ALOHACARE

Medicare Program Attachment

THIS ATTACHMENT ("Attachment") to the Agreement is entered into by AlohaCare, a Hawaii corporation (hereinafter referred to as "Plan"), and (hereinafter referred to as "Provider").

WHEREAS, the Centers for Medicare & Medicaid Services ("CMS") of the U.S. Department of Health and Human Services ("HHS"), which administers the Medicare program, requires certain terms and conditions in the agreements between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions;

WHEREAS, Provider wishes to furnish health care services ("Services") to Plan's beneficiaries, and Plan desires Provider to provide access to such services for such beneficiaries;

WHEREAS, Plan and Provider seek to amend their Agreement to meet all the applicable Medicare laws, regulations and CMS instructions for a Medicare Advantage organization including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA").

NOW, THEREFORE, it is hereby mutually agreed by and between the parties as follows:

ALOHACARE		**PROVIDER**	
SIGNATURE	DATE	SIGNATURE	DATE
NAME		NAME	
TITLE		TITLE	

ARTICLE I

DEFINITIONS

1.1 "Plan" means AlohaCare, a not-for-profit Hawaii corporation formed as a medical delivery system which has been awarded a contract by CMS to provide or arrange for the provision of Covered Services to Members enrolled in Plan.

1.2 "State" means Hawaii.

1.3 "Medicare" means a Federal program authorized by Title XVIII of the Social Security Act, as amended, which provides health insurance to elderly and disabled persons.

1.4 "Medicare Advantage (MA)" is the statutory name applicable to an alternative to the traditional Medicare program in which individuals eligible to receive benefits under Medicare may elect to receive such benefits from a private entity contracted with CMS to provide benefits through a plan.

1.5 "Medicare Advantage Organization (MA organization)" means a public or private entity organized and licensed by State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

1.6 "AlohaCare Advantage Plus" is the business name of the plan offered by AlohaCare to provide benefits under the Medicare Advantage program.

1.7 "Completion of Audit" means Completion of Audit by the Department of Health and Human Services ("HHS"), the Government Accountability Office ("GAO"), or their designees of a MA organization, MA organization contractor or Related Entity.

1.8 "Downstream Entity" means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

1.9 "Final Contract Period" is the final term of the contract between CMS and the MA organization.

1.10 "First Tier Entity" means any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

1.11 "Related Entity" means any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or Delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

1.12 "Medicare Advantage (MA) Member" is an eligible individual who has elected to enroll with Plan and whose enrollment has been confirmed by CMS.

1.13 "Delegation" means delegation to Provider of a MA contractual obligation that is the responsibility of Plan.

1.14 "MA Evidence of Coverage" is a legally binding statement of coverage, revised annually, between a MA Member and Plan under which a MA Member is entitled to receive coverage for certain hospital, medical and other associated health care services.

ARTICLE II

PROVIDER OBLIGATIONS

2.1 Policies and Procedures. Provider, its Related Entity, contractor, subcontractor, first-tier or Downstream Entity contractors and subcontractors, agree to comply with Plan's policies and procedures.

2.2 Right to Inspection. HHS, the Comptroller General, or their designees, have the right to inspect, evaluate, and audit any pertinent information for any particular contract period, including, but not limited to any contracts, books, documents, papers, and records of Provider, its Related Entity, contractor, subcontractor, first-tier or Downstream Entity contractors and subcontractors relating to MA Members for a period of ten (10) years from the final date of Plan's CMS contract period or from the Completion of Audit date, whichever is later.

2.3 Confidentiality and Accuracy. Provider, its Related Entity, contractor, subcontractor, first-tier or Downstream Entity contractors and subcontractors, agree to safeguard MA Member privacy and confidentiality and to assure the accuracy of MA Member health records. Provider shall comply with this requirement in a manner consistent with professionally recognized standards in health care and as required by Federal, applicable State statute and regulations, and Federal guidelines, specifically including (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information; (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas; (3) maintaining the records and information in an accurate and timely manner; and (4) ensuring timely access by MA Members to the records and information that pertain to them.

2.4 Beneficiary Held Harmless. Provider, its Related Entity, contractor, subcontractor, first-tier or Downstream Entity contractors and subcontractors, shall not hold any MA Member liable for payment of any amount fee that is the legal obligation of Plan, or for dual-eligible MA Members in AlohaCare Advantage Plus, for Medicare Part A and B cost-sharing that is the legal obligation of the State Medicaid Agency. Participating Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Provider shall accept either Plan's payment as a payment-in-full or bill the appropriate State source and will not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the MA Member under Medicaid if the individual were not enrolled in such a plan. This provision shall apply (but is not limited to) in the event of Plan insolvency, contract breach, or termination of the Agreement.

2.5 Any services or other activities performed by Provider, a Related Entity, contractor, subcontractor, or first-tier or Downstream Entity in accordance with a contract or written

agreement shall be consistent with, and in compliance with, Plan's contractual obligations.

2.6 Delegation Regulations. If Plan delegates to Provider any MA contractual obligation that is the responsibility of Plan, and Provider subsequently delegates any of those activities or responsibilities under this Attachment to any Related Entity, contractor, subcontractor, or first-tier or Downstream Entity, the following requirements will apply to any Related Entity, contractor, subcontractor, or provider.

2.6.1 Written arrangements must specify:

2.6.1.1 The delegated activities and reporting responsibilities;

2.6.1.2 The ability of CMS or Plan to revoke the Delegation activities and reporting requirements or specify other remedies in instances where CMS or Plan determines that such parties have not performed satisfactory or has not satisfactorily performed in conformance to contractual requirements;

2.6.1.3 That the performance of the parties will be monitored by Plan on an ongoing basis;

2.6.1.4 That the credentials of medical professionals affiliated with the party or parties will be either reviewed by Plan; or the credentialing process will be reviewed and approved by Plan and Plan will audit the credentialing process on an ongoing basis;

2.6.1.5 If Plan delegates the selection of providers, contractors, or subcontractors, the Plan retains the right to approve, suspend, or terminate any such arrangement;

2.6.1.6 The Related Entity, contractor, or subcontractor, first-tier or Downstream Entity must comply with all applicable Medicare laws, regulations, reporting requirements and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate assist, and provide information, as requested; and maintain records a minimum of 10 years.

2.7 Prompt Payment and Submission of Claims. Plan and Provider shall be bound by the payment terms, including prompt payment provisions, set forth in Article IV of this Agreement and the compensation rates specified in the Medicare Fee-For-Service Compensation Exhibit. Plan and Provider shall also comply with all applicable Federal and State statutes and regulations regarding timely submission of claims by Provider and prompt payment of claims by Plan. In the event that the terms for submission and/or payment of claims in the Agreement are more expedient than as required by statute or regulation, then the Agreement terms shall govern.

2.8 Reporting Requirements. Provider, its Related Entity, contractor, subcontractor, first-tier or Downstream Entity, shall cooperate with Plan in support of data collection and validation of data as required by CMS for risk adjustment and other purposes.

2.9 Accountability. Plan oversees and is accountable to CMS for any functions or responsibilities that are described in the Medicare regulations. Provider, its Related Entity, contractor, subcontractor, first-tier or Downstream Entity shall cooperate with Plan in meeting these requirements by complying with Plan's policies and procedures.

2.10 Medicare Laws and Regulations. Provider, its Related Entity, contractor, subcontractor, first-tier and/or Downstream Entity shall comply with all applicable Medicare laws, regulations and CMS instructions.

2.11 Benefit Continuation. Provider, its Related Entity, contractor, subcontractor, first-tier or Downstream Entity shall continue to provide or coordinate care for MA Members as set forth in Paragraph 6.4 (or as applicable) of the Agreement.

2.12 Participation Procedures. In the event that Provider is a Medical Group Practice, and Provider terminates or suspends a physician that provides services to MA Members, Provider must give the affected individual written notice of the reasons for the action and the affected physician's right to appeal the action and the process and timing for requesting a hearing. In the event that Plan terminates or suspends a Provider, Plan shall provide the affected Provider with written notice of the reasons for the action and, except for terminations for cause under Paragraph 6.3.1 of the Agreement, Provider's right to appeal the action and the process and timing for requesting a hearing.

2.13 Fraud and Abuse. Consistent with the preceding and to the extent applicable, Provider, its Related Entity, contractor, subcontractor, first-tier or Downstream Entity contractors and subcontractors may be required to monitor for Fraud, Waste and Abuse consistent with CMS guidance. To the extent applicable, Provider acknowledges that certain CMS guidance on Fraud, Waste and Abuse may be implicated by this Agreement and agrees to take appropriate actions to identify and/or monitor for such activities, including but not limited to producing Provider's plan to monitor for Fraud, Waste and Abuse. Provider shall ensure that its employees, vendors, Related Entity, contractor, subcontractor, first-tier or Downstream Entity contractors and subcontractors, and/or other providers furnishing Covered Services under this Agreement receive training in applicable fraud and abuse topics. In the event there is a substantiated case of fraud or abuse involving a MA Member, Provider shall coordinate with Plan's Compliance Officer on required investigation and reporting activities in compliance with Medicare's Managed Care Manual, including any future related guidelines. Plan shall train Provider on any applicable CMS requirements related to fraud and abuse prevention, detection, and reporting.

2.14 Reports and Administration. Provider shall cooperate in providing Plan with such information and assistance regarding MA Members, Participating Providers and Provider's performance under this Agreement as Plan may reasonably require in filing such reports.

2.15 Compliance with Medicare Appeals. Provider shall adhere to Medicare's appeals, expedited appeals and expedited review procedures for MA Members, including gathering and forwarding information regarding appeals to Plan, as necessary.

2.16 Conflict. To the extent that any of the provisions in this Attachment conflict with provisions in the underlying Agreement and any subsequent related amendment(s), attachment(s), or agreement(s), the terms above control.

ARTICLE III

COMPENSATION AND BILLING

3.1 Compensation. Plan compensation to Provider for Covered Services shall be set forth in a separate attachment entitled "AlohaCare Medicare Fee-For-Service Compensation Exhibit."

3.2 Billing. Provider shall document each encounter or episode of service provided to a MA Member involving a Covered Service by submitting to Plan within Medicare Fee-For-Service timely filing guidelines, using the appropriate Billing Form and any necessary medical documentation.