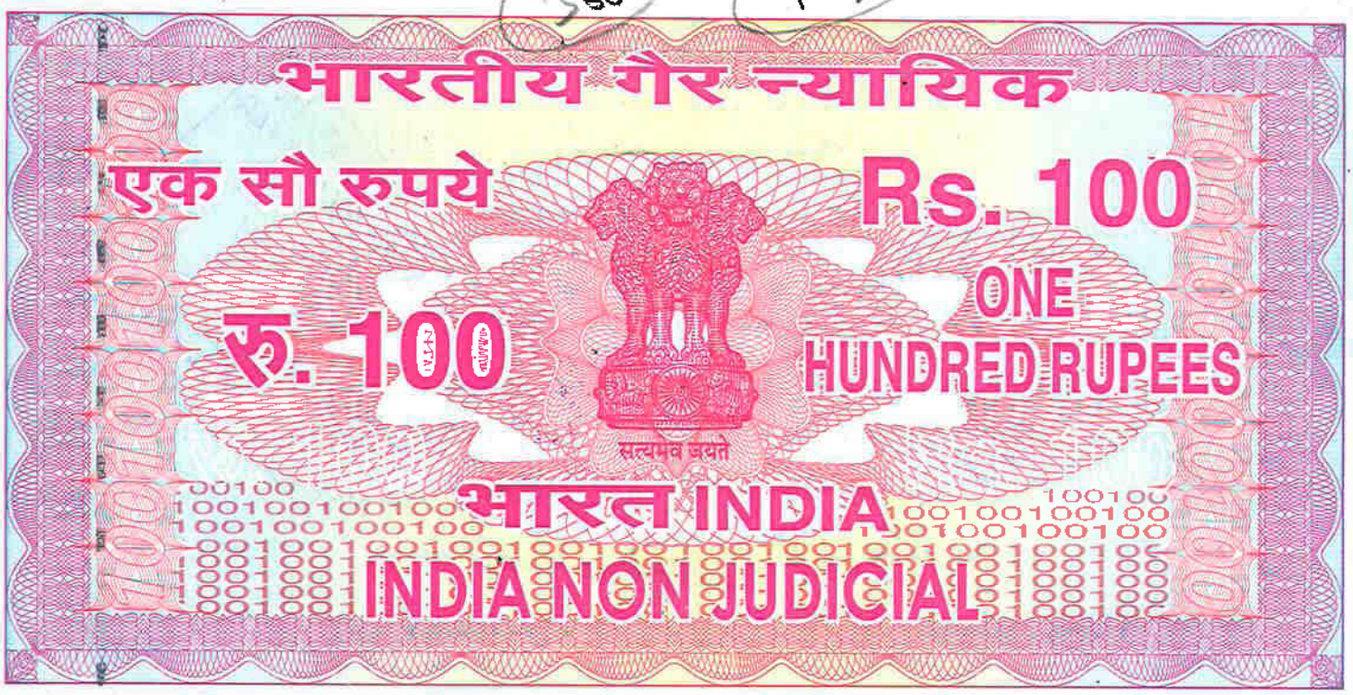

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Tripartite Agreement

THIS AGREEMENT is executed on this 23rd day of Aug-17 at Mumbai, India

BY AND AMONGST

DHFL GENERAL INSURANCE LIMITED, a Company registered under the Companies Act, 2013, having its Registered Office at 10th Floor, TCG Financial Centre, BKC Road, Bandra Kurla Complex, Bandra (East), Mumbai- 400098 ('DHFL GI" or "Insurer"), which expression shall unless repugnant to the subject or context thereof, mean and include its successors and assigns) and duly registered with Insurance Regulatory and Development Authority of India ("IRDAI") under the Insurance Act, 1938 bearing Certificate of Registration No: 155, duly represented by Dr. Sangita Shinde, Assistant Vice President – Health Claims of the Insurer of the First Part.

AND

HI-TECH MEDICAL COLLEGE & HOSPITAL, BHUBANESWAR under Vigyan Bharati Charitable Trust

and having its Registered office at Health Park, Pandara, P.O- G.G.P Colony, Rasulgarh, Bhubaneswar – 751025, Dist – Khurda hereinafter referred to as "PROVIDER/provider" which expression shall unless it be repugnant to the context or meaning thereof be deemed to mean and include its successors and permitted assigns), of the SECOND PART.

Srnt. Dipti V. Mistr
Vice President - Executive Management

DHFL General Insurance Limited
Mumbai

Dr. Sangita Shinde
AVP, Health Claim

Chief Operating Officer
Hi-Tech Medical College & Hospital
Health Park, Rasulgarh, Bhubaneswar-25

AND

Various Parties, as detailed in Annexure-1 to this Agreement (which would form an integral part of this Agreement), are the appointed TPA's for Insurer hereinafter referred to as "TPA" (which expression shall unless it be repugnant to the context or meaning thereof be deemed to mean and include its successors and permitted assigns), of the THIRD PART.

All the three parties will collectively be referred as Parties and individually as a Party.

Whereas, Insurer is inter alia engaged in carrying out General insurance business in India including the business of health insurance or providing health cover by issuing various Health Insurance policies to its customers and is also providing cashless health care facilities to its customers/Insured/beneficiaries as per the terms and conditions of the said Health Insurance Policies, and for this purpose has created a network of providers.

The Administration of the various Health Insurance policies are to be done by the TPA, including processing of the cashless requests and processing of various claims arising out of the said various Health Insurance Policies excluding settlement of claims which will be done by Insurer.

The Provider means a hospital or nursing home or day care center duly recognized and authorized by appropriate authorities to impart heath care services to the public at large and Provider has expressed its desire to join Insurer's network of Providers and has represented that it has requisite facilities to extend medical facilities and treatment, including treatments covered under various Health Insurance Policies issued to the customer/insured/beneficiaries of the Insurer on terms and conditions herein agreed.

Insurer has on the basis of desire expressed by the Provider and on its representation agreed to empanel the Provider as Network Provider for rendering complete health services.

Now this Agreement witnessed as under:

Article 1: Effective Date

1.1 The Parties hereby agree that the Effective date of the Agreement shall be the date on which the Agreement is executed.

Article 2: General Provisions regarding the Provider

2.1 The Provider shall Register in the Hospital Registry ROHINI maintained by Insurance Information Bureau (IIB).

2.2 The Provider may endeavours to meet the pre-accreditation entry level standards laid down by National Accreditation Board for Hospitals (NABH) or such other standards or requirements as may be specified by IRDAI from time to time.

2.3 The Provider shall treat Insurer's beneficiaries in a courteous manner and according to good business practices.

For L General Insurance Limited
Mumbai
Dr. Sangita Attinde
AVP. Health Claim

Paramount Health Services & Insurance TPA Pvt. Ltd.
IRDA LICENCE NO. 80

Smt. Dipti V. Maste
Vice President - Executive Managemnet

Chief Operating Officer
Hi-Tech Medical College & Hospital
Health Park, Rasulgarh, Bhubaneswar-25

2.4 Only the Insurer shall have the authority to repudiate a claim.

2.5 The Provider shall extend priority admission facilities to the beneficiaries, as far as possible.

2.6 Provider shall ensure that best medical treatment / facility is extended to the beneficiary.

2.7 Provider shall have a dedicated officer(s) in the administration department assigned for insurance/ contractual patient and the officer(s) shall learn the various types of medical benefits offered by and under the different insurance plans of the Insurer.

2.8 The agreement is subject to the detailed schedule of fees submitted by the Provider which has to be mutually agreed with Insurer.

2.9 Provider shall allow Insurer/TPA official(s) to visit the beneficiary and also check the indoor papers/treatment being given to the beneficiary.The Insurer/TPA shall not interfere with the medical treatment of the patient. However, the medical team of Insurer/TPA reserves the right to discuss the treatment plan with treating doctor(s). Access to billing and medical records and indoor papers shall be allowed to Insurer/TPA as and when necessary or asked for.

2.10 Provider & Insurer/TPA agree to comply with all the statutory and regulatory requirements and follow the law of land.

2.11 Providers shall comply with requirements of Insurer like standardized billing, ICD-10 / PCS codingand other requirements that the IRDAI directs the Insurer / TPA / Network Providers from time to time.

2.12 Provider agrees to have Inspection, Audit (including Medical/Bills Audit) and give Access rights on regular or on ad-hoc basis with Insurer/TPA audit team.

2.13 This agreement is subject to the detailed mutually agreed tariff schedule which will be shared by the Provider through TPA in electronic form and shall be an integral part of this agreement. Any revision in the tariff schedule shall be subject to prior intimation to TPA and the Insurer. The Insurer and the TPA shall maintain tariff schedule in electronic form.

2.14 Provider will separately list package charges as mentioned in proposal cum offer documents as Annexure 1 and 2 which form an integral part of this agreement. Such package charges must be inclusive of stay, medicines, consumables, surgical fees, operation theatre etc. No additional payment would be entertained unless the medical team of Insurer/TPA agrees with treating consultant for any deviation. It is agreed further that the Provider shall be governed by the norms, directions, ceilings and stipulations of the IRDAI issued from time to time.

2.15 The hospital agrees to follow the pricing structure agreed to between both parties without any deviation.

2.16 For procedures not defined within the pricing structure, the hospital shall employ rational and logical reasons for billing. Any clarifications sought by DHFL GI or any of its TPA regarding the bill shall be provided by the hospital.

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Dr. Sangita Shinde
AVP, Health Claim

Health Insurance TPA Pvt. Ltd.
IRDA Licence No. 006

FAMILY HEALTH PLAN INSURANCE LTD.

Smt. Dipti V. Maste
Vice President - Executive Managemnet

Health Insurance TPA Pvt. Ltd.

Chief Operating Officer
Hi-Tech Medical College & Hospital
Health Park, Rasulgarh, Bhubaneswar-25

Article 3: Code of Conduct, Customer Services & Relations

3.1 The hospital shall not disclose, display, discuss, share or circulate this document, its enclosures and any payment issues or problems with the customer or the Insurer to / with any third-party other than its own staff.

3.2 In case the Hospital has any issues, the same needs to be clarified urgently with the Insurer. Any harassment or denial of service to the customer without prior notice to the Insurer shall be construed as violation of this agreement.

3.3 Provider agrees to display, free of charge, their status of empaneled Provider of Insurer/TPA at their reception/admission desks along with the display and other materials supplied by Insurer/TPA whenever possible for the ease of Insurer/TPA beneficiaries, as may be suggested by the Insurer/TPA.

3.4 The Provider shall convey to their attached consultant to keep the beneficiaries only for the required number of days of treatment and carry out only the required investigation & treatment for the ailment for the cure of which he/she is admitted. Any other incidental and/or additional investigation required by patient for his/her benefit and not payable by Insurer / TPA , the consultant shall have to inform the patient or his/her attendant that the cost of the same shall be borne by the patient, and to this effect, the Provider shall obtain the consent in writing of the patient/his/her attendant, and any dispute in this behalf shall be handled exclusively by the Provider without recourse to the Insurer/TPA, and the Provider undertakes to Indemnify the Insurer/TPA in this behalf.

3.5 All the Parties to the Agreement shall adhere to the applicable turnaround time for each of the services to be rendered by the respective Parties.

Article 4: Identification of Beneficiaries

4.1 The beneficiaries will be identified by the Provider on the basis of an ID card issued to them bearing the logo of Insurer/TPA. The ID card may have photograph or signature or thumb impression of the beneficiary. In case when ID card issued does not contain photograph or signature or thumb impression of the beneficiary, provider will verify the identity of the beneficiary on the basis of any government approved identity proof. Copy of the same need to be submitted along with the claim document. In certain cases of large corporate where ID cards are not issued by Insurer/TPA, Beneficiary may have only the Authority letter / Pre-certification issued by Insurer/TPA along with the employee ID number of the corporate, which shall be accepted and acted upon by the Provider.

4.2 For the ease of beneficiary, the Provider shall display the recognition and promotional material, rate card, network status and procedures for admission supplied by Insurer/TPA at prominent location, preferably at the reception and admission counter and Casualty/Emergency departments, and at such other places as suggested by the Insurer/TPA, free of cost. The Provider also needs to inform its reception and admissions facilities regarding the procedures of admission and obtaining authorization as per the article 4 clause 4.3 of this Agreement.

4.3 It is advisable to take a photocopy of the ID card and/or authority letter, pre-certification issued by TPA, as the case may be, to be submitted later with the bill or to keep as proof of the beneficiary being treated.

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IRDA Licence No. 006

Smt. Dipti V. Maste
Vice President - Executive Management

DHFL General Insurance Limited
Mumbai

Dr. Sangita Shinde
Authorised Signatory
Health Claim

Chief Operating Officer
Hi-Tech Medical College & Hospital
Health Park, Rasulgarh, Bhubaneswar-25

Article 5: Provider Services - Cashless facility admission Procedure

The insured is entitled for cashless access at the Provider for all such ailments which are covered under the Health Insurance Policy, Sum Insured limits/sub-limits i.e. not specifically excluded under the policy. The Provider shall be reimbursed as per the tariff agreed under this agreement for different treatments or procedures. The procedure to be followed for providing cashless facility shall be:

5.1: Preauthorization procedure-planned admissions:

5.1 Request for hospitalization shall be forwarded by the provider immediately after obtaining due details from the treating doctor in the preauthorization form prescribed by the Authority i.e. "request for authorization letter" (RAL). The RAL shall be sent electronically along with all the relevant details in electronic form to the 24-hour authorization /cashless department of the insurer or its TPA along with contact details of treating physician and the Insured. The insurer's or its TPA's medical team may consult the treating physician or the insured, if necessary.

5.2 If the treating physician of the provider identifies any disease or ailment as preexisting, the treating physician shall record it and also inform the insured immediately.

5.3 In cases where the symptoms appear vague / no effective diagnosis is arrived at, the medical team of the insurer or its TPA may consult with treating physician / insured, if necessary.

5.4 The RAL shall reach the authorization department of insurer or its TPA 7 days prior to the expected date of admission, in case of planned admission.

5.5 If "Article 3" above is not followed, the clarification for the delay needs to be forwarded along with the request for authorization.

5.6 The RAL form shall be dully filled in clearly mentioning Yes or No and/or the details as required. The form shall not be sent with nil or blank replies.

5.7 The guarantee of payment shall be given only for the medically necessary treatment cost of the ailment covered and mentioned in the request for hospitalization. Non covered items as per terms and conditions of the policy, like Telephone usage, food provided to relatives/attendants, Provider registration fees etc must be collected directly from the insured.

5.8 The authorization letter by the insurer or its TPA shall clearly indicate the amount agreed for providing cashless facility for hospitalization.

5.9 In the event of the cost of treatment increasing, the provider may check the availability of further limit with the insurer or its TPA.

5.10 When the cost of treatment exceeds the authorized limit, request for enhancement of authorization limit shall be made immediately during hospitalization using the same format as for the initial reauthorization. The request for enhancement shall be evaluated based on the availability of further limits and the hospital may be required to provide valid reasons for the same. No enhancement of limit is possible after discharge of insured.

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Smt. Dipti V. Maste
Vice President - Executive Management

Raksha Health Insurance TPA Pvt. Ltd.

IFFCO-TOKIO General Insurance Limited Mumbai

Dr. Savita Shinde
VP Health Claim

Chief Operating Officer
Hi-Tech Medical College & Hospital
Health Park, Rasulgarh, Bhubaneswar-25

5.11 Further, the insurer or the TPA who is acting on behalf of the Insurer shall accept or decline such additional expenses within a maximum of 24 hours of receiving the request for enhancement. Absence of receiving the reply from the [Insurer] within 24 hours shall be construed as denial of the additional amount.

5.12 In case the insurer has opted for a higher accommodation / facility than the one eligible under the policy, the Provider shall explain the effect of such option and inform the beneficiary at the time of admission as regard to owing the responsibility of such expenses by the insured including the proportionate expenses which have a direct bearing due to upgradation of room accommodation/facility. In all such cases, the Insurer [Insurer] shall pay for the expenses which are based on the eligibility limits of the insured. However, provider may charge any advance amount/security deposit from the insured only in such cases where the insured has opted for an upgraded facility to the extent of the amounts to be collected from the insured.

5.13 Insurer guarantees payment only after receipt of RAL and the necessary medical details. The Authorization Letter (AL) shall be issued within 48 hours of receiving the RAL.

5.14 In case the ailment is not covered or the given medical data is not sufficient for the medical team of the authorization department to confirm the eligibility, insurer or its TPA shall seek further clarification/ information immediately.

5.15 Authorization letter [AL] shall mention the authorization number and the amount guaranteed for the procedure.

5.16 In case the balance sum available is considerably less than the cost of treatment, provider shall follow their norms of deposit/running bills etc. However, provider shall only charge the balance amount over and above the amount authorized under the health insurance policy against the package or treatment from the insured.

5.17 Once the insured is to be discharged, the Provider shall make a final request for the pre-authorization for any residual amount along with the standard discharge summary and the standard billing format. Once the provider receives final authorization for a specific amount, the insured shall be allowed to get discharged by paying the difference between the pre-authorized amount and actual bill, if any. Insurer upon receipt of the complete bills and documents shall make payment of the guaranteed amount to the provider directly.

5.18 Due to any reason if the insured does not avail treatment at the Provider after the pre-authorization is released and any payment is made in this regard, the Provider shall return the amount to the insurer immediately.

5.19 All the payments in respect of pre-authorised amount shall be made electronically by the insurer to the provider as early as possible but not later than a week, provided all the necessary electronic claim documents are received by the insurer.

5.20 Denial of authorization (DAL) for cashless is by no means denial of treatment by the health facility. The provider shall deal with such case as per their normal rules and regulations.

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5.21 Insurer shall not be liable for payments to the providers in case the information provided in the "request for authorization letter" and subsequent documents during the course of authorization, is found incorrect or not disclosed.

5.22 Provider, insurer and its TPA shall ensure that the procedure specified in this Schedule is strictly complied in all respects.

Article **6: Preauthorization procedure –Emergency Admissions:**

6.1 In case of emergencies also, the procedure specified in 4.1 (1), (2) and (3) shall be followed.

6.2 The Insurer / TPA may continue to discuss with treating doctor till conclusion of eligibility of coverage is arrived at. However, any lifesaving, limb saving, sight saving, emergency medical attention cannot be withheld or delayed for the purpose of waiting for authorization. Provider meanwhile may consider treating him by taking a token deposit or as per their norms.

6.3 Once an authorization is issued after ascertaining the coverage. Provider shall refund the deposit amount to the Insured if taken barring a token amount to take care of non-covered expenses.

Article 7: Preauthorization Procedure-RTA/MLCs:

7.1 If requesting a pre- authorization for any potential medico-legal case including road traffic accidents, the Provider shall indicate the same in the relevant section of the standard form.

7.2 In case of a road traffic accident and or a medico-legal case, if the victim was under the influence of alcohol or inebriating drugs or any other addictive substance or does intentional self-injury, it is mandatory for the Provider to inform this circumstance of emergency to the Insurer / TPA.

Article 8: Authorization Letter (AL)

8.1 Authorization letter shall mention the amount, guaranteed class of admission, eligibility of the patient or various sub limits for rooms and board, surgical fees etc. wherever applicable, as per the benefit plan for the patient.

8.2 The Pre-Authorization letter shall also mention validity of dates for admission and number of Days approved for hospitalization, if any. If extension of days is required, provider will need to take necessary approval along with supporting documentation.

8.3 In the event the room category, if any, is not available the same shall be informed to the Insurer / TPA and the Insured. For such cases, if the Insured is admitted to a class of accommodation higher than what he is eligible for and/or in case the Insured has opted for a higher accommodation / facility than the one eligible under the policy, the provider shall explain the effect of such option. In all such cases the Insurer shall only pay for the expenses which are based on the eligibility limits of the Insured.

8.4 The AL has a limited period of validity – which is 15 days from the date of sending the authorization.

8.5 AL is not an unconditional guarantee of payment. It is conditional on facts presented when the facts change the guarantee changes.

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Paramount Health Services & Insurance TPA Pvt. Ltd.
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Chief Operating Officer
Hi-Tech Medical College & Hospital
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Article 9. Reauthorization:

9.1 Where there is a change in the line of treatment a fresh authorization shall be obtained from the Insurer /TPA immediately this is called a Reauthorization.

9.2 The same pre-authorization form shall be used for the reauthorization, and the same turnaround times as specified shall apply.

Article 10: Discharge:

10.1 The following documents shall be included in the list of documents to be sent along with the claim form to the Insurer / TPA. These shall not be handed over to the Insured.

A. Original pre-authorization request form.
B. Authorization Letter.
C. Original Discharge card
D. Original investigation reports,
E. All original prescription & pharmacy receipt etc

10.2 Where the Insured requires the discharge card/reports or other relevant medical documents, photocopies of the same can be handed over at his or her own expenses and these have to be clearly stamped as "Duplicate & originals are submitted to insurer /TPA". Where, the insured requests for any of the original reports, the insurer shall arrange forwarding the originals by duly endorsing the settlement of the claim on such original reports. However, the insurer or its TPA may retain a copy of such reports as per their operational requirements.

10.3 The discharge card/Summary shall mention the duration of ailment and duration of other disorders if any like hypertension or diabetes etc. and operative notes in case of surgeries. The clinical detail shall be sufficiently and justifiably informative. In addition, the Provider shall provide all the relevant details pertaining to past treatment availed by the Insured available with the Provider. The Standard Contents of Discharge Summary Format:

a. Patient's Name*
b. Telephone No / Mobile No*
c. IPD No
d. Admission No
e. Treating Consultant/s Name, contact numbers and Departments/Specialty
f. Date of Admission with Time
g. Date of Discharge with Time
h. MLC No / FIR No*
i. Provisional Diagnosis at the time of Admission
j. Final Diagnosis at the time of Discharge
k. ICD – 10 code(s) or any other codes, as recommended by the Authority, for Final diagnosis*
l. Presenting Complaints with Duration and Reason for Admission
m. Summary of Presenting Illness
n. Key findings, on physical examination at the time of admission
o. History of alcoholism, tobacco or substance abuse, if any
p. Significant Past Medical and Surgical History, if any*
q. Family History if significant/relevant to diagnosis or treatment
r. Summary of key investigation during Hospitalization*
s. Course in the Hospital including complication if any*
t. Advice on Discharge*
u. Name & Signature of treating Consultant / Authorized Team Doctor
v. Name & Signature of Patient / Attendant*

* refer to Guide Notes for filling Discharge Summary format as below

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Vice President - Executive Management

Chief Operating Officer
Medical College & Hospital
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a. The patient's name shall be the official name as appearing in the Insurance Policy document and the attendants should be made aware that it cannot be changed subsequently, because in some cases the attendants give the nick names which are different from documented names. As a matter of abundant precaution, all personal information should be shown to the patient/attendant and validated with their signature.
b. The contact numbers shall be specifically those of the patient and if pertaining to attendant, the same should be mentioned.
c. Where applicable, copy of MLC/FIR needs to be attached.
d. Responses to point (5.3) (b), (k) and (p) are desirable but not mandatory
e. Significant past medical and surgical history shall be relevant to present ailment and shall provide the summary of treatment previously taken, reports of relevant tests conducted during that period. In case history is not given by patient, it should be specified as to who provided the same.
f. Either Summary of key investigations shall appear chronologically consolidated for each type of investigation or investigation reports will be submitted separately by Hospital .
g. The course in the Hospital shall specify the line of treatment, medications administered, operative procedure carried out and if any complications arise during course in the Hospital, the same should be specified.
h. Discharge medication, precautions, diet regime, follow up consultation etc should be specified. If patient suffers from any allergy, the same shall be mentioned.
i. The signatures/Thumb impression in the Discharge Summary shall be that of the patient because generally the patient is discharged after having improved. In other cases, like Death summary or transfer notes in case of terminal illness, the attendant can sign. In such cases, the inability of the patient to sign should be recorded by the attending doctor.

1. Signature of the Insured on final provider bill shall be obtained.

2. In the event of death or incapacitation of the Insured, the signature of the nominee or any of insured's family who represents the Insured as such subject to reasonable satisfaction of Provider shall be sufficient for the Insurer /TPA to consider the claim.

3. Standard Claim form duly filled in shall be presented to the Insured for signing and identity of the Insured shall be confirmed by the Provider.

Article 11: Billing:

11.1 The Provider shall submit original invoices along with receipts of payment made directly to Insurer / TPA and such invoices shall contain, at the minimum, following information:

a) the Insured's full name
b) the Insured's address;
c) the admitting consultant;
d) the date and time of admission and discharge;
e) the procedure performed and procedure code according to ICD-10-PCS or any other code as specified from time to time;
f) the diagnosis at the time of treatment and diagnosis code according to ICD-10 or any other code as specified from time to time;
g) the description of each Service performed, together with associated Charges;
h) whether this is an interim or final bill/account;
i) the Insured's signature (in original)

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11.2 The Provider shall submit the following documents with the final invoice:

a) copy of pre-authorization letter;
b) fully completed claim form or the relevant claim section of the pre-authorization letter, signed by Insured and the treating consultant along with hospital stamp and seal;
c) original and complete discharge summary and billing form in the standard form, including the treating Consultant's operative notes if any;
d) original investigation reports with corresponding prescription/request;
e) Pharmacy bill with corresponding prescription/request;
f) any other statutory documentary evidence required under law or by the Insured's policy; and
g) Photocopy of the Insured's valid photo identification (e.g. voter's Smart card/ID card, Passport or driving license etc).

11.3 The Provider shall submit the final invoice and all supporting documentation required within 7 days of the discharge date.

11.4 Standard Format for Provider Bills: The provider shall submit bills as per enclosed standard formats (i.e. Annexure 4 to this Agreement, which forms an integral part of this Agreement)

Article 12: PROCESS NOTE FOR DE-EMPANELMENT OF PROVIDERS

The Insurer shall follow the de empanelment process as described in Schedule B of IRDA Circular Reference No IRDA/TPA/REG/CIR/059/03/2016 dated 28-03-2016.

Article 13: Provider financial details

Provider shall provide following details to the Insurer/TPA for payment processing

1) PAN
2) TAN (TDS deduction), GST No
3) Bank Account details including IFSC codes
4) Copy of Cancelled Cheque

Article 14: Payment Terms & conditions

14.1 All payments would be made directly by the Insurer to the Provider. Insurer agrees to pay all the eligible bills within 30 days of the receipt of bill at their nominated Offices along with all the original relevant documents, complete in all respects.

14.2 In case certain billed items are not correlated with corresponding report, such amount will be deducted from the final bill. However, the provider may send these reports within 60 days of receiving the payment to get the deducted amount. Due reason for deductions if any will be given at the time of settlement of the bills

14.3 Payment will be done electronically (RTGS/NEFT) to the bank account of the Provider, subject to deduction of tax at source as applicable under the relevant laws.

14.4 ECS payment would be construed as due receipt if a provider omits to send a stamped receipt of the payment received immediately on receipt of the payment.

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AVP. Health Claim

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Article 15: Limitations of Liability and Indemnity

15.1 Insurer/TPA will not interfere in the treatment and medical care provided to its beneficiaries. Insurer/TPA will not be in any way held responsible for the outcome of treatment or quality of care provided by the Provider.

15.2 Insurer/TPA shall not be liable or responsible for any acts, omission or commission of the Doctors and other medical staff of the Provider and the Provider agrees without any demur to Indemnify fully the Insurer/TPA, as the case may be, in case the Insurer/TPA is saddled with any liability, charges, compensation, and the like, due to any act of omission or commission of the doctors, any other medical or para-medical staff or any other staff or official or for any deficiency in service on the part of the Provider.

15.3 Notwithstanding anything to the contrary in this Agreement, neither Party shall 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 or negligence.

Article 16: Confidentiality

16.1 All the parties to this agreement undertake to protect the secrecy of all the data of Insurer/TPA beneficiary/s and trade or business secrets of Insurer/TPA and shall not share the same with any unauthorized person for any reason whatsoever with or without any consideration. Provided that the aforesaid onus regarding confidentiality shall not apply, in case the disclosure of any such confidential information is consequent upon any direction of any governmental, statutory authority or a court of law or tribunal.

Article 17: Termination

Insurer/TPA shall reserve the right to terminate this agreement by giving 30 days' written notice if:

17.1 The Provider violates any of the terms and conditions of this agreement; or

17.2 Increases fee schedule, without notice and confirmation of Insurer/TPA

17.3 Insurer/TPA comes to know of wrong and fraudulent practices, misrepresentation, inadequacy of service or other non-compliance or default on the part of the Provider. The Insurer may dis-empanelthe Provideror otherwise modify this agreementfor reasons of any fraud, misrepresentation, inadequacy of service or other non-compliance or default on the part of TPA or network provider; provided no such cancellation ormodification shall be done by the Insurer unless the concerned TPA or network provider is given an opportunity of being heard, subject to Guidelines specified by the Authority, if any.

17.4 Insurer/TPA observes cases of overstay and over provisioning/charging without adequate explanation by the Provider.

17.5 Termination with Mutual Consent: Either side can terminate this agreement on a mutual consent basis after giving 30 days' notice to the other Party.

17.6 Either Party may terminate this agreement upon 30 days' notice in writing to the other Party, provided however that in the event of a material breach by either Party of the terms hereof, the other Party/Parties may terminate this agreement with immediate effect.

Paramount Health Services & Insurance TPA Pvt. Ltd. IRDA Licence No. 006

Smt. Pinki V. Maste Vice President - Executive Management

FAMILY HEALTH PLAN INSURANCE LTD.

DHFL General Insurance Limited Mumbai

Dr. Sangita Shinde AVP Health

Chief Operating Officer Hi-Tech Medical College & Hospital Health Park, Rasulgarh, Bhubaneswar-25

Article 18: Non-Exclusivity

18.1 Insurer/TPA reserves the right to appoint other provider(s) in the same area/location and the provider shall have no objection for the same and vice-versa.

Article 19: Change of TPA / Insurer Prerogatives:

19.1 The Provider is well aware that the policy is issued by the Insurer and the TPA is being engaged for policy administration purpose. The Provider agrees to continue providing services/Cashless benefits, even if the Insurer has either changed the TPA or if its agreement with the TPA has expired. In such a scenario, the Provider agrees to include the name of the incumbent TPA in the Agreement by way of suitable addendum and shall continue to provide uninterrupted services to the beneficiaries of Insurer.

Article20: RepresentationsandWarranties

EachPartyrepresentsthat:

20.1 It has the power and authorization to enter into this agreement and perform its obligations hereunder and the execution of this agreement does not violate or is inconsistent with its bylaws and other constituent documents.

20.2 The individual(s) signing this agreement, whose name appears below, has the authorization to execute and deliver this agreement.

Article21: Governing Laws and Artbitration

21.1 This agreement shall come into force from the date as mentioned herein above and shall be in force until terminated by the parties in accordance with the provisions of this agreement. Any amendments in the clauses of the Agreement can be effected only in writing with the consent of all the Parties hereto.

21.2 This agreement shall be governed by the laws of India and in the event of any dispute or difference arising between the parties with respect to the subject matter hereof or any of the terms or clauses of this agreement, the same shall be endeavored to be settled amicably mutually, and in the event of any failure to arrive at mutually amicable settlement, the dispute or difference shall be referred for determination by the sole arbitrator to be appointed by the Insurer, who shall conduct its proceedings in accordance with the Arbitration and Conciliation Act, 1996, as amended, time to time. Subject to arbitration, the Courts at Mumbai (Here mention the city) shall have exclusive jurisdiction over any matter arising out of this agreement. The venue of arbitration shall be at Mumbai (Here mention the city which would come under the jurisdiction of the court as mentioned above) and that the arbitral proceedings shall be conducted in English language and that the cost of arbitration shall be borne equally by the parties concerned.

21.3 Neither Party shall transfer its rights or obligations in any manner what so ever without the prior consent of the other parties.

21.4 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.

DHFL General Insurance Limited
Mumbai

Dr. Sangita Shinde
AVP Health Claim

Paramount Health Services & Insurance TPA Pvt. Ltd.
IRDA Licence No. 006

Smt. Dipti Panda
Vice President - Executive Management

FAMILY HEALTH PLAN INSURANCE LTD.

Chief Operating Officer
Hi-Tech Medical College & Hospital
Health Park, Rasulgarh, Bhubaneswar-25

Article22-OtherProvisions

22.1 In case the provider has any issues, the same needs to be clarified urgently with the Insurer/TPA, as the case may be. Any harassment or denial of service to the Insured/Beneficiary without prior notice to the TPA/Insurer shall be construed as violation of this Agreement.

22.2 Any notice or communication between the parties shall be considered as duly delivered on the earliest of the following:

a) When delivered by hand, on the day received at the Registered Office by the Addressee.

b) If delivered by facsimile transmission/electronic mail or electronic transmission at the following facsimile transmission number/e-mail id, then upon confirmation of proper receipt

In Case of Notice to Insurer Dr. Sangita Shinde Head – Health Claims Phone: E-mail:sangita.shinde@dhflinsurance.com	In case of Notice to Provider Name of Network Provider Address: Hi-Tech Medical College & Hospital, Bhubaneswar Phone: 9090952401 Facsimile: E-mail : jpanda@hi-techmedical.org
With a copy to: Mr.Vijay Sinha Managing Director & Chief Executive Officer DHFL General Insurance Limited Corp. Office Address: DHFL House, 2nd Floor, 19, Sahar Road, Off Western Express Highway, Ville Parle (East), Mumbai-400099 Phone: 022-66006999 Facsimile: 022-66006998 E-mail: vijay.sinha@dhflinsurance.com	In case of Notice to Provider Name of Network Provider Address: Hi-Tech Medical College & Hospital, Bhubaneswar Phone: 9090952401 Facsimile: E-mail : jpanda@hi-techmedical.org

22.3 Either Party may in the event of change in its contact person, address, or facsimile numbers shall communicate the same to the other Party by means of a notice as per the provisions of this clause.

22.4 If dispatched by post then seven (7) days after the date of mailing by registered post acknowledgement due or under certificate of posting by prepaid certified mail or registered mail direct to the address of the parties.

Paramount Health Services & Insurance TPA Pvt. Ltd.
IRDA Licence No. 000

Article-23: Miscellaneous:

It is agreed by and between the Parties:-

Smt. Jyoti V. Maste
Vice President - Executive Management

DHFL General Insurance Limited
Mumbai

Dr. Sangita Shinde
AVP-He

23.1 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.

Chief Operating Officer
Hi-Tech Medical College & Hospital
Health Park, Rasulgarh, Bhubaneswar-25

23.2 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.

23.3 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 IRDAI Guidelines on Standardization of Health Insurance issued vide Circular No.: IRDA/HLT/REG/CIR/146/07/2016dated29th July, 2016and the IRDAI (Health Insurance) Regulations, 2016, the parties shall be bound by the same. In case there is any inconsistency or repugnancy between the provisions of the aforesaid IRDAI 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 IRDAI Guidelines and Regulations, and that the same shall be deemed to have been engrafted in this agreement.

23.4 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.

23.5 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.

23.6 The Provider shall adhere to the agreed payment reconciliation process on a regular basis.

23.7 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.

23.8 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 IRDAI) as opted by any insured in terms of the IRDAI (Health Insurance) Regulations, 2016 or any amendment modification thereto.

In witness thereof this agreement was executed by or on behalf of the parties the day and year first before written.

Annexure 1:

Signed and delivered by the within named:

Paramount Health Services & Insurance TPA Pvt. Ltd.
IRDA Licence No. 006

Signed by For and on behalf of **DHFL GENERAL INSURANCE LIMITED**

Name & Designation:

Smt. Dipti V. Haste
Vice President - Executive Management

Provider:

FAMILY HEALTH PLAN INSURANCE LTD.

DHFL General Insurance Limited
Mumbai

Dr. Sangita Shinde
AVP. Health Claim

Signed by For and on behalf of **Provider**

Name & Designation: **Mr. Jyotirmaya Panda, Chief Operating Officer**

Chief Operating Officer
Hi-Tech Medical College & Hospital
Health Park, Rasulgarh, Bhubaneswar-25

TPA:

DHFL General Insurance Limited
Mumbai
Dr. Sangita Shinde
AVP. Health Claim

Signed by For and on behalf of**Paramount Health Services & Insurance TPA Pvt. Ltd. IRDA License No:** 006 dated 22 Feb 2017

Name & Designation: Paramount Health Services & Insurance TPA Pvt. Ltd.
IRDA LIC No.:- 006
Smt. Dipti V. Maste
Vice President:- Executive Management

Signed by For and on behalf of**Family Health Plan Insurance TPA Ltd.IRDA License No:** 013 dated 18 Jan 2017

Name & Designation: Vinod Pelnekar
Manager Networking

Signed by For and on behalf of**Raksha Health Insurance TPA Pvt. Ltd.IRDA License No:** 015 dated 28 Feb 2017

Name & Designation: For Raksha Health Insurance TPA Pvt. Ltd.
DR VISHAL SHARMA
CHIEF OPERATING OFFICER

Annexure 2: Claim Form and RAL

Paramount Health Services & Insurance TPA Pvt. Ltd.
IRDA Licence No. 006
Smt. Dipti V. Maste
Vice President - Executive Managemnet

DHFL General Insurance Limited
Mumbai
Dr. Sangita Shinde
AVP. Health Claim

FAMILY HEALTH PLAN INSURANCE LTD.