	
20	Health Benefit packages: Cardiac and diabetes preventive care	Is there any guideline for the utilization of OPD diagnostic benefits by multiple members of the same family during the same period/Day?	
	HOSPITALISATION EXPENSES BENEFIT: Pathology and radiology tests: Medical procedures include basic Radiological imaging and diagnostic tests such as X-ray, USG, Haematology, pathology etc. However, High end radiological diagnostic and High-end histopathology (Biopsies) and advanced serology investigations packages can be booked as a separate add-on procedure if required. Surgical packages are all inclusive and do not permit addition of other diagnostic packages.	Clarify whether packages for hospitalization include the basic investigations	a. Though some radiological imaging and diagnostic tests are part of Medical Procedures. There are some radiological and diagnostic packages that can also be blocked in addition to the Medical Package. b. The bidder may refer to Annex 1 of Schedule 3 of Volume II of the tender Document.
		Clarify whether the EHCPs can claim the additional investigations included in Diagnostic Laboratory (IPD & OPD) category over and above the "defined medical packages".	
		Investigation, screening is covered under multiple sections , there is an overlap of covers. For e:g it is covered under Cardiac & Diabetes preventive care, day Care treatment & follow up care & OPD diagnostic care also. Pls clarify.	
		As per definition of Day care procedures admission is mandatory however all screening & diagnostic tests are eligible under day care definition. Pls clarify.	
		OPD consultancy is required from the same empaneled hospital where the patients will be treated.	No.
21		REINSTATEMENT OF SUM INSURED (pg no. 22) : SI re-instatement will be done on what basis, do we get the expiring policies Sum Insured utilization detail or complete process details	Clause 4 B of Volume II of the tender document pertains to the renewal of policy cover period with the implementing insurer; therefore, the insurance company will have the utilization details.

22		The Transaction Management System allows blocking of Packages with a maximum back-date of 5 days. In a scenario where the beneficiary is already admitted in an EHCP during the time of registration of such beneficiary, then the commencement of risk cover shall be effective to a maximum of 5 days prior to the day the beneficiary is registered. –How this process will manage	The process is integrated in the TMS. The bidder is required to refer to Clause 7 e) d. of Volume II of the Tender Document.
23	The GoM has decided to evaluate the overall functionality of the Megha Health Insurance Scheme; and has now decided to implement a restructured scheme in convergence with PMJAY. The scheme shall be referred to as the Megha Health Insurance Scheme Phase 5 (herein after referred to as MHIS 5), providing an insurance cover of ₹ 5,30,000 for all eligible beneficiaries on a family floater basis to Beneficiary Family Units through a network of empanelled hospitals.	* We understand that all beneficiary family units (MHIS or PMJAY) are eligible for an additional Rs.30,000/- OPD cover over and above SI of Rs.5,00,000/-. * Clarify whether the additional cover of Rs. 30,000 is for OPD coverage only or the same can be utilized for IPD coverage also. * Is there any specific guideline for utilization of this additional coverage of Rs. 30,000/-? If yes then provide the guidelines.	The insurance coverage of ₹ 5,30,000 is available to all households under MHIS and PMJAY. The utilisation of benefits for OPD is subjected to terms given in Clause 3 and Annex 1 of Schedule 3 of Volume II of the Tender Document.
24	The insurance cover shall also allow utilisation of multiple medical and surgical packages in a single instance of hospitalisation. In such a situation, the medical or surgical package with the highest rate shall be considered as the primary package and shall be payable at 100%, there upon the second package shall be payable at 50% of the applicable rate and the third and subsequent packages shall be payable at 25% of the applicable rate.	Provide scenarios where the EHCPs can block medical and surgical packages together during the same hospitalization period, i.e., between a continuous admission and discharge in a particular hospital.	AKI + DIALYSIS + AV FISTULA CREATION / Empyema thoracis + Intercostal drainage / pneumothorax + Intercostal drainage.
		Is there any specific guideline for claiming medical and surgical packages together? Provide the guidelines in this respect.	Yes. Bidder is required to refer to Clause 5 C. of Volume II of the Tender Document.
		Clarify whether the EHCPs can claim additional packages for diagnostics done (OPD diagnostics) and drugs given (High-end Drugs) during the hospitalization while utilising medical & surgical packages.	Bidder is required to refer to Annex 1 of Schedule 3 of Volume II of the Tender Documents.
		In case scenarios mentioned above are admissible, clarify if the same calculation logic would be applicable or not. Furthermore, confirm the process to derive final admissible amount.	

		Provide guidelines for cases where hospitalization is for prolonged period (i.e., more than the Average - LOS as mentioned in the package master).	Bidder is required to refer to Schedule 3 of Volume II of the Tender Documents.
25		Would all claims be admitted on an online mode and would offline claims also have to be considered.	All Claims are to be initiated through the TMS (both online and offline)
	Claim Mangement : CLAIM PAYMENTS AND TURN-AROUND TIME :The Insurer shall require the EHCPs to submit their Claims electronically within 21 days after the patient is discharged. If the EHCP fails to submit the claims within 21 days, the EHCP shall take a written permission from SNA for submission of claims or the claim may be rejected. Claims submitted beyond 21 days of discharge of patients will not be admissible	Clarify whether there are any specific criteria regarding the relaxation of said TAT for claim submission.	The terms mentioned in the relevant clause shall be in effect to the matter concerning TAT.
		We understand that while taking the permission from SNA the EHCP has to initiate communication within 21 days of discharge of the patient justifying delay in claim intimation to avail such exemption. - Suggest if otherwise	
26	EMPANELMENT OF HEALTHCARE PROVIDERS	Clarify whether EHCP can raise pre-authorization for non empanelled speciality under the "Unspecified Package" category.	No
27	RIGHT OF APPEAL AND REOPENING OF CLAIMS : The Empanelled Health Care Provider shall have a right of appeal against a rejection of a Claim by the Insurer, if the Empanelled Health Care Provider feels that the Claim is payable. Such decision of the Insurer may be appealed by filing a complaint with the DGNO in accordance with Clause 30 of the Insurance Contract.	Provide a defined timeline for placing such an appeal before DGNO.	There is no timeline, the Insurer or the Hospital can appeal anytime to the DGNO.
		What would be the actionable if the EHCPs fail to appeal within the defined timeline.	
28	If the total expenses incurred by the Beneficiary exceeds the available Sum Insured under the Covers (after taking into account the co-payment obligations), 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.	Clarify whether disclosure of other insurers' coverage is mandatory for the beneficiary & the treating EHCPs.	Not mandatory. Bidder is required to refer to Clause 10 C of Volume II of the Tender Document.

29		What is the defined timeline for taking action against hospital (fast track empaneled) in case a hospital is found to be wrongfully empaneled.	Bidder is required to refer to Clause 16 f) of Volume II of the Tender Document.
30	Exclusion : Intentional self-injury/suicide.	Confirm whether the consequent/ delayed effect of Intentional self-injury/suicide is covered or not	Not Covered.
	Sterilization, Fertility and Sex Change procedures	We understand that any Sterility and fertility procedures are not covered under the policy. And any packages used with such intention would not be admissible. Please confirm.	Not Admissible.
31	Health Benefit packages: Medical Oncology	Provide capping on the number of cycles for chemotherapy cycles/regimens against individual packages.	As per the PMJAY guidelines on tentative capping chemotherapy, cycles/regimens are detailed in STGs. These STGs have been adopted from the guidelines of National Cancer Grid (NCG) as the specialty has been adopted from PMJAY as is, the guidelines are in line with PMJAY and NCG. It may be noted that restrictions are not made mandatory to ensure the required flexibility for providing cancer care at facility level.
		Provide adjudication guidelines to follow when there is a mismatch between Target end-organ Vs chemo regimen of package.	Adjudication guidelines are detailed by NCG and PMJAY and the same shall be adopted and followed in any such case presented.
		We understand that if the EHCPs are claiming chemotherapy under any of the indicated medical Oncology packages, they will not be allowed to claim an additional high-end drugs package if available - Suggest if otherwise	Additional high-end drugs for medical oncology treatment are permitted to be booked if they are not included in the regimen listed under MHIS 5.
32	PROCESS FOR CASHLESS ACCESS SERVICE ; Patient from any category admitted in Private ward shall only pay out of pocket for the room rent expenditure and any other facilities which is not part of the treatment or recovery process of the patient	We understand that patient from any category admitted in Private ward shall only pay out of pocket for the room rent expenditure and a patient opting to upgrade from the general ward to a Private room category shall only pay the difference amount for such upgrade out of his pocket. Furthermore, he may need to pay if availing services for "any other facilities which is not part of the treatment or recovery process of the patient." - Suggest if otherwise	Insurer will process the claims as per the package rate listed in Schedule 3 of the Contract

		We understand that if the patient gets treatment in the general ward, HDU, and ICU, the EHCP is not entitled to collect any additional amount from the beneficiary. Please confirm.	HDC/ICU/Isolation are all different level of care and not Room category
		Confirm if charging beneficiaries in any other way towards any other heads by the empanelled EHCPs, during the claimed period, are prohibited and can be considered a gross violation of policy guidelines.	Insurer will intimate to the office of the SNA of such activity for further investigation before a final decision is taken.
33	New-born child shall be automatically covered from birth up to the expiry of policy for that year for all the expenses incurred in taking treatment at the hospital as in-patient. This new born will be considered as a part of insured family member till the expiry of the policy subject to exclusions given in Schedule 1 of the Insurance Contract	Clarify whether the newborn needs to be registered afresh through the BIS after the policy expiry to provide cover in the following policy period.	Refer to Clause 2 f and Clause 3 A f) (ii) of Volume II of the Tender Document.
	Child Care Benefit: If the child is an infant between 0 and 12 months, this benefit can be availed either by identification of the child as a new-born by a registered Beneficiary or by registration of the child as a Beneficiary	If the baby is below 1-year-old at the time of policy expiry, will the baby be covered under the new policy by selecting him/her as a newborn by an already registered beneficiary?	
34	Provides cover for expenses incurred by a Beneficiary who is a pregnant woman in respect of ante-natal and post-natal care provided by an Empanelled Health Care Provider, subject only to the Exclusions given in Schedule 1. This ante-natal and post-natal care benefit shall only be available to a Beneficiary who is: a) A pregnant woman aged18 years and above; and b) Giving birth to her first or second child, unless she: (x) delivered twins during the first birth, or (y) she has only one living child.	Whether the conditions (a) & (b) is applicable for delivery also	Clause 3 B iii of Volume II of the tender documents pertains to only the specified Maternity Benefit (ANC, PNC, etc).
35	Chronic Care Package: If the baby requires stay beyond the upper limit of usual stay in Package no MN004A or MN005A for conditions like severe BPD requiring respiratory support, severe NEC requiring prolonged TPN support	Maximum payable amount under Neonatal care packages is not mentioned in the package master. Provide the same (sub limit if applicable) in case any capping is applicable. Please confirm the same for the neo-natal packages S.No 473 to 478	The package is limited to the available sum insured

36	Considering the nature of internet connectivity in the state of Meghalaya, there can be instances where empanelled hospitals in remote areas may not have internet access connectivity, the EHCP shall raise claims via the Offline Transaction Management Software once in 30 days provided that shall raise claims via the Offline Transaction Management Software once in 30 days provided that shall raise claims via the Offline Transaction Management Software once in 30 days provided that the hospital is already registered in the offline mode.	Provide criteria and list of hospitals registered under offline mode. Also, provide the process flow for the same.	The list keeps changing from time to time depending upon the connectivity coverage in Meghalaya. The insurer implementing MHIS 5-PMJAY will have the list of such hospitals which will be shared by the SNA.
37		Whether fresh e-cards to be issued for existing MHIS beneficiaries.	The registered beneficiaries of MHIS IV & PMJAY need not to be re-registered and no new card is to be issued.
38		Whether the existing Hospital transaction software, call centre and kiosks for smart cards issuance for the existing scheme will be handed over to the prospective bidder.	a) Bidders should refer to Clause 16 of Volume II of the tender documents (insurance contract). Infrastructure pertaining to hospital hardware will be available at the EHCPs and it is the insurer's obligation to review functionality of hardware/software at EHCP's. b) Bidders should refer to Clause 17 of Volume II of the tender documents pertaining to District Kiosk obligations and Clause 26 of Volume II of the tender documents for Call Centre Services.
39		Kindly clarify whether the actuary certificate can be signed by Chief underwriter.	The actuary certificate will need to be signed by the appointed actuary of the Insurance Company
		At what frequency do the Insurance company need to submit the actuarial certificate? What is the notice period (time frame) for either parties in case if any one party doesn't wish to renew the policy.	a) The actuarial certificate for determining loading of premium for renewal of policy has to be submitted after completion of 6 months of policy period. The actuarial certificate for Refund for premium has to be submitted after the completion of the 12-month policy. b) Bidders may refer to Clause 7 d of volume II of the tender documents pertaining to renewal of policy cover period.

40		As per page no.40 of Insurance Contract, it is mentioned that 'Insurer has to email all rejected cases on a weekly basis to the Medical Officer of the State Nodal Agency at doctor.claims@mhis.org.in as per the format given in Annexure 11.' Also it is mentioned in page no. 42, that 'The Insurer shall submit a weekly detail of Claims and Report of claims as per the formats listed under Annexure 11 to the email id claims.officer@mhis.org.in Annexure-11 has not been provided in the tender document. Hence kindly arrange to provide the same.	The format shall be provided upon execution of the Insurance Contract.
41		As per page no.24, the bidders are required to submit a copy of document which provides proof that the Insurance Company has a group health insurance policy covering at least 50,000 families in any two of the last three completed financial years.Kindly let us know whether the policy copies or a declaration can be submitted.	True Certified Copies are to be Submitted.
42		As per Annexure-H, under point no.c, the Memorandum of Association and Article of Association of Company is required to be submitted. For the above requirement, since the volume is large, we request your consideration on submitting the 1st and last two pages of AoA & MoA.	The Memorandum of Association and Articles of Association forms a part of the documents required to be submitted along with the Bid Application Letter which is important for the evaluation of the Technical Bid. It is required for all Bidders to submit the MoA and AoA.

43		As per page no.30 of Volume-II, If the Insurer's average Claim Ratio for the full 12 months is in excess of 120 percent, then the SNA will be liable to pay 50% of additional claim cost in excess of the total Premium. We suggest that if in case the incurred claim ratio exceeds 100% in any policy period, under such instance, the excess amount over and above 100% shall be shared in equal proportion between the insurance company and RSHAA. In case the loss ratio exceeds 100% then the SHA will be liable to pay 50% of additional claim cost in excess of the total Premium already paid by it and remaining 50% shall be borne by the insurance company.	The term in excess of 120 percent shall remain. No consideration will be made to change the 120% to 100%.
44		Whether single or multiple insurance companies will be awarded and districts allocated for implementing the scheme.	Bidder may refer to Clause 29 E d. as added/amended through the Addendum/Corrigendum issued 18.07.2022.
45		As per AB PMJAY scheme the expenses towards IEC activities to be borne by SHA. Kindly confirm in case if the Insurance Company arranges for sensitization programme, workshop and Health camps for awareness and increasing enrolment as advised by SHA, whether the incurred expenses shall be considered as part of IEC activities and reimbursed to the Insurance Company.	There will be no financial burden to the Insurance Company with regard to IEC activities. The bidders may refer to Clause 18 Volume II of the Tender documents.
		As per the tender, IEC is to be done by the Insurance Company. Is there any limit on IEC expenditure? And will it be part of claim while calculating the claim ratio.	
46		Hospital with the list of Bronze, silver & Gold is required.	There is no empanelled hospital with Bronze, Silver and Gold Certificate in MHIS 4-PMJAY.
47		What are the changes from the previous tenders.	Bidders are requested not to refer to the MHIS 5-PMJAY Tender Document issued in April 2022. The points of differences between MHIS 4 and MHIS 5-PMJAY is given in the Presentation during the Pre-bid Meeting as well as uploaded along with the Revised Tender Documents, Addendum/Corrigendum, etc on 18.07.2022.
		In view of the revised tender, are there any changes in the past information shared with us i.e. presentation "1-MHIS-5-Pre-Bid-Meeting-25.04.2022", enrolment and claims summary and responses to the last pre-bid queries.	

48		Please give more clarity on renewal premium calculation. The calculation should be at the end of 10th month as 6 month is too early to decide on the renewal.	Renewal of Policy shall be determined by the Claim Ratio to be calculated for a period of 6 months. No changes will be made in this regard.
49		Is premium guaranteed for 6,88,552 beneficiary families (MHIS- 3,41,809 and PMJAY- 3,46,743).	Yes. Premium payment is guaranteed for all the identified eligible households.
50		Referring to the presentation, the revised limits of General Ward Unspecified Procedure as per April 2022 tender were as follows: General Ward - INR 2100, HDU - INR 3300, ICU - INR 8500 and ICU with vent - INR 9000. Are there any further changes in these limits. Also please provide us the percentage split of claim amount for General Ward Unspecified Procedure by the types of wards.	There will be no change in any of the rates as specified. The Bidders are requested to refer to the terms of the Revised MHIS 5-PMJAY RFP and the MHIS 5-PMJAY Insurance Contract as issued on 18.07.2022. The bidders should not refer to the MHIS 5-PMJAY Tender Documents issued in April 2022. Information on percentage split of claim amount given under Sl. No. 1.
51		If there is any other input or additional information which may have an impact on the pricing of this scheme, kindly share it with us.	Efforts have been made to share all details which may have any impact on the pricing of this scheme.

Ramkumar S, IAS
Member Secretary, Tender Committee,
Chief Executive Officer,
Megha Health Insurance Scheme &
Additional Secretary, Health and Family Welfare,
Government of Meghalaya, Shillong.