MEMORANDUM OF UNDERSTANDING (MOU)

This Agreement made at ______ on this ___day of _______ 2015, BETWEEN 1 ) United India Insurance Company Limited, an insurance company registered with the Insurance Regulatory & Development Authority of India having registration number [545] and having its registered office at 24, Whites Road, Chennai, Tamil Nadu hereinafter called the “Insurer” of the One Part

2) ___________________________ Hospital/Nursing home owned and run by Managing Superintendent / Director / Proprietor – being Registered Public Charitable Trust / Private body / individual having its Registered Office at ____________________________________________ hereinafter referred to as “NETWORK PROVIDER” (which expression shall unless it be repugnant to the context or meaning thereof shall mean and include the persons for the time being and from time to time constituting the said private organization / Trust, survivors or survivor of them) of the Second Part.

AND

3) ------------------------------------------ herein after referred as “Third Party Administrator” licensed by the Insurance Regulatory and Development Authority under the Third Party Administrator - Health Services Regulation 2001 (name, address, IRDA License number as per list attached) (Hereinafter referred to as the “TPA /TPAs” which expression shall, unless repugnant to the context or meaning thereof, be deemed to mean and include its successors and permitted assigns) of the Third Part. (“The Insurer”, “Network Provider” and the “TPA” are individually referred to as a “party” and collectively as “parties”)

1. The Insurer is an insurance company licensed under IRDA to provide Healthcare insurance coverage to its Insured / Beneficiary families having got the mandate from the Government of Uttarakhand to cover MSBY Card Holders from all 13 districts of the State to Beneficiary families against specified surgical / Therapeutic procedures for which purpose Insurer has created a network of Health Service Providers.

2. ___________________________________________ ( The Network Provider ) desires to join the said network of Providers and is willing to extend cashless medical facilities for the surgical/Therapeutic procedures as per the scheme guidelines.

3. ___________________________________________ “TPA” a Third Party Administrator licensed by the Insurance Regulatory and Development Authority under the Third Party Administrator - Health Services Regulation 2001 under License No…….. And having its registered office at ………………………………. ________ Will be administering the health policy services of the provider on behalf of insurance company.

4. The Provider/s has accepted the offer made on the terms and conditions hereinafter appearing

Hospital Service Agreement
NOW THIS AGREEMENT WITNESSETH AND IT IS HEREBY AGREED BY AND BETWEEN THE PARTIES HERETO AS FOLLOWS:

1. **Effective Date**

   -This agreement will be in force from its date of affectivity for a period of six months initially subjected to extension in case of extension of the scheme or early termination as per any clause in this MoU.

2. **General Provisions**

   2.1. Provider warrants that it fulfils minimum empanelment criteria as per the proforma uploaded on MSBY website ([www.ukhfws.org](http://www.ukhfws.org)).

   2.2. Provider agrees to serve the MSBY beneficiaries as per the scheme guidelines available on MSBY website ([www.ukhfws.org](http://www.ukhfws.org)) or issued from time to time by SNA.

   2.3. Provider agrees to follow the electronic mode of processes unless the use of BCP mode is required to process in case of IT failure mechanism.

3. **Speciality or Specialities Empanelled**

   3.1. Provider hereby declares that the hospital has requisite infrastructure as per MSBY guidelines in relation to specialty services for which empanelment is done and agrees to provide quality diagnostic and treatment services as per the standard protocols.

   3.2. Provider hereby declares that hospital did not exclude any other specialty service deliberately from the scheme inspite of having such facility and agrees to empanel for the specialties for which adequate infrastructure is available.

   3.3. Specialties Provider agrees not to refuse admission of MSBY patient in any specialty where it has consultants and equipment.

   3.4. Provider agrees to follow the guidelines issued by the SNA / Insurer on specific specialties.

4. **Cashless Service Under Packages**

   4.1. The Provider agrees to provide total cashless transaction to the Beneficiary right from his reporting to discharge under the scheme.

   4.2. The hospital agrees to the package to be authorized even for those patients who were admitted as non-MSBY out of ignorance but subsequently identified as MSBY beneficiary during the course of his/her stay in the hospital. In the meanwhile any payment received from the patient shall be refunded immediately after getting pre-authorization approval and before discharge of the patient from the hospital duly obtaining a receipt from the patient.

**Hospital Service Agreement**
4.3. Pre-Authorisation & Claim Procedure for Hospitalisation, Day Care Treatment, OPD Diagnostic Benefit or Follow Up Care

(a) The empanelled Health Care Provider shall follow the procedure set out below:

The Empanelled Health Care Provider shall first confirm the identity of the beneficiary presenting with MSBY Card and/or other identification document by matching the details as entered in Beneficiary Database by accessing the database electronically.

(b) The Empanelled Health Care Provider shall verify electronically that

The Beneficiary is being admitted for a medical treatment or surgical procedure requiring hospitalisation or that the Beneficiary will undergo a day care treatment for which a package rate has been fixed or that the beneficiary has sought OPD Diagnostic benefit or Follow Up care for which the package rate is fixed.

(i) The proposed medical treatment, Surgical Procedure, Day Care Treatment, OPD Diagnostic Benefit or Follow Up care is not excluded and the conditions for utilisation of such benefit have been met.

(ii) The available sum insured is sufficient to meet the package rate needed for the beneficiary. If so, the available sum insured shall be utilised to the extent of the package rate. If the available sum insured is insufficient to meet the package rate, then the sum insured shall be utilised to the extent available and the balance amount shall be charged from the beneficiary at the time of discharge.

(c) The Empanelled Healthcare provider shall make a pre-authorisation request for providing the proposed medical treatment, surgical procedure, OPD Diagnostic Benefit or Day Care Treatment by furnishing or entering the necessary as required in the Web-Based/alternate IT application.

(d) Upon successful request for pre-authorisation an acknowledgement receipt shall be generated by Web-based/alternate IT application mentioning the time, date and other details of the pre-authorisation requests made.

(e) The Insurer (through TPA) shall decide, within 3 hours for districts in plain and 4 hours for districts in hills of receipt of pre-authorisation request from an empanelled health care provider or MSBY network hospital, whether a Claim is admissible or not.

(f) The approval or denial of pre-authorisation shall be intimated to Empanelled Healthcare Provider via same Web-based/ alternate IT application.
(g) Upon approval of the pre-authorisation request the empanelled healthcare provider shall proceed with the Medical or Surgical treatment, Day Care Treatment, OPD Diagnostic Benefit, Follow-up care as per plan. In case of denial of pre-authorisation requests the service provider shall proceed as per treatment plan.

(h) The Empanelled Healthcare Provider shall not be entitled for any reimbursement for providing any medical treatment, Surgical Procedure, Day-Care Treatment, OPD Diagnostic Benefit or Follow-Up care unless a pre-authorisation request is approved by the insurer.

(i) At the time of discharge of beneficiary the empanelled healthcare provider shall submit all claim documents on Web-Based/alternate IT application.

(j) all public hospitals shall confirm the identification of the Beneficiary, match the details of the package required and available sum insured. The public Empanelled Hospital shall also need to make a pre-authorisation request for which due acknowledgment will be generated. However, the Public Empanelled Healthcare Provider may go ahead with the treatment plan as per package required without waiting for the approval of pre-authorisation

(k) All Private Empanelled Healthcare Providers shall be required to follow all the procedures as mentioned above except in case when a Beneficiary shall present for an “Emergency Medical Treatment or Surgical Procedure. In such cases Private Empanelled Healthcare Provider shall not be required to raise a pre-authorisation request and go ahead with required treatment or procedure without waiting for its approval as required.

(l) Cashless Access Service in event of IT failure shall be carried out by the Empanelled Healthcare Provider by following the process as outlined in Business Continuity Plan.

5. **Sum Insured**

For each Policy Cover Period, the Sum Insured in respect of the Cover for each Beneficiary Family Unit shall be ₹ 50,000; and as on the date of a Claim Payment by the Insurer, shall stand reduced by all Claim Payments made as on that date in respect of the Cover, for the remainder of such Policy Cover Period. The maximum liability of the insurer per family for a policy period including extension of the policy, if any, shall not exceed ₹ 50,000.

**Sum Insured on Family Floater Basis**

The Covers shall be provided to each Beneficiary Family Unit on a family floater basis covering the members of the Beneficiary Family Unit, i.e., the Sum Insured will be available to any or all members of such Beneficiary Family Unit for one or more Claims during each Policy Cover Period.
6. Benefits:

The provider hereby agrees to provide the following benefits to each enrolled Beneficiary covered by such Policy for the Policy Cover Period and to the extent of the Sum Insured:

6.1. Hospitalization Expenses benefit: for a Medical Treatment or Surgical Procedure subject only to the Exclusions. Hospitalization expenses shall include, amongst other things:

(i) Registration charges; (ii) Bed charges (General Ward or ICU, as the case may be); (iii) Nursing and boarding charges; (iv) Surgeons, anaesthetists, Medical Practitioners, consultants fees, etc.; (v) Anaesthesia, oxygen, operation theatre charges, cost of surgical appliances, etc.; (vi) Medicines and drugs; (vii) Cost of prosthetic devices, implants, organs, transfusions etc.; (viii) Screening, including X-Ray and other diagnostic tests, etc.; (ix) Food to the Beneficiary; (x) Cost of treating any complications arising during Hospitalization; and (xi) Any other expenses related to the Medical Treatment or Surgical Procedure provided to the Beneficiary by an Empanelled Health Care Provider. (if blood transfusion is indicated it can be charged as per package vide code No.1345).

6.2. Day Care Treatment benefit: for a Day Care Treatment subject only to the Exclusions. This benefit is limited to the available Sum Insured.

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

6.3. OPD Diagnostic benefit: for specified diagnostic care provided by specified public health facilities across the state only. The OPD diagnostic benefit does not extend to any diagnostic care provided by a provider that would otherwise be covered by any of the other hospitalisation or day care benefit benefits under the Cover. This benefit is limited to: (1) the available Sum Insured; and (2) a maximum of 5,000 for all instances of OPD diagnostic care, in each Policy Cover Period.

6.4. Pre-hospitalization and Post-hospitalization Expenses benefit: one day prior to Hospitalization or Day Care Treatment and for continuous Follow-up Care for up to 5 days after discharge or Day Care Treatment. Pre-hospitalization and post-hospitalization expenses shall include, amongst other things:

(i) Screening, medicines and consultations in the 1 day period prior to Hospitalization or Day Care Treatment; (ii) Screening and medicines in the 5 days after Hospitalization or Day Care Treatment; and (iii) any other expenses related to such pre-hospitalization or post-hospitalization.

6.5. Follow-up Care benefit: for Follow-up Care provided by provider in addition to the pre-hospitalization and post-hospitalization expenses benefit, and it will only be available in respect of expenses incurred by the Beneficiary once the 5 day post-
hospitalization period has been completed. This benefit will only be available in relation to Follow-up Care provided consequent to a Medical Treatment or Surgical Procedure for which Hospitalization or Day Care Treatment provided under the Cover, and not otherwise.

This benefit is limited to: (1) Follow-up Care that is provided such that the first Follow-up Care visit occurs within 120 days of discharge by an Empanelled Health Care Provider; (2) ₹300 per Follow-up Care visit and (3) a maximum of four instances of Follow-up Care visits, minimum gap of at least 7 days in between subsequent visits in same hospital in each Policy Cover Period. This benefit is further limited to the available Sum Insured. Follow-up Care expenses shall include:

(i) OPD consultation expenses; (ii) expenses of Screening; and (iii) expenses of medicines and drugs.

The medicines will be handed over to the Beneficiary by the Empanelled Health Care Provider and the costs thereof will then be claimed from the Insurer as part of the prescribed Package Rate.

6.6. Transportation benefit: provides cover for cost of transportation incurred by the Beneficiary in travelling to and from the premises of the Empanelled Health Care Provider for availing of Hospitalization or Day Care Treatment or for Follow-up Care.

This benefit is limited to ₹100 per occurrence of Hospitalization or Day Care Treatment or visit to an Empanelled Health Care Provider for Follow-up Care. The transportation benefit will be paid to the Beneficiary by the Empanelled Health Care Provider and will then be claimed from the Insurer as part of the Package Rate.

Further, this benefit is limited to a maximum of 10 instances of Hospitalization or Day Care Treatment or Follow-up Care during each Policy Cover Period.

Each of the benefits specified above shall be available for all pre-existing conditions, diseases, illnesses or injuries affecting the Beneficiaries on the date of commencement of each Policy Cover Period, subject only to the Exclusions.

7. Package Rates

7.1. The Package rates are the maximum rates indicated for respective medical or surgical or day care procedure.

7.2. Provider has agreed to the continuation of the agreed tariff for the period of this agreement.

7.3. In the event of more than one procedure is being undertaken in one sitting other than those of routine/standard components of the surgical procedure, the package amount will be as under

- 100 per cent for the procedure with the highest package rate
- 75 per cent for the accessory procedure
7.4. Provider under any circumstances will not refuse to undertake procedure on the ground of insufficient package rates.

7.5. The Network hospital cannot claim anything from SNA or patient.

7.6. In all other disputes related to package rates and technical approvals of pre-authorizations, the matter will be referred to a Technical Committee of the Insurer / SNA and is binding on the provider.

8. Quality of Services

8.1. There should be no discrimination between MSBY & other patients with regard to quality of services.

8.2. The Provider will treat MSBY Beneficiary families in a courteous manner and according to good business practices.

8.3. The Provider will extend admission facilities to the Beneficiary families round the clock.

8.4. Provider will ensure that the best and complete diagnostic, therapeutic and follow-up services based on standard medical practices / recommendations are extended to the Beneficiary.

8.5. The provider agrees to provide quality service to the beneficiary by following standard protocols for diagnosis and treatment. It is also mandatory for the provider to assess the appropriate need and subject the beneficiary for treatment / Procedure.

8.6. The provider agrees to provide quality medicines, standard prosthesis. Implants and disposables while treating the beneficiary families.

8.7. The Provider agrees to assist and cooperate with the medical auditing team from the SNA / Insurer as and when required.

8.8. The hospitals Morbidity and Mortality cases will be subject to scrutiny by the MSBY society / Insurer.

8.9. The provider agrees to take sole responsibility in submitting the patient details online and if any discrepancy is found in this regard the Provider agrees to abide by decisions of TPA/Insurer.

8.10. Government will be authorized to issue guidelines with respect to maintenance of service levels & also for reduction of mortality related to patient care services.

8.11. The provider shall use generic drugs and formulations for the treatment of patients.
9. Documentation & MIS

9.1. The provider will ensure that documentation of MSBY patients are done using standard formats supplied / available online such as admission card, referral card, investigation reports, original hospital bill & discharge summary etc.

9.2. The hospital should maintain medical and administrative records as per directives of the scheme.

9.3. SNA and Insurer reserve the right to visit the Beneficiary and check his medical data with or without intimation as and when required.

9.4. The provider will allow the Medical Audit team from SNA / Insurance Company/ TPA to inspect the hospitals including audit by without obstruction and co-ordinate with them during Surprise and Regular Inspections.

9.5. The Provider agrees to keep printouts of all online documents in the case sheet and make available as and when required for verification by field staff / doctors of the SNA or Insurance/TPA.

10. Display of Boards and Banners

10.1. Provider agrees to display their status of preferred Provider of MSBY Community Health Insurance Scheme at their reception / admission desks.

10.2. Provider agrees to display their status of specialties empanelled in MSBY Community Health Insurance Scheme at their reception / admission desks.

10.3. Provider agrees to display availability of beds in the hospital and also display specialty wise bed occupancy under MSBY Community Health Scheme at their reception / admission desks.

10.4. Provider agrees to display the process flow of MSBY within the hospital at the MSBY kiosk.

10.5. Provider agrees to make available of the list of diseases with package rates covered under MSBY community Health Insurance scheme in the form of Booklet supplied by the MSBY society/ Insurer at their reception / admission desks.

10.6. Provider agrees to display other materials supplied by MSBY society /Insurer for the ease of Beneficiary families.
11. Preference to Beneficiary Families

11.1. The Provider agrees not to deny admission for the beneficiary for want of pre-authorization approval.

11.2. The provider agrees to provide Operation Theatre and weekly schedules for the surgeries / therapies to be performed for the Beneficiary families.

12. Medical Camps and Awareness

Empanelled Hospitals may organise free Health camps in nearby places or any of the districts in the State to provide outreach benefit to the beneficiaries. However, organising health camps is not an obligation to the hospitals and this is purely on voluntary basis.

13. Payment Terms and Condition

13.1. Insurer hereby agrees and undertakes to pay all the eligible bills within 30 working days after submission of all supporting documents including post-operative investigations and reports as required online.

For a delay in making payments to hospital beyond 30 days Insurer shall pay an interest of 0.5 per cent every fifteen days on total amount payable.

The payments to the provider are made by the Insurer after deducting Taxes (TDS) as per prevailing IT Rules, and accordingly Insurer will issue the Form No. 16A at the end of Financial Year. Provider hereby agrees to comply all the formalities required in fulfilling regulations of Income Tax Dept.

13.1. The provider agrees to submit the core banking number IFSC code to the insurer to facilitate electronic fund transfer for settling the claims. The payment will be done directly by the Insurer to the provider by NEFT/Electronically.

13.3. The provider agrees to perform Surgeries / Medical Treatment within 24 hrs. From the date of approval of cashless authorization, if in case of postponed the surgery/treatment the provider will inform the reason to TPA on the same day through Mail or Fax..

13.4. Claim settlement shall be done as per Claim Settlement Guidelines of Insurance Company.

13.5. The power to deny a claim lies solely & only with the Insurer.

13.6. If provider is not satisfied with the decision of Insurer in this regard, then it can appeal to Grievance Redressal online with available software application ( SNA ) for rejected claims separately.

14. Limitations of liability and Indemnity
14.1. The Provider will be responsible for all commissions and omissions in treating the patients referred under the scheme and will also be responsible for all legal consequences that may arise. Insurer/TPA/SNA society will not be held responsible for the choice of treatment and outcome of the treatment or quality of the care provided by the provider and should any legal complications arise and is called upon to answer the provider will pay all legal expenses and consequent compensation, if any.

14.2. The Provider admits and agrees that if any claim arises out of alleged deficiency in service on their part of on the part of their men or agents, then it will be the duty of the provider to answer such claim. In the unlikely event of Insurer/Society/TPA being proceeded against for such cause of action and any liability was imposed on them, only by virtue of its relationship with the provider and then the provider will step in and meet such liability on their own.

14.3. Notwithstanding anything to the contrary in this Agreement, neither Party will be liable by reason of failure or delay in the performance of its duties and obligations under this Agreement if such failure or delay is caused by acts of God, Strikes, lock-outs, embargoes, war, riots civil commotion, any orders of Governmental, Quasi Governmental or local authorities, or any other similar cause beyond its control and without its fault of negligence.

14.4. The Provider undertake for applicability of terms and conditions mentioned and in all the MOUs executed for all the phases in-lieu of this MOU.

15. Confidentiality

15.1. All the stakeholders undertake to protect the secrecy of all the data of Beneficiary families and trade or business secrets of and will not share the same with any unauthorized person for any reason whatsoever within or without or consideration.

15.2. The provider agrees to protect the confidentiality under this agreement and ensures not to recruit ex-employees of insurer/TPA anytime during this agreement and also for a further period of one year from the date of expiry of this agreement.

16. Termination

Any deficiency in service by the empanelled hospitals (Provider) or noncompliance of the provisions of MOU will be scrutinized by the Empanelment Committee of the Insurer/TPA/SNA and make deliberations to suspend / de-list / stop payments or any other appropriate action based on the nature of the complaint against the Provider.

The Provider shall abide by the deliberations made by the Insurer.

Process to be followed for De-Empanelment of Empanelled Health Care Providers
Step 1 – Putting the Empanelled Health Care Provider on "Watch-list"

(a) If the Insurer believes that any of the events listed in the de-empanelment Clause of insurance contract has occurred or if the Insurer believes that the performance of the Empanelled Health Care Provider raises any doubts, based on the Claims data analysis and/or the medical audit conducted by the Insurer, then the Insurer or its representative shall put that Empanelled Health Care Provider on the watch list.

(b) The data of such Empanelled Health Care Provider shall be analysed very closely on a daily basis by the Insurer or its representatives for patterns, trends and anomalies.

(c) The Insurer shall immediately inform the State Nodal Agency about the Empanelled Health Care Provider which has been put on the watch list, within 24 hours of taking such action.

Step 2 – Suspension of the Hospital

(a) An Empanelled Health Care Provider may be temporarily suspended in the following cases:

(i) If an Empanelled Health Care Provider which is on the "Watch-list", if the Insurer observes continuous patterns or strong evidence of irregularity based on either Claims data or medical audits.

(ii) If an Empanelled Health Care Provider is not on the "Watch-list", but the Insurer observes at any time that it has data/evidence that suggests that the Empanelled Health Care Provider is: (x) involved in any unethical practice; (y) in material breach of the provisions of the Services Agreement with the Insurer; or (z) its representative(s) is/are involved in financial fraud related to the Beneficiaries; or the Empanelled Health Care Provider is engaged in any other Fraudulent Activity.

(iii) If a directive is given by State Nodal Agency based on the complaints received by it or data analysis or field visits done by the State Nodal Agency.

In each of these cases, the Insurer may immediately suspend the Empanelled Health Care Provider from providing services to the Beneficiaries and institute a formal investigation in accordance with Step 3 below.

(b) The Empanelled Health Care Provider, the district authority and the State Nodal Agency should be informed of the decision of the Insurer to suspend an Empanelled Health Care Provider within 6 hours of taking such action so that no fresh admission of Beneficiaries may be undertaken. Further, at least 24 hours’ prior notice should be given to the Empanelled Health Care Provider so that no fresh admissions are made.

(c) To ensure that suspension of the Empanelled Health Care Provider results in its being barred from making fresh admissions of Beneficiaries, the Insurer shall make a provision in the software installed at the Empanelled Health Care Provider premises so that the Empanelled Health Care Provider cannot send electronic Claims to the Insurer or its representatives.

Notwithstanding the suspension of an Empanelled Health Care Provider, the Insurer shall ensure that it shall honour all Claims for any expenses that have been pre-authorized or blocked on the MSBY Cards before the effectiveness of such suspension.
(d) The Insurer shall immediately notify the TPA or its representatives that are responsible for Claims processing of such suspension of an Empanelled Health Care Provider. Further, the Insurer shall not and shall instruct its TPA or representatives not to process any Claims received from the suspended Empanelled Health Care Provider during the period of such suspension.

(e) The Insurer shall promptly send a formal letter to the Empanelled Health Care Provider regarding its suspension. Such notice shall specify the timeframe within which the formal investigation will be completed by the Insurer.

(f) The Insurer shall issue an advertisement in the local newspaper specifying that the health care services will be temporarily stopped at the suspended Empanelled Health Care Provider within 24 hours of such suspension. The newspaper and the content of message will be jointly decided by the insurer and the district level administration of the State Nodal Authority.

Step 3 – Detailed Investigation

(a) The Insurer may launch a detailed investigation into the activities of an Empanelled Health Care Provider in the following situations:

(i) If such Empanelled Health Care Provider has been suspended.

(ii) Upon receipt of a complaint of a serious nature from any of the stakeholders in the Scheme.

(b) The detailed investigation may include field visits to the Empanelled Health Care Provider, examination of case papers, meetings with the Beneficiaries (if needed), examination of hospital records, etc. The Empanelled Health Care Provider shall be required to fully cooperate with and provide access to all information to the Insurer and its representatives that are conducting such investigation.

(c) If the investigation reveals that the report, complaint or allegation against the Empanelled Health Care Provider is not substantiated, then the Insurer shall immediately revoke the suspension notice (if the Empanelled Health Care Provider has been suspended) and inform the State Nodal Agency of the revocation of such suspension.

(d) A letter regarding revocation of suspension shall be sent to the Empanelled Health Care Provider within 24 hours of the Insurer taking such decision.

(e) The Insurer shall, within 24 hours of revoking the Empanelled Health Care Provider's suspension, issue an advertisement in the local newspaper notifying Beneficiaries of the re-commencement of health care services at such Empanelled Health Care Provider's premises. The newspaper and the content of message will be jointly decided by the insurer and the district Authority.

(f) The Insurer shall activate the software installed at the Empanelled Health Care Provider premises so that the Empanelled Health Care Provider can send electronic Claims to the Insurer or its TPA or representatives. Such activation shall be done within 24 hours of the revocation of suspension.

Step 4 – Action by the Insurer
(a) If the investigation reveals that the report, complaint or allegation against the Empanelled Health Care Provider is correct then the following procedure shall be followed:

(i) The Empanelled Health Care Provider shall be issued a "show-cause" notice seeking an explanation for the aberration and a copy of the show cause notice shall be sent to the State Nodal Agency.

(ii) After receipt of the explanation from the Empanelled Health Care Provider and its examination, the Insurer may either drop the charges or take any necessary action.

(iii) The Insurer shall be entitled to take any one or more of the following actions against the Empanelled Health Care Provider, based on the seriousness of the issue and other factors involved: (x) issue a warning to the concerned Empanelled Health Care Provider; or (y) Intimate the State Nodal Agency and shall present all details of the steps 1, 2 and 3 described above and taken by insurer in each instance of hospital violating the rule.

(b) The entire process (other than any delays caused due to a delay by the State Nodal Agency in conveying its approval or disapproval) shall be completed within 30 days from the date of suspension of the concerned Empanelled Health Care Provider.

In addition to de-empanelment of an Empanelled Health Care Provider for cause, the Insurer shall have the right to de-empanel an Empanelled Health Care Provider at the end of a Policy Cover Period, provided that: (i) the Insurer has obtained the prior written consent of the State Nodal Agency for such de-empanelment; and (ii) the Insurer ensures that an adequate number of health care providers are available in the block/district in which such Empanelled Health Care Provider is situated.

Step 5 – Actions to be taken after De-empanelment

Once an Empanelled Health Care Provider has been de-empanelled under the Scheme (De-empanelled Health Care Provider), the following steps shall be taken:

(a) A letter shall be sent to the concerned De-Empanelled Health Care Provider regarding this decision with a copy to the State Nodal Agency, the relevant District Kiosk and the Insurer’s representatives that are responsible for Claims processing.

(b) If the De-Empanelled Health Care Provider appeals against the decision of the Insurer, all the aforementioned actions shall be subject to the decision of the concerned Grievance Redressal Committee.

3. **Grievance by the De-empanelled Health Care Provider**

The De-Empanelled Health Care Provider may approach the relevant Grievance Redressal Committee for redressal of its grievance against the actions of the Insurer. The Grievance Redressal Committee shall take a final view within 30 days of receipt of a representation from the De-Empanelled Health Care Provider. However, such health care provider shall continue to be de-empanelled until a final view is taken by the Grievance Redressal Committee. The Grievance Redressal Mechanism shall be as set out in the Insurance Contract.

4. **Special Cases for De-empanelment**

If at the end of the risk cover under the Policy for a district, the Insurer does not wish to continue with a particular Empanelled Health Care Provider in a district it can de-empanel that...
Empanelled Health Care Provider after prior approval from the State Nodal Agency. However, it should be ensured that adequate Empanelled Health Care Providers are available in the district for the Beneficiaries.

5. Jurisdiction
   a. Any dispute arising of this MOU will be subject to arbitration as per Arbitration Act and subject to the jurisdiction of Dehradun courts only.
   b. Any amendments in the clauses of the Agreements can be effected as an addendum, after the written approval from both the parties.

6. Commencement
   The Effective Date of this Agreement is the date of signature by the Parties (if signed by the parties on separate dates, the latter of the three) and shall remain in full force till the end of the policy period in the scheme.

7. General Conditions
   7.1. Neither party shall be liable for any failure or delay in performance under this Agreement to the extent said failures or delays are proximately due to causes beyond that party's reasonable control and occurring without its fault or negligence, including, but not limited to: natural disaster (earthquake, hurricane, flood); war, riot or other major upheaval; performance failures of external parties to the Agreement (e.g., disruptions in telephone service attributable to the telephone company). As a condition to the claim of non-liability, the party experiencing the difficulty shall give the other party prompt written notice of the occurrence. Dates by which performance obligations are scheduled to be met will be extended as agreed between the parties.

   7.2. During the term of this Agreement the Provider authorizes TPA and INSURER to make reference to the Provider and its affiliated providers as part of “TPA” Provider Network to the Beneficiaries. Provider, provider affiliates, and “TPA” shall not otherwise use the other Party’s name, symbol or service mark without prior written consent, which shall not unreasonably be withheld.

   7.3. All notices from one party to the other party pursuant to this Agreement shall be in writing and shall be delivered either personally, by nationally recognized overnight delivery service, courier services, or by certified or registered post.

   7.4. The date of receipt and effective date of the notice will be determined as follows:
   i. The date on the signed receipt if delivered personally, by overnight service, or courier.
   ii. The date indicated on the return receipt if delivered by registered or certified mail.
7.5. It is agreed by and between the parties:-

a. The Article and other headings contained in this Agreement are for reference purposes only and shall not affect the meaning or intention of this Agreement.

b. No amendment to this Agreement is valid unless it is reduced to writing and duly signed by all the parties, unless the amendment is deemed to be automatic as per the terms of this agreement.

c. In the event of any inconsistency between the provisions of this Agreement and the Schedules/annexure hereto, the provisions of the Agreement shall prevail over that of the Schedule. However, both the parties agree and understand that the IRDA guidelines on Standardization of Health Insurance issued vide IRDA/HLT/CIR/036/02/2013 dt. 20/02/2013 and the IRDA (Health Insurance) Regulations, 2013, the parties shall be bound by the same. In case there is any inconsistency or repugnancy between the provisions of the aforesaid IRDA Guidelines and Regulations on the one hand and the provisions this Agreement on the other, the parties shall be bound by the former for all their intents and purposes. The parties hereto agree that the provisions of this agreement are in addition to and not in derogation of any of the provisions of the aforesaid IRDA Guidelines and Regulations, and that the same shall be deemed to have been engrafted in this agreement.

d. If any or more provisions of this Agreement, or any part or parts thereof, should, for any reason, be found to be illegal, unenforceable or of no effect in any respect, the same shall be severed from this Agreement and the remaining provisions shall be valid and binding and shall not in any way be affected or impaired thereby.

e. The Insurer shall have discretion at all times, in modifying, adding, deleting or cancelling the contents of this agreement, at its sole discretion, and that the other parties shall be bound by the same.

f. Any express waiver of any term or condition in this Agreement or waiver of a breach of such term or condition shall not constitute a waiver of any of the other terms and conditions or of any future breach or breaches of any term or condition or operate as a continuing waiver.

g. Neither party can assign its right and obligations under this Agreement to any third party, without the prior written consent of the other two parties. However, this shall not apply to any right or obligation that would befall any party to this agreement on account of portability of insurance (subject to the Regulations of IRDA) as opted by any insured in terms of the IRDA (Health Insurance) Regulations, 2013 or any amendment modification thereto.

h. Neither party shall transfer its rights or obligations in any manner whatsoever without the prior consent of the other parties.

Hospital Service Agreement

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i. This agreement is entered into by the parties hereunto on principal to principal basis, and as such neither party shall be deemed to be the agent of the others or partner of the others

Signature and Seal of Hospital................................................................. Place: ................................................... Date:

Signature of Witness ...............................................................................

Signature and Seal of Insurer ............................................................... Place: ................................................... Date:

Signature of Witness ...............................................................................

Signature and Seal of TPA................................................................. Place: ................................................... Date:

Signature of Witness .............................................................................