Sl No	Query	Remarks
1	Removal of Solvency Ratio as a criterion for participation in Government Tenders	Relaxed for PSUs. Corrigendum
2	Last 3 years premium and claims data with dump	Data Dump made available in the website
3	As per the Office Memorandum dated 02.07.2022 issued by DFS (attached herewith), PSU Companies may be allowed to take part in tender. Kindly confirm whether the clause	Relaxed for PSUs. Corrigendum
4	Certified copies of Public Disclosure Reports or any other Reports submitted to IRDAI as per current IRDAI Regulations – whether same can be relaxed as there are disputed / legal cases, delay in submission of claim documents which remains outstanding in our book due to which maintaining claim settlement of 95% is a challenge for PSU companies (More than 95% claim settlement ratio in health insurance business)	Changes in criteria given in Corrigendum
5	per current IRDAI Regulations – whether same can be relaxed as supportive document can be an issue Turnaround Time (TAT) for Claims (95% settled within 30 days)	Changes in criteria given in Corrigendum
6	Certified copies of Public Disclosure Reports or any other Reports submitted to IRDAI as per current IRDAI Regulations – whether same can be relaxed as supportive document can be an issue Cashless Pre-authorization Approval (95% within 6 hours)	
7	Certified copies of Public Disclosure Reports or any other Reports submitted to IRDAI as per current IRDAI Regulations – whether same can be relaxed as supportive document can be an issue (Payment to Hospitals within 7 Days of Claim Approval (95%))	
8	Certified copies of Public Disclosure Reports or any other Reports submitted to IRDAI as per current IRDAI Regulations – whether same can be relaxed as supportive document can be an issue (Discharge Summary Processing within 24 Hours (95%))	
9	Certified copies of Public Disclosure Reports or any other Reports submitted to IRDAI as per current IRDAI Regulations – whether same can be relaxed as supportive document can be an issue (Grievance Closure Rate (>95% within 30 days))	
10	Certified copies of Public Disclosure Reports or any other Reports submitted to IRDAI as per current IRDAI Regulations – whether same can be relaxed as supportive document can be an issue (Claims Investigated for Fraud (Minimum 5% of high-cost claims))	
11	Certified copies of Public Disclosure Reports or any other Reports submitted to IRDAI as per current IRDAI Regulations – whether same can be relaxed as supportive document can be an issue (Recovery from Fraudulent Claims (Minimum 60%))	
12	Certified copies of Public Disclosure Reports or any other Reports submitted to IRDAI as per current IRDAI Regulations – whether same can be relaxed as supportive document can be an issue (Reporting of Suspected Fraud to IRDAI (100% compliance))	
13	Certified copies of Public Disclosure Reports or any other Reports submitted to IRDAI as per current IRDAI Regulations – whether same can be relaxed as supportive document can be an issue (Triggered Field Investigations (Minimum 10% of high-cost claims))	
14	Certified copies of Public Disclosure Reports or any other Reports submitted to IRDAI as per current IRDAI Regulations – whether same can be relaxed as supportive document can be an issue (Time taken for Fraud Investigation Closure (Minimum 90% within 30 days))	
15	Kindly elaborate the requirements /documents required regarding AI / ML algorithms. (AI / ML Based Systems as per Clause 3.1.12 Documentation and necessary evidence that the Bidder's AI / ML algorithms is be capable of a. Reducing the incidence rate of 30 day re-admissions / hospitalizations b. Case management when the patient is in the hospitalization to minimize fraud, waste, abuse and unnecessary stays in the hospital.)	Bidder to submit written confirmation of avaiability of AI/ML and present capability during presentation

16	Kindly confirm whether the clause requirement can be relaxed for PSU companies till the time of tender documents submission. Same can be implemented if selected. (AI / ML Based Systems as per Clause 3.1.12 Documentation and necessary evidence that the Bidder's AI / ML algorithms is be capable of a. Reducing the incidence rate of 30 day re-admissions / hospitalizations b. Case management when the patient is in the hospitalization to minimize fraud, waste, abuse and unnecessary stays in the hospital.)	No Change
17	policy which might have run during the FY 2024-25): name of insurance company that serviced the contract, Premium rate per family, number of beneficiary families actually enrolled, number of beneficiary families covered on which premium was paid (minimum guaranteed), total premium paid by SHA (installment wise), policy start and end date, reported claims (Total number and amount), approved claims (Total number and amount), rejected claims (Total number and amount), paid claims (Total number and amount), outstanding claims (Total number and amount) and ICR of the scheme clearly mentioning the date up till which the data is provided.	1. Premium, household numbers, IC and Coverage details uploaded in website. 2. Claims details , may please infer from claim dump available in the website.
18	Please share the claim data dump for last 3 policy years, separately for AB-PMJAY and CMHIS(EP) scheme.	Available in the website
19	Kindly provide Claims count and amount of top 20 packages /procedures along with the changes (if any) in the corresponding package rates for the expiring and proposed scheme for both CMHIS(GEN) and CMHIS(EP) category scheme separately.	Claim Dump and Health Benefit Package Changes already provided in the website
20	revised due to being unreasonably low or as per revised CGHS rates along with the changes in the corresponding package rates for the expiring and proposed scheme for CMHIS(EP) category. The numbers provided in the pdf document "Proposed changes in Tender Document" are not clear.	Claim Dump and Health Benefit Package Changes already provided in the website
21	In the document "Proposed changes in Tender Document", it is mentioned that "remove Location based incentives on room rates" i.e. location based incentives are removed, however, we understand that Location Based incentives are introduced in the proposed tender (Pg 21 Volume III). Kindly clarify.	Location Based incentives remain for surgical/dialysis procedures.
22	Kindly share the Empaneled Hospital list both for GEN and EP category separately with categorization into Public hospitals, Private hospitals in Nagaland, Hospitals outside the state -Tier 1,2 and 3 cities. Also specify the accreditation levels of hospitals and applicable incentive as per last tender and as per proposed tender for easy comparison against each hospital.	List of empanelled hospitals available in the website. Bidder may do their own due dilligence to check current accreditation level of hospitals.
23	Kindly confirm that the public hospitals were paid 100% of CGHS room rent base rates under CMHIS(EP) in the last scheme which shall now be paid at the rate of 30%. What is the total reported claim amount corresponding to room rent in last year.	Yes. Bidder may infer from the claim dump provided.
24	Kindly confirm that Normal Vaginal Delivery package was not reserved for public Hospitals for PMJAY-CMHIS (GEN) in the last scheme. Please also provide the claims count and amount reported, rejected and approved for this package during the past year (with clear mention of policy period).	Bidder may infer from the claim dump provided.
25	Please provide the claims count and amount reported, rejected and approved for Immunotherapy/Targetted Therapy under Medical Oncology Packages during the past year (with clear mention of policy period).	
26	Please confirm how many packages are reserved for public hospitals in the proposed tender vs. previous tender. Are there any changes in the number of empaneled hospitals in the proposed tender viz-a-viz last tender.	Empanelment is an ongoing process. Please refer to the website for latest list of empanelled hospitals

27	Kindly share the HBP package (N-HBP 2025 for CMHIS (GEN) and CMHIS(EP)) in excel.	Excel Sheet uploaded in the website.
28	**Claims MIS dump of 2024-25**, which includes claimant wise tagging (preferably UHID wise, or else names can be masked too), claimed amount and incurred amount, procedure code tagging, district tagging, Claim Received Date, Date of Admission, Date of Discharge, Hospital/provider name, hospital/provider district, Hospital/provider district.	Claim Dump avaialble in the website.
29	**Expiring policy copies**, if possible & Per Family last Year Rate / Premium	Premium, household numbers, IC and Coverage details uploaded in website.
30	**Clarification on Enrolment** – When will we receive the complete member data (including age, gender, relation) of 3.76 lakh families? How will the enrolment process be conducted?	Enrolment is an ongoing process. Current enrolled families uploaded in the website. IC will only be responsible for verification of demographic details and approval, not the end-to -end enrolment process
31	**policy**)?	No
32	Has there been any change in the package rates, from the previous year (**2024-25 policy**)?	Refer to Annexure 1- Changes in Tender from previous policy
33	**Post Hospitalization claims** – whether it will be deducted from the balance Sum Insured?	Yes
34	**Top Up policy** – Whether the Top Up policy will be voluntary or compulsory? Who will bear the premium for the Top Up policy? What was the enrolment percentage of the expiring Top Up policy?	compulsory, state will pay premium for the top up, all eligible Employee pensioner beneficiaries are covered under the top up.
35	daughter and includes grand-father, grand-mother, grand-child, adoptive father or mother, adopted son or daughter living together as a single household. As regards government servants and government retirees, the definition of family shall be as per the Central Services (Medical Attendance) Rules 1944 — a government servant's wife or husband as the case may be, and parents, sisters widowed sisters, widowed daughters, minor brothers, children, step children, divorced/separated daughters and stepmother wholly dependent upon the government servant and are normally residing with the government servant. 1.We understand that the identification criteria for the family members are based on the Aadhar based enrolment 2.We understand that, in laws are not covered in both categories. Specific to Govt servants and Govt retirees, grand children/grand parents not covered	1. Identification criteria is as per government rules given. 2. In laws are covered only if both husband and wife are government employees/pensioners.
36	1.8.1 N-HBP 2025 for CMHIS (GEN)- Bundled package costs: The package cost shall be all inclusive cost which is payable for a particular procedure (including medical management cases). Cost of Implants, high end drugs and diagnostics may be additional in case of a few specific procedures. Refer to Schedule 3 of the Insurance Contract (Part 3 of this RFP) for components of package, inclusions and exclusions. We understand that there will be no out of pocket expenditure other than mentioned bundle package rates for any beneficiary category under CMHIS(GEN) and CMHIS(EP)	Pleaser efer to Clause 5.4 , all treatment will be on cashless basis unless as specified in Schedule 3F.

37	1.8.2 N-HBP 2025 for CMHISIEP) -Under the Scheme, all Beneficiaries under Category 3 (GoN employees) and Category 4 (GoN pensioners shall be entitled to inpatient care with differential room entitlement as per their employee grade a) Room rent is applicable only where prescribed treatment package rates are not available. Room rent includes charges for occupation of bed, diet for patient, charges for electricity and water supply, linen charges, nursing charges and routine up keeping. c) For patients availing medical management packages, room rents, medicines and consumables shall be booked as per utilisation, and paid as per the rates defined in Schedule 3B. d) Private ward, semi- private ward, and general ward are as per the definitions given by CGHS. Entitlement to rooms and exceptions in case of non-availability of entitled category accommodation, admission to higher or lower category of accommodation, etc shall be as per extant CGHS guideline. 1.Kindly clarify the applicability of additional room rent in cases claimed under the Unspecified Code (UC), as such cases are typically considered under the UC package when no specific package is available. 2.For patients availing a per-day medical package, please confirm whether room rent is an additional to the per-day medical package of Rs- 2310. If the room rent is additional , kindly clarify the claim settlement guidelines, considering that the medical package already includes the accommodation component. 3.We understand that the applicability of hospital room rent is governed solely by CGHS	1. Room rents are only applicable for CMHIS (EP) beneficiaries. applicable room rents will apply for treatment book under unspecified package as per the eligibility of the patient. 2. Separate room rent is not appliable for fixed per day package under PM-JAY/CMHIS (GEN) 5 lakh category. 3. Yes
38	empanelled hospitals except for cases mentioned in Clause 1.8.2.6. which shall be on a reimbursement basis. Clause no. 1.8.2.6 not available in the RFP Vol I.	updated as per corrigendum.
39	1.8.2 d d. For treatment of CMHIS (EP) beneficiaries outside Nagaland in GOI hospitals empanelled through CGHS: Kindly clarify the guidelines for outside Nagaland Hospital empanelment for CMHIS (EP)	same as already provided.
40	emergencies: CMHISIEP) beneficiaries can avail treatment in non-empanelled hospitals in case of emergencies provided there are no CMHISIEP) empanelled hospitals in the city/town or when Specific procedures not available in any of the empaneled hospitals with approval of the State Medical Committee. Beneficiaries shall avail reimbursement for the treatment undertaken as per actuals or the applicable rates under N-HBP 2025 for CMHISIEP), whichever is lower. Claim submission and processing shall be through a separate portal developed specifically for this purpose. 1. we understand that the re-imbursement facility is only to provide out side state hospitals 2.Whether the pre-approval from State Medical committee required for such admission. Confirm mode of flow of approval from State medical committee to Insurer 3.Time line for intimation to insurer - suggest to make at least on the day of admission or before the admission 4.Time line for document submission - suggest maximum within 7 days of discharge 5.Please share the re-imbursement claim details for the last policy period 6.Whether claim submission portal for reimbursement claim available with state or Insurer to provide the same	These cases will be paid by NHPS, and not covered under Insurance Cover.

41	Insurance (excluding personal accident or travel cover) of at least Rs. 500 crores every year for the in the last three consecutive Financial Years immediately preceding Bid Due Date in India. 3.3.6 - The Bidder shall have Gross Direct Premium Income from Health Insurance (excluding personal accident or travel cover) of at least Rs. 100 crores in the last three consecutive Financial Years immediately preceding Bid Due Date in India. Please confirm the requirement as both the requirements are same except the mentioned amount. Also confirm whether the required Gross Direct Premium Income shall be considered as	please read as Rs. 500 crores. Corrected in corrigendum
42	Certified copies of Public Disclosure Reports or any other Reports submitted to IRDAI as per current IRDAI Regulations: marked as Annexure Qual-54 for the following - Average solvency margin of at least 1.5 in 2021-22, 2022-23, 2023-24 - More than 95% claim settlement ratio in health insurance business - Turnaround Time (TAT) for Claims (95% settled within 30 days) - Cashless Pre-authorization Approval (95% within 6 hours) "- Payment to Hospitals within 7 Days of Claim Approval (95%) - Discharge Summary Processing within 24 Hours" (95%) - Grievance Closure Rate (>95% within 30 days) - Claims Investigated for Fraud (Minimum 5% of high-cost claims) - Recovery from Fraudulent Claims (Minimum 60%) - Reporting of Suspected Fraud to IRDAI (100% compliance) - Triggered Field Investigations (Minimum 10% of high cost claims) - Time taken for Fraud Investigation Closure (Minimum 90% within 30 days) **As the required parameters are very specific in nature and not a part of standard public disclosure, requesting you to accept certificate issued by Chartered Accountant in fulfilment of the said technical requirement**	Changes in criteria given in Corrigendum
43	7.7.1.e.ix Format: Qual- 5 Point h Format Qual- 6 Point 13 Documentation and necessary evidence to be produced by the Bidder which provides proof that the Bidder has AI / ML algorithms in place with capabilities as per Clause 3.1.12: marked as Annexure Qual-5-i - Reducing the incidence rate of 30 day readmissions / hospitalizations - Case management when the patient is in the hospitalization to minimize fraud, waste, abuse and unnecessary stays in the hospital. Please clarify whether undertaking regarding availability of such system, given by the bidder on their letter head duly signed by authorized signatory shall suffice the said requirement.	1. undertaking regarding availability of such system, given by the bidder on their letter head duly signed by authorized signatory. 2. Present capability in the presentation.
44	7.7.1.g Performance Bank Guarantee / Performance Security: Qual 7 Please clarify on this requirement. In any of the volumes of the tender documents nothing is mentioned about such performance bank guarantee related process, amount or format.	Removed. Changes in Corrigendum

45	7.7.1.h Presentation to be made in person (date, time and venue to be shared at a later date) as per Clause 3.2.1 Neither clause 3.2.1 nor any other point of the tender document specify any such requirement. Please clarify.	Required. Changes in Corrigendum
46	Qual -6 Checklist for Qualification Bid - Point number 11 to 14 Document No. (Reference no. to be provided in the Qualification Bid) mentioned against these points are not in sequence to the previous Qual Nos. (For example Qual-5-f is mentioned against both Point 10 & Point 11). Please rectify the format accordingly	Updated as per corrigendum.
47	Point 46 Performance Bank Guarantee / Performance Security No such page containing such details available in Volume II of the tender document	Removed. Changes in Corrigendum
48	Pre and Post Hospitalisation expenses to be covered - For medical cases, any drugs prescribed for post hospitalization can be booked on actuals (refer to Schedule 1 shared), however for surgical cases any drugs/consumables/investigations can be booked as post hospitalization drugs/consumables/investigations capped at Rs.10,000 in addition to the fixed surgical package list shared. i.We understand that the post hospitalization medicines for medical packages are subject to post hospitalization period of 15 days and can't be booked separately ii.Please clarify For surgical packages post hospitalization expenses are covered with a capping of 10000 per family per year or is it for per claim iii.Kindly share the claimed data for the post hospitalization cases for CMHIS(EP) iv.We understand that the package rates are all inclusive only and pre and post hospitalization investigations and medications are covered in the package itself v.Kindly confirm whether the post-hospitalization expense are processed only in TMS for CMHIS(EP)	i. For medical packages, all medicines on actualsfor CMHIS (EP). No additional charges to be booked beyond fixed package rate for PM-JAY and CMHIS(GEN). ii. Per claim iii.claim dump made available in website iv. Package rates are all inclusive, except for Medical/conservative packages for CMHIS (employees and pensioners) v. yes
49	be paid separately as per prescribed rate limit as mentioned in Schedule 3B. In bundled package cases, post-hospitalization claims must be supported with a doctor's consultation document and other supporting documents like medicine & investigation bills as applicable. 5.4.8.d Post hospitalization charges upto 15 days covering drugs/consumables/investigations shall be paid separately as per prescribed rate limit as mentioned in Schedule 3B. In bundled package cases, post-hospitalization claims must be supported with a doctor's	same as above
50	funding over and above AB PM-JAY CMHIS wallet (if required) for availing healthcare services as provided in Schedule 5. Please clarify what are the possible other sources of funding. We understand that funding from other sources must be disclosed to the insurer and subject to necessary due diligence to avoid any possible fraud, waste, or abuse of the funds. 5.10.3 All AB PM-JAY CMHIS beneficiaries shall have the option to use other sources of funding over and above AB PM-JAY	No change

51	The SHA shall be responsible for a.Generating awareness about enrolment, organising enrolment drives either directly or through independent agencies. b.Providing the Insurer with appropriate level of access rights to the Beneficiary Identification System (BIS) portal on which all AB PM-JAY CMHIS e-card requests shall be generated and verification and approval exercise will take place. c.Timely intervention and decision on all e-card rejection requests forwarded on the BIS portal by the Insurer as per the provisions of Clause 6.2.3 or by any other card verification agency that the SHA at its sole discretion and at its own cost may deploy. a.What is the proposed timeline to organise enrolment drive by SHA? b.Whether the e-card generation access for CMHIS (EP) category beneficiaries given to EHCPS or not c.Whether all categories of beneficiaries can be get registered at EHCP c. Please confirm Whether the SHA intend to deploy card verification agency d.Please share the total no of cards issued in all categories e. please share category wise no of families at least one member got issued the card	a. Enrolment is ongoing, no specific proposed timeline.
52	Agreement") are executed with the EHCPs as per the template prescribed by the SHA. Parties to all such provider agreements shall be the EHCP and the SHA, subject to the provisions of Clause 7.1.5 a and Clause 7.1.5 b for public EHCPs. Kindly share the PSA template as mentioned 8.2.1 The Insurer shall be responsible for ensuring that agreements ("Provider Service Agreement") are executed with the EHCPs as per the template prescribed by the SHA. Parties to all such provider agreements shall be the EHCP and the SHA, subject to the provisions of Clause 7.1.5 a and Clause 7.1.5 b for public EHCPs. Kindly share the PSA template as mentioned	Shall be shared shortly
53	excluding only service tax and any cess, if applicable) and after settling all claims, if there is surplus: 100 percent of leftover surplus should be refunded by the Insurer to the SHA as per timeline mentioned in Schedule 11C Payment Related KPIs. The surplus amount to be refunded shall be calculated after a defined administrative cost is adjusted which is given as follows: i.Administrative cost allowed at 10% if claim ratio less than 65%. ii.Administrative cost allowed at 12% if claim ratio between 66% - 75%. iii.Administrative cost allowed at 15% if claim ratio between 76% - 85%. 1.Please clarify whether "defined percent for expenses of management" and "defined administrative cost" are same or not. 2.Please confirm whether "claim ratio" mentioned in point no. i., ii. and iii. refers to pure claim ratio or it includes expenses of management to determine percentage of allowed administrative cost. For example, if pure claim ratio after one policy year for the selected insurance company remains at 65% (claim paid divided by total premium I and expenses of management is 8% thus the loss ratio become 73%, then whether the allowed percentage of	1. same 2. pure claim ratio.
54	12.2.7 However, Payment of Premium by SHA and Refund of Premium by the Insurer are two separate activities. Payment of Premium shall be as per Clause 12.1 and Refund of Premium by Insurer shall be as per Clause Please clarify if the due premium is more than the refundable amount, how could Insurer refund the amount?	Refund appliable only as per clause 12.2. 4 as above.

55	any circumstance whatsoever, to undertake any such earmarked procedure without pre-authorisation unless under i.We understand that the preauthorization need to be done on the date admission for the admissibility of case (whether pre-auth to be rejected in case pre-auth initiated after the procedure) ii.Kindly clarify the acceptable pre-auth delay conditions other than	query incomplete
56	16.1.1 The Insurer shall require the EHCPs to submit their Claims electronically as early as possible but not later than 7 (seven) days after discharge of a AB PM-JAY CMHIS patient in the defined format to be prescribed by the SHA. 1. Please confirm the actionable from insurer in case delayed submission - whether such claims to be rejected 2.Kindly confirm the applicable timeline for claim query response	As per extant guidelines.
57	16.1.6 If the Insurer rejects a Claim, the Insurer shall issue an electronic (e)-notification of rejection to the EHCP stating details of the Claim summary; reasons for rejection; and details of the District Grievance Nodal Officer We understand that the TMS remark is considered as the electronic notification	Details of rejection to be emailed to hospital marking a copy to NHPS.
58	and at the time of execution of this Contract, been black-listed or been declared as ineligible from participating in government sponsored Schemes (including the AB PM- JAY) by the IRDAI, Central Government or any State Government. We understand this condition not applicable for historical limited debarment from certain State Governments for a specific period and valid only of the current status of such direction if any	as mentioned in the clause.
59	grievances. 27 Grievance Redressal Please provide the timeline applicable for stakeholders to submit grievances.	as per extant guidelines on grievance redressal.
60	Schedule 4: Exclusions to the Benefits under the Policy Kindly clarify whether alcohol & Drug induced ailments and assault related treatments excluded or not	not excluded
61	2 Quotation Benefit cover Quotation 1 Risk Cover (RC) of Rs. 53,00,000 (Rupees FiveThree Lakh only on a family floater basis per eligible family for hospitalization for the CMHIS (GEN) beneficiaries. Please confirm the mentioned amount as it is not matching with the tender RFP documents	correction in corrigendum.
62	16.1.4 Every rejection of a claim by the Insurer shall be supported by: (a) A signed note from the Insurer's Medical Officer specifying the reasons for rejection; (b) A clear reference to the applicable policy clause, package guideline, or exclusion invoked for rejection; and (c) A checklist of missing or deficient documents. All rejections below INR 50,000 shall be reviewed at the SHA level. All rejections exceeding INR 50,000 shall be reviewed by a Joint Review Committee (SHA representative, Insurer's Medical Head, and an Independent Medical Expert appointed by SHA). The SHA's decision in case of a deadlock shall be final and binding.16.1.5 All claim rejections citing the ground of "treatment not conforming to standard medical practice" shall automatically trigger an Independent Medical Review by the State Medical Committee. The decision of the State Medical Committee shall be final, binding, and non-appealable on the Insurer. We understand that the rejection case review decision by SHA is under purview of the grievance redressal committee	as given in the clause.

63	16.1.10 Claims Adjudication - Turn-Around Time (TAT) and Penalty for Delay The Insurer shall strictly adhere to the Turn-Around Time (TAT) for claim settlement as prescribed under this Contract and its Schedules. Any failure to adhere to the prescribed TAT shall attract a penalty of 0.5% of the claim amount per day of delay, subject to a maximum penalty of 10% of the claim amount for each delayed claim. If more than 10% of total claims processed in any calendar month breach the prescribed TAT, SHA shall have the right to withhold up to 25% of the subsequent premium installment until such claims are settled to SHA's satisfaction. SHA's decision in this regard shall be final and binding. We understand that the Turnaround time is subject to the TMS 2.0 technical issue	Yes.
64	4 18.3 Investigations pursuant to any such alert shall be concluded by the Insurer within 0714 (seven) days and all final decision related to outcome of the Investigation and consequent penal action, if the fraud is proven, shall vest solely with the SHA., in accordance with the extant guidelines for deempanelment and guidelines on recoveries and other actions post confirmation of fraud and other irregularities issued by the NHA/SHA. Please confirm the number of days mentioned as the same seems to be wrong	14(Fourteen) days. Changes in Corrigendum
65	III .1 In addition to the existing KPIs, the following shall also apply:1. Submission of UTR for all payments to hospitals within 24 hours of release, with a copy to SHA . We understand The TMS 2.0 having , payment integration functionality , and the UTR numbers are getting updated in TMS 2.0 . Please clarify whether separate mail intimation is required	separate email initimation to be sent.
66	Location based incentives on room rates and reduce room rates for public hospitals at only 50% of rate payable for private hospitals 1.We understand that the room rent revision is applicable to CMHIS (GEN) and CMHIS(EP) 2. Whether this reduction of rates applicable in govt institutes like AIMS	Room rent is only applicable for CMHIS (EP). This reduction is applicable for government hospitals in Nagaland.
67	Revision of packages for some of the existing packages for CMHIS (EP) as per revised CGHS Rates Kindly share the list of rate revised packages with package code 111.2.4 Revision of packages for some of the existing packages for CMHIS (EP) as per revised CGHS Rates Kindly share the list of rate revised packages with package code	Refer to Annexure 1- Changes in Tender from previous policy
68	Berlin- Frankfurt -Munster M0047A,M0047B,M0048A,M0048B BFM Schedule - 90 package (cyclophosphamide, Vincristine, Adriamycin,Dexamethason e UKALL) . Kindly clarify the logic of package cost for M0047A,M0047B,M0048A,M0048B(BFM Schedule) -package amount 176000	The difference in package costs for the same package is due to the package codes M0047A and M0048A being assigned rates for the induction phase, while M0047B and M0048B correspond to rates fixed for the continuation phase.

69	The Union Cabinet approved a major expansion of the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) on September 11, 2024. Under this decision, all senior citizens aged 70 and above will receive health coverage, regardless of their income. Please confirm whether such beneficiaries shall be covered under the proposed scheme. If yes then what will be the count of such beneficiaries and whether detailed data for such beneficiaries are available with NHPS or not. Senior Citizen Coverage: The Union Cabinet approved a major expansion of the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) on September 11, 2024. Under this decision, all senior citizens aged 70 and above will receive health coverage, regardless of their income. Please confirm whether such beneficiaries shall be covered under the proposed scheme. If yes then what will be the count of such beneficiaries and whether detailed data for such	not yet approved in Nagaland. However, as a universal scheme, between CMHIS and PM-JAY everyone in the state is covered.
70	financial reports and other relevant documents are under preparation / validation phase. Considering the said scenario please confirm whether the bidders can consider such details till FY 2023-24 for all requirements demanding details till last Financial Years immediately preceding Bid Due Date	Agreed.
71	Please confirm whether deduplication has been done between the beneficiary database of AB-PMJAY & CMHIS	Yes. Aadhaar based deduplication.
72	Please provide the following data: a)We have received the claim dump provided by your good office and currently analyzing the same. Please provide such claim dump separately for cases treated outside Nagaland also. b)Enrolment data/summary c)Previous year's policy schedule & benefit/coverage details, addition deletion of lives d)Last year's per family rate/premium & total premium paid last year. (In Excel format) for ABPJAY category. e)For Pensioners & Employees total count and amount claimed as re-imbursement for the last 5 years f)Kindly provide the district-wise and hospital-type wise (public and private) claim count and amount for the currently running scheme. Please include the dates for which the data are being provided. g)Kindly provide the claim count and amount, with a breakdown into pre-auth approved, paid, outstanding, and rejected. Please provide month-wise data for the current policy. h)Month on month number of claims reported, paid, rejected and outstanding in current policy and previous policy i) Existing claim data provided has details missing like rejection reasons. Please provide such details.	a. may refer to the hospital state in the claims data for segregation. b. enrolment date not available. c. Refer to document under "closed tenders" d. Uploaded in website e. Pensioners did not have medical reimbursement. f. Refer to claim dump g. Refer to claim dump h. Refer to claim dump i.rejection reason currently not available in the data warehouse. j. refer to list of empanelled hospitals uploaded.
73	Kindly Provide last year's and proposed package list in excel format	uploaded in the website.
74	We understand that an employee or pensioner & his family can avail of only those packages listed under N-HBP 2025 for CMHIS (EP) package master. And the CMHISGEN) beneficiaries and their families can exclusively avail themselves of treatment under the N-HBP 2025 for CMHIS (GEN) package master. The Packages and eligible rooms selection would be determined according to the beneficiary category CMHIS (EP) and CMHIS (GEN), respectively. Please clarify.	Yes, packages are determined as per the beneficiary category.Only CMHIS (EP) is eligible for floor rent based on their pay level.

75	District wise Family Details Please provide 1.District wise Family count (for Both EP & GEN categories) 2. Avg Family Size/Total lives to be covered for both CMHIS (GEN) & CMHIS (EP)	district details avaialable in the enrolled beneficiary data dump.
76	Employees posted outside state Please provide no. of employees posted outside state/ state wise (as the case may be) Employees posted outside state Please provide no. of employees posted outside state/ state wise (as the case may be)	not available.
77	Pensioner definition Please confirm whether the family pensioners (spouse of deceased govt employee) covered under the scheme. If yes no. of such families	Yes. No data available on numbers.
78	1. Incumbent insurer	Refer to policy details uploaded
79	2. Expiring TPA	Paramount TPA
80	3. Expiring ICR & incurred amount (2024-25)	Infer from claims dump
81	4. No. of lives to be covered	Households to be covered data provided in RFP Vol I.
82	5. No. of outstanding claims & OS amount	Infer from claims dump
83	6. Family size	Refer to Census data.
84	7. In case of claim settlement, who has the final decision making power?	Insurer, with the provision of audit/review as per guideline
85	Policy start date.	1st May 2025.
86	Claims dump for last three years missing.	Available in the claims dump
87	Inception premium and total GWP for three FY's are missing.	Refer to policy details uploaded
88	Terms for policies missing.	Refer to RFP Volume II and III.
89	Member/Family count at inception and that in the end of policy year is missing. Last three years details required.	Refer to Beneficiary data dump uploaded.
90	Member Demography age wise missing.	Refer to Beneficiary data dump uploaded.
91	Hospital empanelment would be done by TPA or insurance company.	By state, with assistance as required from Insurer.
92	Existing TPA details missing.	Paramount TPA
93	Coverage for members need to be extended for a year on Pro Rata basis (For members getting enrolled in mid of year)	no. coterminus with policy end date.
94	Is there any requirement for physical COI and E Card for members and employees?	No
95	**RFQ PPT** Required documents for Eligibility and Qualification Criteria in RFP	please refer to corrigendum
96	clarity.	Removed point 6.
97	**RFQ PPT** Page no 22 – 21st Point – AI/MI Based system as per clause 3.1.12. Not able to find out clause 3.1.12 in the RFQ.	Updated as per corrigendum. Please read as 3.2.1 a
98	**RFQ PPT** Page no 22 – 22nd Point – 3.1.14. Not able to find out clause 3.1.14 in the RFQ.	Updated as per corrigendum.deleted

99	**Proposed Changes PPT** compared to last Year PDF – Point 2	Please refer to updated excel sheet.
100	**Proposed Changes PPT** Cover Quotation 1 Risk Cover (RC) of Rs. 53,00,000 (Rupees FiveThree Lakh only) on a family floater basis per eligible family for hospitalization for the CMHIS (GEN) beneficiaries	Please refer to updated excel sheet.
101	**Proposed Changes PPT** compared to last Year PDF – Point 3 – Some of the points (example 3.1.1) are missing	Please refer to updated excel sheet.
102	**RFQ PPT** – Page no 15, text missing after **Rs. 2 lakhs on**	Please refer to updated excel sheet.
103	**RFQ PPT** – Page no 19, Point no 2.5 – Pls confirm how many no of quote are required (3 or 4).	Please refer to updated excel sheet.
104	**RFQ PPT** The Bidder shall have done the group health policy cover (excluding personal accident or travel cover) of at least 50,000 families in the past three consecutive completed Financial Years, immediately preceding Bid Due Date – Request clarity on the point.	50,000 families each of the past three consecutive Financial Years
105	Enrolment process and the role of the Govt in driving it	Enrolment is an ongoing process. Current enrolled families uploaded in the website. IC will only be responsible for verification of demographic details and approval, not the end-to -end enrolment process
106	Premium Payment Schedule and Data receipt – Data will be huge, will it be shared on SFTP or Mail.	premium payment schedule already provided in RFP Vol II. All claim data will be available in the claim processing portal (NHA TMS).
107	Clause 1.7 of volume 1 RFP; Clause 12.2.6 of Volume 2 Draft insurance contract these clauses are contradictory w.r.t State Govt's liability. Please clarify if above 120% claim ratio liability will be 50% each between State Govt and Insurance company	As per RFP Vol II-Draft Contract Clause 12.2.6
108	Clause 1.8 of Volume 1 RFP Please provide excel sheet of all HBP for Gen and EP.	uploaded in the website.
109	Clause 2.5 of Volume 1 RFP Just for our understanding please clarity - for General category what is the purpose of splitting cover in to 3 lakh base cover and 2 lakh add on cover?	Please refer to RFP Vol 1- Clause 10.4.5.
110	Clause 3.3 of Volume 1 RFPClause 3.3 of Volume 1 RFP In list of documents required point no 8 to 18 these are published in public disclosures or IRDAI does not collect it. Is it ok if we provide our information by self certification and undertaking of it being true?	No, but please refer to corrigendum for changes
111	Clause 3.3 of Volume 1 RFP: Table point 21 Demonstrating AI and ML capabilities on a paper is a difficult task. Can we give self declaration regarding the capabilities?	Self declaration and to be demonstrated during presentation.

	Clause 7.1.1 (c) of Volume I RFP: Power of Attorney In our company practice of giving power of attorney is not followed. Rather the authorized employees of the company are given authorized by the Board of directors of the company for signing bid/letter etc on behalf of the company. Hope this document will suffice. Last year also this document was allowed.	Allowed.
	Clause 7.1.1 (g) of Volume I RFP: Performance bank guarantee There is no format available for performance bank guarantee (PBG) in tender document. Please clarify if PBG is applicable	Removed. Refer to corrigendum.
	Index at the start of the document and actual pages of the items are matching. There seems to be less number of pages with compared to mentioned in index. Please confirm if any pages are missing.	
	Average solvency margin of at least 1.5 for the financial years 2021-22, 2022-23, 2023-24	
	NL26 - Solvency Margin	
	More than 95% claim settlement ratio in health insurance business: NL37 - Claims Data Note: claim settlement ratio is not calculated but numbers are disclosed as per said form format of IRDAI	
	Turnaround Time (TAT) for Claims (95% settled within 30 days): NL 48 - Disclosures on Quantitative and Qualitative Parameters of Health services rendered Point F covers TAT for Payment. As per IRDAI format bucketing is <30 days, 1 to 3 months, 3 to 6 months, more than 6 months. Please review tender requirement	
	Cashless Pre-authorization Approval (95% within 6 hours): NL 48 - Disclosures on Quantitative and Qualitative Parameters of Health services rendered Point E covers TAT for cashless preauthorization	
	Payment to Hospitals within 7 Days of Claim Approval (95%): NL 48 - Disclosures on Quantitative and Qualitative Parameters of Health services rendered Point F covers TAT for Payment. As per IRDAI format bucketing is <30 days, 1 to 3 months, 3 to 6 months, more than 6 months. Please review tender requirement	
	Discharge Summary Processing within 24 Hours (95%): There is no such IRDAI or public disclosure format	Please refer to corrigendum
	Grievance Closure Rate (>95% within 30 days): There is no such IRDAI or public disclosure format. Closest format is NL 45 which talks about overall Grievance Disposal for all lines of business	
	Claims investigated for Fraud (Minimum 5% of high-cost claims): There is no such IRDAI or public disclosure format	
	Recovery from Fraudulent Claims (Minimum 60%): There is no such IRDAI or public disclosure format	
	Reporting of Suspected Fraud to IRDAI (100% compliance): There is no such IRDAI or public disclosure format	
	Triggered Field investigations (Minimum 10% of high-cost claims): There is no such IRDAI or public disclosure format	
	Time taken for Fraud investigation Closure (Minimum 90% within 30 days): There is no such IRDAI or public disclosure format	
	Since when the anti-viral scheme has been implemented in state?	Oct-22
	Against these families, if enrolment over and above these numbers will be paid on prorata basis.	Yes
	How many new enrolments done in last policy period(last 12months in Cat 1)? How much families are left out in the State of Nagaland for coverage	Please refer to beneficiary data dump.

131	4. The count of families enrolled in Category 3 and 4, which includes employees and pensioners, for the last three years, as well as the expected number of families which will be enrolling at the start of the policy period.	Please refer to beneficiary data dump.
132	5. Will IC get the enrolled family data with date of enrolment?	Please refer to beneficiary data dump.
133	6. Role of insurance company if any in identifying the potential beneficiary, their BIS registration, premium collection etc?	Enrolment is an ongoing process. Current enrolled families uploaded in the website. IC will only be responsible for verification of demographic details and approval, not the end-to -end enrolment process. Premium will be paid by NHPS for all beneficiaries.
134	7. Process and guideline to avail the TOP up SI utilisation.	Consider the base+top up as a single wallet.
135	8. 4.8.2- Note section give reference of cost of medicine to be paid as per package (in medical management) and in surgical case, the investigation/ consumables cost is capped to 10K. need the utilisation of said claim separately to understand it better. Also, the PMJAY indicate all the cost should be part of package then why we wish to pay it separately? (reference of Shcedule-1)	investigation/consumable cost is only applicable for CMHIS (EP). No additional amount beyond fixed package rate can be booked under PM-JAY/CMHIS(GEN).
136	9. Section 5.4.3- Room rent capping in medical management case (7): has this been configured in TMS system or to be handled manually.	Configured in TMS as per the employee/pensioner beneficiary's entitlement.
137	10. Does the TMS flag the beneficiary/ employee category as it has been described?	Yes.
138	11. Do IC need to do any specific agreement with Tata cancer institute, or it would be in flow of PMJYA?	No.
139	12. Please provide the claims record of beneficiary availed the treatment at TATA centre.	not available.
140	13. Record of specified beneficiary group taken treatment at non network hospital in emergency. Claims count / amount for claims settled under reimbursement mode.	not under insurance cover.
141	and paying to hospital. IC should be part of the agreement, and it should be tripartite agreement.	No Change
142	15. 11.1.1: it states that the contract of 3 years and no mention of renewal (2nd year onwards) on mutual consent.	Agreed. Revision in corrigendum
143	16. Clause-18.4: it suggests to release 75% of amount in case claim is under investigation and could not got completed in 14days time for final adjudication. Has this approach been configured in TMS system?	No.
144	17. 22.4: it suggests that insurer to work with all the hospital empanelled under CGHS. Instead, should it not be as all hospital empanelled under PMJAY?	No Change.
145	18. Do IC have to do the BIS approval also? Also, any card to be made for Non PMJAY beneficiary?	Yes. For PM-JAY and CMHIS beneficiaries.
146	19. In KPI sheet, expectation is to settle the claim within 7days. We suggest to make this to 15days in line with standard PMJAY guideline	Agreed. Revision in corrigendum
147	20. Any change in hospital incentive criteria in compared to previous tender.	Please refer to the corrigendum

148	21. Clause-2 of Vol-3: needs to be understood. It depicts the 2 incentive table.	Please refer to Vol III-Schedule 3D/3F
149	a. Is that the 1st table talk for only employee/ pensioner category benefit	Please refer to Vol III-Schedule 3D/3F
150	b. And 2nd table for PMJAY?	Please refer to Vol III-Schedule 3D/3F
151	c. Has this been applied in current policy too?	Yes
152	22. In addition:	
153	a. Last 3years claims record- beneficiary group wise- families covered/ claim count/ amount	Claims data dump provided in the website.
154	b. The package wise, beneficiary category wise claims – count and amount for last policy	Refer to claims data dump provided.
155	c. Summary of the scheme for the last 3 years including total premium paid, ICR, families covered, number of claims, claims amount and outstanding claims.	Please refer to the policy details uploaded and claims data dump.
156	d. Count of EHCP over the last 3 years.	Please refer to the CMHIS website.
157	e. Claims paid data package and non-package wise, including breakdown of data for high-end drugs and implants	Refer to claims data dump provided.
158	23. As per clause 2.5 page 19 of Volume 1- IC is required to submit 3 separate quotations (premium per annum per family) in financial bid but in table below and financial bid quotation against 4 coverages are to be submitted. Please clarify.	Please refer to the corrigendum for correction.
159	24. Which last 3 completed financial years to be considered. As FY 2024 – 2025 is just concluded and annual report / balance sheet are under preparation. Suggest to consider 2021 – 2022, 2022 - 2023, 2023 – 2024.	agreed as suggested
160	S.NO.4 there is requirement of Gross Direct Premium of INR 500 Cr from health insurance. Whereas in same table at S.NO. 6 the same requirement is of INR 100 Cr. these two points are contradictory please clarify.	Please refer to the corrigendum for correction.
161	26. With reference to the Clause 3.3 page no. 21 of volume 1 – in point mentioned at S.No. 19 we understand requirement of 50 K families under State / Government Health Insurance Schemes in last 3 consecutive completed financial years. Please clarify.	no change.
162	27. Which TMS is being used in the state of Nagaland for claims management. If it is TMS 2.0 then what would be the mechanism to place AI / ML algorithms. Please provide details for the same as in TMS 2.0 there is no provision for IC to download the data as well.	TMS 2.0 for PMJAY/CMHIS GEN Convergence TMS for CMHIS(EP). Data dump from State data warehouse will be provided in regular intervals.
163	120% of premium), will the calculation and cost-sharing be conducted separately for CMHIS (GEN) and CMHIS (EP) pools, or will these be combined for the purpose of computation?	No Change. Read the clause.
164	**2. Evaluation of Premiums**: Will the selection of the successful bidder be based on the lowest combined premium (basic + top-up) quoted for both CMHIS (GEN) and CMHIS (EP), or will each scheme's quotation be evaluated and awarded independently?	please see clause 10.4
165	**3. Claim Rejection Review Timeline**: What is the stipulated timeline within which the Joint Review Committee must issue a final decision regarding claim rejections exceeding ₹50,000?	to be discussed Detailed guideline will be issued in the first month of policy after due consultation with stakeholders

166	**4. Penalty During Fraud Investigations**: Will penalties for delays in claim settlement be applicable in cases where claims are under investigation for suspected fraud?	no penalty
167	**5. Penalty Cap**: Is there a cap or upper limit on the total penalties that can be imposed on the insurer in a particular month?	No
168	**6. Interim Payments & Fraud Recovery**: If an interim payment of 75% is made to a hospital due to delays in fraud investigation, will the insurer be entitled to recover the amount if the claim is later confirmed to be fraudulent?	Yes
169	adjudication in court, will insurers still be required to settle the full claim amount within 14 days?	No
170	**8. Local Presence Requirement**: For insurers who do not have a direct operational presence in Nagaland, will partnering with a local TPA meet the eligibility requirement of having a presence in the state?	No change. As per requirement set out in RFP Vol III- Schedule X.
171	**9. Pricing of Non-CGHS Procedures**: For procedures not covered under CGHS rates, what mechanism will be followed to determine the applicable pricing?	Please refer to Vol III: Schedule 3C and 3F
172	**10. Applicability of Revised Rates**: Will the revised CGHS-linked package rates and enhanced procedure rates be applicable prospectively from the commencement date of the new policy, or will they also apply retrospectively to treatments already initiated?	Please refer to Vol II-Clause 5.12
173	**11. Claims Data**:	Please refer to the poly details document and claims/beneficiary data dump uploaded in the website.
174	1. Summary of claims for the last three policy years.	
175	2. Claim dump for the latest policy year in Excel format.	
176	3. Claim analysis report as received from the TPA, including the claim generation date.	
177	**12. Inception Data**:	
178	1. Total number of members and families covered at policy inception.	
179	2. Per family premium at inception.	
180	**13. Policy Closure Data**:	
181	1. Active member count and number of families at the end of the expiring policy.	
182	2. Total premium collected as per the system records.	
183	**14. Policy Tenure**:	
184	1. Start and end date of the expiring policy.	
185	**15. Previous Service Providers**:	
186	1. Name of the insurer and TPA engaged during the last policy year.	
187	**16. Changes in Terms**:	
188	1. Details of any changes in terms & conditions or package rates as compared to the previous policy year.	Please refer to the Annexure 1 uploaded in the website.
189	**17. GIPSA Package Rates**:	
190	1. Whether any GIPSA (General Insurance Public Sector Association) agreed package rates are applicable to PPN network hospitals listed under the scheme.	No
191	**18. Claims by Package**:	
192	1. Package-wise, treatment-wise, and disease-wise claim data for the last year.	Please refer to the claims data sump
193	**19. OPD & Health Checkup Coverage**:	
194	1. Details of coverages provided under OPD and health checkups.	Please refer to the Schedule 3 and its sub schedules
195	2. List of exclusions, if any, applicable to OPD or health checkup services.	Please refer to the Schedule 3 and its sub schedules

196	requirement of Rs 500 Crore, while clause 3.3 (S. No. 6) refers to Rs 100 Crore. Could you please confirm the correct GWP requirement to ensure our submission is accurate?	correction in corrigendum.
197	***On "Annexure 1- Changes in Tender from Previous Policy"***, *"Quotation 1 Risk Cover (RC) of Rs. 53,00,000 (Rupees Five Three Lakh only) on a family floater basis per eligible family for hospitalization for the CMHIS (GEN) beneficiaries"*	
198	**Query**- It is mentioned about Risk cover in Quotation as Rs. 53,00,000 (need clarification on this)	to be read as Rs.3,00,000(Rupees Three Lakh Only)
199	***On "Annexure 1- Changes in Tender from Previous Policy"***, *"If the Insurer's average Claim Ratio for the full 12 months is in excess of 120 percent then the SHA and Insurance Company shall each bear 50% of additional claim cost in excess of the 120% of the total Premium. The calculation of excess claims shall be done separately for 5 lakh Insurance Coverage beneficiaries and 20 lakh Insurance Coverage beneficiaries"*	
200	**Query**- For above point need clarification whether cost sharing will be triggered after 120% LR is achieved on overall scheme or can be triggered even if 120% LR is achieved in any of the scheme categories.	to be calculated separately for 5 lakh category and 20 lakh category.
201	What is the weightage of each point mentioned in the Technical Bid and Financial Bid.	Techical is only qualifying. No weightage.
202	***Under Section 1.8.2 – RFP Document – Volume 1***, Under the Scheme, all Beneficiaries under Category 3 (GoN employees) and Category 4 (GoN pensioners shall be entitled to in-patient care with differential room entitlement as per their employee grade	
203	**Query:** If the beneficiary chooses a higher room than he / she is entitled to, the claim will be approved as per the entitled room only. Please confirm if the understanding is correct.	Yes.
204	***Under Section 3.3 - Required documents for Eligibility and Qualification Criteria – RFP Document – Volume 1***	
205	The Minimum Eligibility criteria mentions that documentary evidence in the form of "Certified copies of Public Disclosure Reports or any other Reports submitted to IRDAI as per current IRDAI Regulations" is required for the following:	Please refer to corrigendum
206	Cashless Pre-authorization Approval (95% within 6 hours)	
207	Payment to Hospitals within 7 Days of Claim Approval (95%)	
208	Discharge Summary Processing within 24 Hours (95%)	
209	Grievance Closure Rate (>95% within 30 days)	
210	Claims Investigated for Fraud (Minimum 5% of high-cost claims)	
211	Recovery from Fraudulent Claims (Minimum 60%)	
212	Reporting of Suspected Fraud to IRDAI (100% compliance)	
213	Triggered Field Investigations (Minimum 10% of high-cost claims)	
214	Time taken for Fraud Investigation Closure (Minimum 90% within 30 days)	
215	**Query**: All the above parameters are operational metrics and there is no report submitted to IRDAI nor there is any public disclosure for the same. We request that data for the last FY can be provided as certified by the authorized signatory of the insurance company.	
216	**Under Section 3.3 - Required documents for Eligibility and Qualification Criteria – RFP Document – Volume 1**	
217	"Certified copies of Public Disclosure Reports or any other Reports submitted to IRDAI as per current IRDAI Regulations" is required for "More than 95% claim settlement ratio in health insurance business"	

218	periods and exclusions. Hence, the claim settlement ratios for retail products are impacted by the tenure of beneficiary in the policy. Since the tender is for a group health insurance policy, the claim settlement ratio should be considered for group health policies only. Also, since no separate submission is done to IRDAI for claim settlement ratio, we request that data for the last FY can be provided as certified by the authorized signatory of the insurance company.	Please refer to corrigendum
219	**On Enrolment and claims-**	please refer to the beneficiary data dump.
220	1. Confirm the total estimated number of families and individuals covered (urban + rural split).	please refer to the beneficiary data dump.
221	2. District wise coverage data.	please refer to the beneficiary data dump.
222	3. Share the detailed list of eligible beneficiaries (validated database).	ongoing, for already enrolled please refer to the beneficiary data dump.
223	4. Confirm inclusion/exclusion criteria for beneficiaries, especially migratory populations.	Please refer to RFP Vol I- Clause 1.3
224	5. Total premium received, claims incurred (paid + outstanding), surplus refunded etc. for previous years (as per attached format).	please refer to the policy details document.
225	6. 3 years claims level data for the previous years to analyze in detail.	please refer to the claims data dump.
226	7. Past 3 years' enrollment details.	please refer to the beneficiary data dump.
227	three years?	Please refer to Annexure 1.
228	9. Is there any revision in package costs and empaneled providers?	Please refer to Annexure 1.
229	10. Age-band wise members mix for all the 3 years.	please refer to the beneficiary data dump.
230	11. Specify the enrollment criteria of - CMHIS General Category.	Please refer to Vol III- Schedule 2
231	up).	No comment
232	Top up?	
233	14. As per Bid data sheet - Policy tenure is for 3 years and as per Insurance Contract documents decided rates are valid for all three years - please elaborate.	May consider consider escalation subject to government approval.
234	15. As per our understanding this policy for PMJAY and CMHIS Employee & Pensioner (EP) beneficiaries only.	Please refer to RFP Vol I- Clause 1.3
235	16. Is CMHIS General Category (GC) part of expiring policy? Or will it be added this year?	Please refer to RFP Vol I- Clause 1.3
236	**On Premium Payment-**	
237	17. Specify timeline for advance premium payment (full year or installments?).	Please refer to RFP Vol II- Clause 12
238	18. Confirm exact timelines for quarterly premium payments (especially for additional enrolments).	Please refer to RFP Vol II- Clause 12
239	19. Will the State Government provide a Guarantee for timely payment of premium?	Please refer to RFP Vol II- Clause 12
240	20. Penalty clause for delayed premium payment by the State — any protection for insurer?	Please refer to RFP Vol III- Schedule 11C.

241	21. Will the premium for new enrollments mid-year be prorated monthly or quarterly?	all premium prorating is done on a day basis, to be paid with the subsequent premium instalment
242	**On Health Benefit Packages, Hospitals and Rates**	
243	22. Confirm if the Schedule 3A HBP 2022 and Schedule 3B Rate List are final.	Please also refer to RFP Vol II-Clause 5.12
244	23. Can package rates be revised based on inflation or cost escalation? If yes, when and how?	Please also refer to RFP Vol II-Clause 5.12
245	24. Are there any hospitals allowed to charge outside the approved package rates?	No
246	25. Who will empanel hospitals — Government, Insurance Company, or jointly?	Government with assistance from Insurer as required.
247	26. In case of SHA overruling a fraud, finding, will the insurer have any right of appeal or arbitration?	As per extant guidelines on Fraud and abuse issued by NHA/SHA.
248	27. For hospital empanelment outside Nagaland (e.g., AIIMS under CGHS), will the insurer have to sign separate MOUs?	No
249	28. In case CGHS/NHA rates change during the contract tenure: ➔ How will package rates under Nagaland scheme be revised — automatically or via separate notification?	separate notification. Please also refer to RFP Vol II-Clause 5.12
250	29. For CMHIS (EP) beneficiaries: ➔ Is billing at higher room entitlement (private ward) mandatory if beneficiary chooses a lower category voluntarily?	no provision to choose a lower category.
251	30. What happens if private room is unavailable — should the insurer apply a room rent downgrade or upgrade?	Yes. Rate may be downlgraded if the eligible higher room is not provided, (to be included in the EHCP MoU)
252	31. Is automatic top-up activation allowed once basic cover is exhausted, or is fresh authorization needed from SHA?	Automatic
253	**Claims**	
254	32. Any restriction on the number of claims allowed under the top-up cover?	no.
255	33. Hospital wise claims for the last 3 years.	please refer to the claims data dump.
256	34. Clarify the exact mechanism for loss sharing after 120% claims ratio.	no change.
257	35. Who will select the Independent Medical Expert for the Joint Review Committee?	Please refer to Volume II, Clause 16.1.4
258	36. For penalties on claim settlement delays (0.5% per day, max 10%): ➔ Is the penalty calculated on gross claim amount or approved claim amount?	approved.
259	**Dispute resolution and fraud related**	
260	37. Mechanism for dispute resolution between hospital and insurer for high-value claims.	Will be shared in hospital MoU
261	38. Can insurer de-empanel hospitals for fraud/misconduct independently?	No.
262	39. What support will the Government provide to control fraud and abuse (legal, police, etc.)?	As per extant NHA/SHA guidelines on fraud and abuse.
263	**Performance Guarantee-**	
264	40. Define triggers for invocation of Performance Guarantee/BG (Bank Guarantee).	Removed. Please refer to corrigendum.

265	**Manpower and Marketing-**	
266	41. Will the Government provide field-level manpower (like Ayushman Mitras)?	Ayushman Mitras are engaged by the hospitals.
267	spend?	No.
268	**Others**	
269	43. Confirm the initial contract period (typically 3 years) and conditions for early termination.	Please refer to RFP Vol II-Clause 28 and Clause 29.
270	losses.	No exit load.
271	45. How will the 25% premium installment withholding process be implemented in case of repeated TAT breaches?	As per guideline.
272	investigations?	No
273	47. What constitutes conclusive proof of fraud sufficient to withhold full claim payment?	As per fraud guideline.
274	48. Can multiple insurers bid together (coosortium) under a single entity with lead insurers or is it strictly prohibited?	prohibited
275	The Bidder shall have Gross Direct Premium Income from Health Insurance (excluding personal accident or travel cover) of at least Rs. 500 crores every year for the in the last three consecutive Financial Years immediately preceding Bid Due data in India	Please refer to corrigendum
276	The Bidder shall have Gross Direct Premium income from Health Insurance (Excluding personal accident or travel Cover) of at least Rs.100 crores in the last three consecutive financial Years immediately preceding Bid due date in India	
277	More than 95% claim settlement ratio in health insurance business The claim no and amount is reported to IRDA however settlement ratio is not reported. There is no standard mythology to report settlement ratio to IRDAI.	Please refer to corrigendum
278	Payment to Hospitals within 7 Days of Claim Approval (95%) At present this is as per agreed terms with hospital .Need to review on this.	
279	Discharge Summary Processing within 24 Hours (95%) Please clarify discharge summary is process by the hospital .IC authorizes claim basis discharge summery and other documents.	
280	We are an established insurance company, empanelled under the IRDAI regulation, and have been operational for the last 8 years with a turnover exceeding INR 1000 Crores. We are keen to participate in the upcoming state insurance scheme to bring significant value to the program. Our team is composed of highly skilled professionals who have successfully implemented various state insurance schemes, including the Rastriya Swasthya Bima Yojana (RSBY) and other state-level initiatives. We believe that such a relaxation will encourage greater participation from capable insurers, ensuring competitive pricing that will ultimately be in the best interest of the state's revenue and the beneficiaries. We look forward to your positive response.	No Change.