# ALOHACARE

# Provider Agreement

THIS AGREEMENT ("Agreement") is entered into by AlohaCare, a Hawaii corporation (hereinafter referred to as "Plan"), and_____(hereinafter referred to as "Provider"), and is effective on the___day of ___ , **2017** ("Effective Date")**.**

WHEREAS, Plan is a pre-paid health plan organized to deliver Covered Services (defined below) to individuals enrolled in Plan;

WHEREAS, Provider is a physician, behavioral health provider, medical group practice, clinic or other provider of health care services;

WHEREAS, Plan and Provider desire to enter into an Agreement whereby Provider shall make its services available to provide health care services to individuals enrolled in Plan;

NOW THEREFORE, in consideration of the premises set forth above and the covenants, terms, and conditions hereinafter set forth, it is hereby mutually agreed by and between the parties as follows:

| **ALOHACARE** | **PROVIDER** |
|---|---|
| SIGNATURE DATE | SIGNATURE DATE |
| NAME | NAME |
| TITLE | TITLE |
| Type of Services Provided: | TAX ID NO. |

**Contents (Check if included):**

1. Provider Agreement ☐
2. QUEST Integration Program Attachment ☐
3. Medicare Program Attachment ☐
4. Amendment(s) No._____ ☐
5. _____ ☐
6. _____ ☐

**Exhibits:**

1. QUEST Integration FFS Compensation ☐
2. Medicare Compensation ☐
3. _____ ☐
4. _____ ☐

## Table of Contents

## ARTICLE I

## DEFINITIONS

1.1 "Authorization" means the process developed by Plan and described in detail within the Provider Manual for Provider to follow prior to the delivery of specified services to a Member.

1.2 "Behavioral Health Facility" means an institution possessing all the required licenses, certifications, and/or accreditations by the appropriate regulatory agencies, which provide mental health and/or substance abuse treatment services in an institutional setting. This is including, but not limited to, a licensed psychiatric hospital, a licensed general acute care hospital that provides psychiatric services, a licensed chemical dependency treatment center, a licensed residential treatment center, a day treatment center or a partial hospital program.

1.3 "Behavioral Health Provider" means a duly licensed psychiatrist, psychologist, Licensed Clinical Social Worker (LCSW), Advanced Practice Registered Nurse (APRN), psychiatric nurse, or other behavioral health provider who is licensed, accredited or certified in Hawaii to provide mental health and substance abuse services who has entered into a provider Agreement with Plan for the provision of Covered Services to Members and has met Plan's credentialing, re-credentialing or other certification or participation requirements.

1.4 "Behavioral Health Services" means the mental health, drug abuse, and alcohol abuse treatment services required to be delivered to Members who are emotionally disturbed, mentally ill, or addicted to or abuse alcohol, prescription drugs or other substances, as described in the contract between Plan and the Medical Service Purchaser, as updated from time to time.

1.5 "Billing Form" means Uniform Billing Form (UB 04) or CMS Form 1500 or other such paper or electronic form as may be approved by Plan for the submission of data and information for payment of services and/or documentation of service utilization.

1.6 "Clean Claim" means a claim submitted on a Billing Form to Plan by or on behalf of Provider that includes all Plan required information and applicable medical documentation from Provider or a third party required by Plan for adjudication. In accordance with section 431:13-108 of the Hawaii Revised Statutes, the term does not include claims that require a coordination of benefits, subrogation, preexisting condition investigation, involve third-party liability or suggest any reason to believe that the claim was submitted fraudulently.

1.7 "Coordination of Benefits" means the allocation of financial responsibility between two or more payers of health care services, each with a legal duty to pay for or provide Covered Services to a Member.

1.8 "Co-payment" is an amount of money, including deductible, coinsurance amounts and/or Member share of costs which is the responsibility of the Member for a rendered Covered Service.

1.9 "Covered Services" are those Medically Necessary services and benefits required to be delivered to Members as described in the contract between Plan and the Medical Service

Purchaser, as updated from time to time in the Plan's Provider Manual and Member materials.

1.10 "Emergency" means a medical condition manifesting itself by a sudden onset of symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1.10.1 serious jeopardy to the physical or mental health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
1.10.2 serious impairment to bodily functions;
1.10.3 serious dysfunction of any bodily organ or part;
1.10.4 serious harm to self or others due to an alcohol or drug abuse emergency;
1.10.5 serious injury to self or bodily harm to others; or
1.10.6 with respect to a pregnant woman having contractions:

1.10.6.1 that there is inadequate time to effect a safe transfer to another hospital before delivery, or
1.10.6.2 that transfer may pose a threat to the health or safety of the woman or her unborn child.

An emergency medical condition shall not be defined or limited based on a list of diagnosis or symptoms.

1.11 "Emergency Services" means inpatient or outpatient services that are:

1.11.1 administered by a provider qualified to furnish emergency services; and,
1.11.2 needed to evaluate or stabilize an Emergency.

1.12 "Medical Record" means medical records kept in paper or electronic form.

1.13 "Medical Group Practice" means a professional corporation, partnership, association, nonprofit corporation, or other entity consisting of two or more physicians who furnish primary care and/or specialty medical services, each of whom is licensed by appropriate state agencies to practice medicine.

1.14 "Medical Service Purchaser" ("MSP") means an employer, trust fund, insurance carrier, governmental agency or any other entity which has an obligation to provide or arrange for the provision of designated medical services or benefits to individuals, and that has entered into a contract with Plan under which Plan shall be responsible for Covered Services to Members. Specific requirements for a MSP are included in the respective Program Attachment (e.g., QUEST Integration Program Attachment/Amendment or Medicare Program Attachment/Amendment).

1.15 "Medically Necessary" means health care services that a Member requires as determined by Plan in accordance with section 432E-1.4 of the Hawaii Revised Statutes. "Medically Necessary" services do not include services provided merely for the convenience of the Member or Provider.

1.16 "Member" means a person entitled to health care benefits from the MSP and is also enrolled in Plan.

1.17 "Participating Provider" means a duly licensed or accredited physician, dentist, acute care hospital, skilled nursing facility, nursing facility, behavioral health provider, inpatient behavioral health facility, multi-hospital system, assisted living facility, health professional, clinic, self-administered group, group practice or other health care provider which has entered into a provider services agreement with Plan for the provision of Covered Services to Members and has met Plan's credentialing, re-credentialing or other certification or participation requirements.

1.18 "Payer" means Plan or other purchaser of Covered Services on behalf of the Member.

1.19 "Post-Stabilization Care Services" means Covered Services related to an emergency medical condition provided after a Member is stabilized in order to maintain the stabilized condition, or to improve or resolve the Member's condition.

1.20 "Provider" is the entity contracting with Plan listed on the first page of this Agreement.

1.21 "Primary Care Provider" ("PCP") means a Participating Provider, assigned by Plan, responsible for the management of a Member's health care who is:

1.21.1 a physician, either a M.D. (Doctor of Medicine) or a D.O. (Doctor of Osteopathy), and shall be a family practitioner, general practitioner, pediatrician, general internist, obstetrician/gynecologist, or geriatrician;
1.21.2 an advanced registered nurse recognized by the State Board of Nursing as a family nurse practitioner, pediatric nurse practitioner or certified nurse midwife;
1.21.3 a physician assistant recognized by the Board of Medical Examiners as a licensed physician assistant; or
1.21.4 other practitioners as allowed by applicable Plan or MSP guidelines.

1.22 "Provider Manual" means the document prepared and made available by Plan that contains guidelines, policies and procedures as updated from time to time regarding Plan's operating policies and procedures. The Provider Manual includes other Plan communications regarding guidelines, policies, and procedures. The Provider Manual and other forms are available online at http://www.alohacarehawaii.org. Only Plan may distribute and change the Provider Manual.

1.23 "Quality Improvement Program" means a program adopted by Plan, as updated from time to time, which sets forth processes and standards to ensure program quality.

1.24 "SEBD" means children and adolescents who meet the criteria for the Hawaii Department of Health's Support for Emotional and Behavioral Development Program.

1.25 "SMI" means a person diagnosed with a serious mental illness.

1.26 "SPMI" means a person diagnosed with a serious persistent mental illness.

1.27 "Utilization Management Program" means a program adopted by Plan, as updated from time to time, which sets forth processes, criteria and standards, activities and requirements that facilitate the review and provision of appropriate services.

## ARTICLE II

## RELATIONSHIP BETWEEN THE PARTIES

2.1 Respective Roles of Parties/Independent Contractors. Except to comply with the Utilization Management and Quality Improvement standards established by Plan, Plan shall not control, direct, supervise, or intervene in any way in the rendering of medical and other health services by Provider, or otherwise restrict Provider from acting within its lawful scope of practice. The provision of all medical and other health services and the results thereof, are the sole responsibility of Provider. Plan shall not restrict or inhibit, in any way, the free communication between Provider and a Member regarding the Member's health care, medical needs, treatment options and incentive agreements that may impact services provided. Plan shall not prohibit Provider from discussing treatment or non-treatment options with Members that may not reflect Plan's position or may not be covered by Plan. Further, Plan shall not prohibit, or otherwise restrict, Provider from advising or advocating on behalf of the Member for Member's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered or to obtain necessary health care services in any grievance system or utilization review process, or individual authorization process. This Agreement sets forth the understandings, rights and obligations of the parties for the purpose of providing reimbursement and other compensation and standards of care for medical and other health services provided to Members. None of the provisions in this Agreement are intended to create, nor should be construed to create, any relationship between Plan and Provider other than that of independent entities contracting with each other for the purpose of effectuating the provisions of this Agreement. Neither party nor any of its respective officers, agents or employees shall be construed to be the officer, agent or employee of the other.

2.2 Non-Exclusivity. This Agreement is not exclusive and neither party is excluded from entering into any contracts or agreements with other entities to provide or arrange to provide health care services to individuals.

2.3 Assignment of Members; No Guarantee. Provider acknowledges that Plan cannot and does not guarantee that Provider will provide services to any particular number of Members or gain a particular amount of revenue as a result of entering into this Agreement or any other agreement with Plan.

## ARTICLE III

## OBLIGATIONS OF PARTIES

3.1 Representation and Warranties.

3.1.1 Execution and Performance. Both parties represent and warrant that the execution and performance of this Agreement has been duly authorized and no corporate action requisite to the execution or performance hereof remains to be taken.

3.1.2 Provider Agreements for Medical Group Practices. In the case of a Medical Group Practice, Provider acknowledges and agrees that all provisions of this Agreement applicable to Provider shall apply with equal force to each provider contracted

with, affiliated with, or employed by the Medical Group Practice, unless clearly applicable only to the Medical Group Practice. A Medical Group Practice shall covenant that all provider agreements entered into in the future shall bind each provider in the same way. Provider shall furnish a roster of contracted providers at least annually or upon Plan's request. Plan may consider a material breach of any provision of this Agreement by any provider associated with a Medical Group Practice to be a material breach by Provider.

3.1.3 Eligibility and Participation. Provider warrants that it is eligible to participate in MSP programs and its contracts with its employees, agents or subcontractors to ensure that services provided shall be provided in accordance with the requirements herein. Provider shall be responsible for assuring that performance by each employee, agent and subcontractor conforms to the requirements of this Agreement, and a failure of such person to so perform may be treated by Plan as a breach or default by Provider. If Plan identifies problems or deficiencies that are subject to the terms of this Agreement, Provider agrees to cooperate with Plan, as can be reasonably expected, to resolve such concerns or problems to the satisfaction of Plan or the MSP.

3.1.4 Provider Assurance. Provider shall ensure the following:

3.1.4.1 that Provider maintains the appropriate current and unrestricted license in good standing, registration and/or certificate to provide health care services in the State of Hawaii;

3.1.4.2 if applicable, that Provider maintain a Drug Enforcement Administration ("DEA") registration certificate that is current and unrestricted;

3.1.4.3 if applicable, that Provider maintain a Certificate of Registration for Controlled Substances ("CSC") that is current and appropriate for the provision of Covered Services;

3.1.4.4 if applicable, that Provider maintain admitting privileges at a Participating Provider facility;

3.1.4.5 if applicable, that physician assistants are appropriately supervised;

3.1.4.6 if applicable, that Primary Care Providers enroll and complete forms for VFC (Vaccines For Children) participation;

3.1.4.7 that Provider has not been excluded from participation in federal or state health care programs and does not employ or subcontract with individuals or entities whose owner or managing employees have been excluded from participation in federal or state health care programs; i.e., who are on the state or federal exclusions list; and,

3.1.4.8 to notify Plan immediately if there is a change in the status of any of the foregoing.

3.2 Credentialing and Re-Credentialing.

3.2.1 Compliance with Plan Process. Provider shall comply with Plan's credentialing and re-credentialing processes as set forth in the Provider Manual. Provider shall submit complete, accurate and timely information on all documents required for such processes. The failure to provide required information may result in the exclusion of Provider as a Participating Provider.

3.2.2 Provider Reviews. Periodically, Plan shall review Provider, which may include an on-site review, to determine that Provider meets the standards of Plan's credentialing policy. Plan will send a written notification to Provider to schedule an on-site review. As permitted by applicable law, Provider shall cooperate in the review by providing Plan with access to all information and copies of all documentation requested specific to Covered Services rendered to Member. Failure to cooperate with the review may result in the exclusion of Provider as a Participating Provider.

3.3 Provision of Services and Eligibility.

3.3.1 Provision of Covered Services. Provider shall provide or arrange for the provision of Covered Services consistent with this Agreement and within the scope of the respective Providers' licenses and certifications to practice and for which Providers have been credentialed, unless Provider has a full panel and is granted a Plan waiver to decline new Members. Provider shall ensure Covered Services are provided to Members in the same manner, in accordance with the same standards and during the same times as its other patients or customers. Provider shall not segregate Members in any way from other persons receiving services, except for health and safety reasons. Provider shall comply with all medical policies and procedures established by Plan as defined in the Provider Manual. In the event that Provider refuses to provide any Covered Service based on moral or religious objections, Provider shall notify the Covered Member who requires such service(s) and make arrangements to refer the Member to another Participating Provider who will provide the service.

3.3.2 Eligibility Verification. In accordance with the Provider Manual, and except for Emergencies, Provider shall verify the eligibility of a Member and receive Authorization, if required, prior to providing Covered Services. Plan shall ensure Provider has access to accurate eligibility information telephonically or electronically 24 hours a day, 7 days a week. Plan shall not be financially responsible for Covered Services provided to a Member who is not eligible for benefits.

3.3.3 Service Interruption. Provider shall notify Plan if at any time during the term of this Agreement, Provider becomes unavailable to provide Covered Services due to family, medical, or other emergencies. Notification due to emergencies shall occur within 48 hours of Provider becoming unavailable. If Provider will be unavailable to provide Covered Services due to a planned leave of absence which will be longer than five (5) business days, Provider shall notify Plan at least three (3) weeks prior to the start of the absence. Any arrangements made by Provider with any other provider to provide Covered Services on Provider's behalf are subject to

Plan approval prior to implementation. If Provider fails to notify Plan of inability or unavailability to provide Covered Services, Plan has the right, if necessary, to immediately transfer the affected Members to other Participating Providers and to make adjustments to compensation as determined by Plan.

3.3.4 Appointment and Accessibility Standards. Provider shall comply with appointment standards as required by the MSP, developed by Plan, and described in the Program Attachment/Amendment and the Provider Manual.

3.3.4.1 Notification of Changes. Provider shall notify Plan immediately in writing of any changes in Provider's normal business hours or office location.

3.4 Payment. Plan shall pay Provider in accordance with the compensation terms set forth in the Compensation Exhibits, attached hereto and incorporated herein by reference, and in accordance with the claims submission and billing terms set forth in Article IV of this Agreement, Program Attachments, Program Amendments and Plan policies. Except for applicable Co-payments, Provider agrees to accept such compensation as payment in full for all Covered Services rendered to Members.

3.5 Coordination of Care.

3.5.1 Role of Primary Care Provider. Primary Care Providers ("PCP") are responsible for the supervision, coordination, the initiation of referrals for specialty care, and provision of Covered Services to assigned Members in accordance with this Agreement. A Primary Care Provider shall maintain continuity of each Member's health care and maintain the Member's medical record as to services rendered by the PCP and information provided to PCP by other providers treating the Member. A PCP shall have admission and treatment privileges in a minimum of one general acute care hospital which is in Plan's network and on the island of service, or with Plan's authorization, have a written arrangement with at least one other Provider with admitting and treatment privileges within an acute care hospital. A PCP in East Hawaii shall have admission and treatment privileges in East Hawaii, and a PCP in West Hawaii shall have admission and treatment privileges in West Hawaii. With the Member's participation and in consultation with any specialist caring for the individual, a PCP shall generate a treatment plan for individuals with special health care needs.

3.5.2 Identification of Certain Members. Provider shall notify Plan if, in the opinion of Provider and as defined by Plan or the Hawaii Department of Human Services, a Covered Member meets the criteria for the following designations:

3.5.2.1 Members with Disability. Provider shall assist in and support Plan's effort to identify, coordinate, manage and/or transition the care of Members who have a disability.

3.5.2.2 Members Requiring Long Term Services and Support. Provider shall assist in and support Plan's effort to identify, coordinate, manage and/or transition the care of Members who are in need of long term services and support.

3.5.2.3 Members with SEBD/SMI/SPMI. Provider shall assist in and support Plan's effort to identify, coordinate, manage and/or transition the care of Members who have a SMI/SEBD/SPMI.

3.5.2.4 Members with Limited English Proficiency (LEP). Provider shall provide access to and support Plan's efforts to provide language interpretation and translation services, which are Covered Services, for any Member who needs such services including, but not limited to, Members with limited English proficiency. Interpretation services shall be offered at no cost to the Member, and Provider shall document the offer and provision of all interpreter services.

3.5.3 Referral Procedures. Provider shall receive referrals from other Participating Providers in accordance with Plan's referral policies and procedures as described in the Provider Manual or other Plan communication documents. Except in the case of Emergencies or Post-Stabilization Care Services, Provider agrees to provide only those Covered Services that are properly referred by the Member's Primary Care Provider and, when required, those that are prior authorized by Plan. Failure of Provider to follow such referral procedures may result in non-payment of fees to Provider.

3.5.3.1 Provider shall comply with the federal physician self-referral law, 42 CFR Part 411, subpart J, as applicable, which generally prohibits a physician from making a referral for designated health services to an entity with which the physician or a member of the physician's immediate family has a financial relationship unless a statutory or regulatory exception applies. Financial relationship is defined as a direct or indirect ownership or investment interest (including an option or non-vested interest) in any entity. The direct or indirect interest may be in the form of equity, debt, or other means and includes an indirect ownership or investment interest no matter how many levels removed from a direct interest or a compensation management with an entity.

3.5.4 Authorization Requirements. Provider shall obtain Authorization for all services requiring prior authorization as detailed in the description of Plan's prior authorization policies and procedures as described in the Provider Manual or other Plan communication documents. Failure to obtain Authorization, as required, may result in non-payment of fees to Provider. Provider agrees to obtain Authorization prior to making a referral to non-Participating Providers.

3.5.5 Notification Procedures. Provider shall notify Plan of certain designated services (such as those identified in the Notification List contained in the Provider Manual) in accordance with Plan's 24 hour notification policies and procedures. Failure of Provider to follow such notification procedures may result in non-payment for services to Provider.

3.6 Laboratory Services. If Provider provides laboratory services, Provider shall comply with the Clinical Laboratory Improvement Act of 1988 ("CLIA") and ensure that any laboratory it uses to provide Covered Services under this Agreement is a Participating Provider.

3.7 Advance Directives. Provider shall comply with federal and state law, including the requirements detailed in 42 CFR Part 489, subpart I and 42 CFR Sec. 417.436(d), and Plan policies regarding advance directives for adult Members, as applicable. At a minimum, Provider shall:

3.7.1 maintain written policies for adult Members receiving care regarding a Member's rights to make decisions about medical care;

3.7.2 require documentation in Member's medical record as to whether the adult Member has executed an advance directive;

3.7.3 not condition the provision of care or discriminate against a Member because of the Member's decision to execute or not execute an advance directive; and,

3.7.4 provide staff education on issues concerning advance directives.

3.8 Member Grievance and Appeal. Plan shall maintain a Member Grievance and Appeal Program. Provider shall cooperate fully with Plan's Grievance and Appeal Program and comply with all final resolutions determined by Plan or, if required, the MSP.

3.9 Newborn Information. To the extent that Provider is aware that a newborn is covered by Plan, Provider shall ensure that the appropriate Plan documentation is completed and submitted to Plan and/or other appropriate agency, as described in Plan's policies, on a timely basis for each newborn to facilitate MSP eligibility. Provider shall notify Plan by the next business day of a newborn's birth or as soon as Provider becomes aware of a newborn's eligibility under Plan.

3.10 Member Safety.

3.10.1 Availability of Emergency Equipment. Provider shall maintain basic emergency equipment, appropriate to Provider, for use in the event that a Member requires emergency care.

3.10.2 Drug Inventories. Provider shall store drugs in a secure and appropriate place, using refrigeration units as required. Provider shall inventory all drugs and dispose of expired drugs on a regular basis.

3.11 Compliance with Plan's Policies, Procedures and Programs. Provider shall comply with Plan's policies, procedures and programs as described in the Provider Manual, provider newsletters, or other Plan communication documents. Notwithstanding Section 8.1 of this Agreement, such policies, procedures, and programs may be modified by Plan as necessary to comply with federal or state law. Plan may revise the Provider Manual to make routine changes. Routine changes are defined as any changes other than changes that are: 1) substantive and 2) inconsistent with the terms of this Agreement. Plan shall make best efforts to provide Provider sixty (60) days prior notice of any non-routine changes or modifications which have a reasonable likelihood of materially affecting Provider's performance of its obligations under this Agreement. Provider shall not be required to comply with such a modification until Provider receives 60 days prior notice. Plan's policies, procedures and programs will include requirements regarding appointment standards, encounter reporting, claims submission, referrals and authorizations, credentialing and re-credentialing activities, participation in Plan's Cultural Competency

Program, Quality Improvement activities, participation in Plan's Utilization Management activities, participation in Plan's compliance plan including Fraud and Abuse Program activities, and participation in corrective action plans initiated by Plan. Provider further agrees to cooperate with any independent quality, utilization review, or program integrity/fraud and abuse audits upon reasonable notice by Plan or as required by applicable MSP, state or federal requirements. Provider's failure to comply with the requirements of this paragraph shall be deemed to be a material breach of this Agreement.

3.12 Books and Records. Provider shall maintain patient, medical and/or behavioral health recordkeeping systems that are: required by applicable law, rule or regulation; complete, including the dates, changes, type and number of services delivered to Members, in conformance with professional licensing or credentialing standards of Plan; in conformance with applicable requirements of Plan and appropriate agencies regarding adequate safeguarding of Members' medical records and appropriate release of confidential information in Member medical records; in conformance with the requirements of regulatory agencies and sufficiently legible and organized so as to allow Plan or a regulatory agency to inspect them and to ascertain the amount, cost, duration and scope of services delivered to the Member; and in conformance with confidentiality requirements and security requirements required by the MSP and state and federal law, including but not limited to the Administration Simplification (AS) provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended, modified or superseded from time to time, Public Law 104-191 and the regulations promulgated thereunder, including but not limited to 45 CFR Parts 160, 162 and 164, if Provider is a covered entity under HIPAA. In addition, Provider shall maintain confidentiality of member records in accordance with 42 CFR Part 431 Subpart F, Hawaii Administrative Rules (HAR) Chapter 17-1702, Hawaii Revised Statutes (HRS) Sec. 346-10, 42 CFR Part 2, HRS Sec. 334-5, and HRS Chapter 577A. Records are to be retained and available for at least ten years from the termination of this Agreement, in accordance with the applicable federal, state or MSP requirements or until any audit or review of Provider's records that is underway is completed, whichever is longest. In addition, records for minors shall be retained and available during the period of minority plus a minimum of seven years after the age of majority per HRS Sections 622-51 and 622-58. Provider shall furnish records and documents to Plan and applicable state and federal agencies, and others, upon request, for the purposes of payment and health care operations which do not require patient authorization.

3.12.1 Access to Books and Records. As permitted by applicable law, upon a minimum of seven (7) business days notice and during Provider's regular business hours, and consistent with applicable HIPAA provisions which do not require patient authorization for the purposes of payment and health care operations, Plan, MSP, the Centers for Medicaid and Medicare ("CMS"), the State Medicaid Fraud Control Unit, the Hawaii Department of Health and Human Services ("DHS"), and any applicable state or federal agencies or their designees shall have the right to inspect, review and make copies of all records maintained by Provider with respect to all services rendered and payments received by Provider from all sources for Covered Services rendered to Members during the term of this Agreement. Plan, MSP, and any applicable state or federal agencies or their designees shall have the right to conduct periodic audits of such records for quality reviews, fraud and abuse investigations, or other purposes that may be delineated in state or federal regulations. Refusal to provide medical records, access to medical records, or the inability to produce the medical records to support a claim or encounter shall result

in the recovery of payment. This provision shall survive the termination of this Agreement.

3.12.2 Medical Records. Provider shall:

3.12.2.1 maintain medical records of each Member in a current, detailed, organized and comprehensive manner and in accordance with customary medical practice, applicable state and federal laws, Plan's accreditation standards and the Provider Manual;

3.12.2.2 provide copies of a Member's Medical Records at the request of Plan, MSP, other providers, or the Member, consistent with applicable HIPAA provisions which do not require patient authorization for the purposes of payment and health care operations, at no cost to Plan, and provide such copies within the timeframes indicated on the request unless a request for extension is made in writing and is substantiated as to the reason the extension is required;

3.12.2.3 allow Plan, MSP, and any applicable state or federal agencies or their designees access to Members' records for Covered Services, whether electronic or paper, during Provider's regular business hours, consistent with applicable HIPAA provisions which do not require patient authorization for the purposes of payment and health care operations.

3.12.2.4 allow the Member to amend his or her Medical Record in accordance with the HIPAA Privacy Rule codified at 45 CFR § 164.526.

3.12.2.5 cooperate with providers of other health plans when a Member is transitioning by supplying all records and information necessary for the new provider to give appropriate care in accordance with the provider's standards of practice.

3.12.3 Provider Cooperation. Provider shall cooperate with Plan in support of data validation and other studies as required by the MSP or licensing and accreditation agencies. Provider shall allow access to or submit complete and accurate medical records to support encounter data upon request of Plan and, consistent with applicable HIPAA provisions, which do not require patient authorization for the purposes of payment and health care operations. This requirement shall survive termination of this Agreement for as long as Plan is required by the MSP or other authorized agencies to show proof of services provided to Members during the term of this Agreement.

3.12.4 Confidentiality of Medical Records. Plan and Provider agree that all Member Medical Records and any other health information shall be treated as confidential so as to comply with all state and federal laws regarding the confidentiality of member records and be consistent with confidentiality requirements in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, modified or superseded from time to time, and the final Privacy Rule issued pursuant thereto (codified at 45 CFR Parts 160 and 164 as amended, modified, or superseded from time to time). According to the terms of Plan's enrollment forms,

agreements with Members and applicable law, Plan is authorized to obtain information from Provider without additional written release by the Member.

3.12.5 Transfer of Records. If a Member is transferred from one Primary Care Provider (PCP) to another, the former Primary Care Provider shall furnish copies of the Member's medical records to the new Primary Care Provider assuming responsibility for the care of the Member within seven (7) business days from receipt of a written request for the records. Such requests can be initiated by Plan, by the new Primary Care Provider, the former Primary Care Provider or the Member.

3.13 Obligation to Notify Plan of Changes. If any of the following events occur to Provider, Provider shall notify Plan immediately. Further, if known to Provider, Provider shall promptly furnish Plan with additional information pertaining to the occurrence, upon reasonable request.

3.13.1 If Provider experiences any change in its professional licensing, professional liability insurance coverage, or certification status;

3.13.2 If Provider's ability to meet the standards of Plan, as set forth in Quality Improvement and Utilization Management Programs, is diminished or impaired;

3.13.3 If Provider refuses to provide any Covered Service(s) based on moral or religious objections;

3.13.4 If Provider's medical staff privileges at a Participating Provider's facility are terminated, denied, not renewed, suspended for patient care issues, restricted or revoked;

3.13.5 If Provider's Participating Provider facility membership or privileges are voluntarily relinquished in lieu of disciplinary action;

3.13.6 If Provider or its insurer is required to pay damages in an action by way of judgment, award or settlement;

3.13.7 If Provider becomes the subject of a disciplinary action before any state licensing board;

3.13.8 If Provider is indicted for, charged by information for, or convicted of a felony;

3.13.9 If Provider becomes impaired or incapacitated in its ability to competently provide Covered Services;

3.13.10 Where there are directors, officers, partners or beneficial owners of five percent (5%) or more of Provider's business entity, if any of these individuals becomes debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations and guidelines issued under Executive Order No. 12549 regarding federal programs;

3.13.11 If Provider is excluded from participation in Medicaid, Medicare or other federal programs;

3.13.12 If Provider becomes unable to provide Covered Services under this Agreement;

3.13.13 If Provider is reported to the National Practitioner Data Bank;

3.13.14 If the Medical Group Practice experiences any significant change in its capacity to provide or arrange for the provision of Covered Services to Members as contemplated by this Agreement, including, but not limited to, any change in the roster of providers associated with the Medical Group Practice;

3.13.15 If Provider has any claims, judgments or convictions brought by governmental agencies involving fraud, abuse, self-referral, false claims, or kickbacks; or

3.13.16 If Provider experiences any significant change in Provider's capacity to provide or arrange for the provision of Covered Services to Members as contemplated by this Agreement, including, but not limited to, Provider's refusal to accept Members as new patients.

3.14 Disclosure of Ownership Information. Provider shall submit full disclosure of ownership information regarding Provider's business entity as specified in and in accordance with 42 CFR §455.101 – 104, including information identifying all persons with an ownership or control interest and their relevant relationships, and the name, address, date of birth, and Social Security number of any managing employee. Disclosure is due at any of the following times: Upon application to the provider network; upon executing an agreement; upon recredentialing; within 35 days after any change in ownership of Provider's business entity or Medical Group Practice, and upon request from Plan or MSP.

3.15 Disclosure of Business Transactions. Provider shall submit within 35 days of the date of a request by Plan, MSP, or any applicable state or federal agencies full and complete information related to business transactions in accordance with 42 CFR §455.105.

3.16 Disclosure of Information on Persons Convicted of Crimes. Provider shall disclose to Plan in accordance with 42 CFR §455.106 the identity of any person who has an ownership or control interest in Provider, or is an agent or managing employee of Provider, and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act. Disclosure is due upon entering into or renewing an agreement, upon written request by Plan, and upon conviction of such a criminal offense.

3.17 Practitioner Performance Data. Provider agrees that Plan may use practitioner performance data including, but not limited to, Healthcare Effectiveness Data and Information Set (HEDIS) scores and survey results for Quality Improvement activities.

## ARTICLE IV

## CLAIMS SUBMISSIONS AND BILLING

4.1 Billing and Compensation. Provider shall receive payment for Covered Services provided under the terms of this Agreement. Provider shall document each encounter or episode of

service provided to a Member involving a Covered Service by submitting the appropriate Billing Form and any necessary medical documentation to Plan, consistent with applicable HIPAA provisions which do not require patient authorization for the purposes of payment and health care operations, within the claim filing deadline specified in the Program Attachment or Program Amendment based on the date of service or date of discharge, as applicable. Provider certifies that all Billing Form data submitted shall be accurate, complete and truthful. Provider shall submit Billing Forms in accordance with industry standards, the Administrative Simplification provisions of the Health Information Portability and Accountability Act of 1996 (HIPAA) requiring use of Standard Transaction and Code sets and other applicable state and federal law and allow sufficient time for notification of claim disposition. Excess re-submission of Billing Forms for the same services may result in the delay of claims processing.

4.1.1 Billing Procedures. Within the claim filing deadline specified in the Program Attachment or Program Amendment following the provision of Covered Services, Provider shall submit to Plan an appropriate Billing Form for Covered Services rendered to a Member and any other documentation required in accordance with Plan's policies and procedures for a Clean Claim. If submitted in writing, Provider shall submit claims to the address provided by Plan. If submitted electronically, Provider shall submit claims in the process required by Plan. Claims that are not submitted within the applicable claim filing deadline shall be subject to denial or reduction of payment by Plan. Claims involving a third party payer not submitted within the applicable claim filing deadline shall be subject to denial or reduction of payment by Plan.

4.1.2 Compensation. Any amount owing under this Agreement shall be paid either within 30 days after receipt of a Clean Claim filed in writing or within 15 days after receipt of a Clean Claim filed electronically, barring any unforeseen major system disruptions or during periods of significant system modifications. If the claim is not a Clean Claim and additional information is required, Plan shall identify the contested portion of the claim and the specific reason for contesting or denying the claim and may request additional required information within 15 days of receipt of submission of a written claim and within 7 days of submission of an electronic claim. If the information received is satisfactory to warrant paying the claim, then the claim shall be paid within 30 days of receiving the additional information in writing, or within 15 days if the additional information was submitted electronically.

4.1.3 Member Surcharges, Co-payments and Share of Cost. Provider may not seek payment from the Member for any Covered Service except for Co-payments.

4.2 Electronic Billing. If Provider requests electronic claim submission, Plan and Provider will mutually agree upon a schedule to implement electronic billing. Provider's system for electronic billing must adhere to all HIPAA Regulations and specifically the HIPAA transaction and code sets.

4.3 Coordination of Benefits/Cooperation with Third Party Liability Recoveries ("TPL"). Provider shall take all necessary steps to notify Plan and coordinate benefits and TPL recoveries with any other source, including reinsurance, that may be liable for the cost of Covered Services provided to a Member. Consistent with the Provider Manual, Plan will coordinate benefits as allowed by state or federal law, or, in the absence of any applicable

law, in accordance with Plan requirements. Subject to other provisions in this Agreement, including that prohibiting billing or collecting from a Member, nothing herein precludes Provider from lawfully seeking and obtaining payment for Covered Services from sources other than Plan.

4.4 Recoupment of Payments. Plan may recoup any payments for services made to Provider due to MSP eligibility or TPL adjustments, audit findings that show such payments to be inappropriate, lack of clinical documentation to support the claim or encounter, Provider's failure or refusal to provide medical records or allow access thereto, or for non-covered services. Any offset will be accompanied by notification to Provider of the individual Member accounts affected. Recoupment based on audit findings may be recovered from a future payment after giving Provider a 30-day written notice of the findings or through other repayment arrangements made with Provider. Recoupment based on eligibility and TPL adjustments may be made on Provider's next payment or through other repayment arrangements made with Provider.

## ARTICLE V

## INSURANCE

5.1 Liability (Malpractice) Insurance. Throughout the term of this Agreement, Provider shall maintain liability insurance in the form of an insurance policy or adequately funded self-insurance program satisfactory to Plan in the minimum amount of $1,000,000 per claim and $3,000,000 in the annual aggregate, or, if applicable, the amount required by the MSP, whichever is less, to cover any loss, liability or damage arising out of acts by or omissions of Provider or its agents, subcontractors or employees. Provider shall obtain and maintain a "tail" policy for a period of not less than five (5) years following the effective termination date of any "claims made policy". The "tail" policy shall have the same policy limits as Provider's liability policy. Plan shall maintain liability insurance to insure Plan and its Board members, officers and employees as required by the MSP. If requested by either party, the other party shall allow inspection of liability insurance certificates during regular business hours upon a minimum of seven (7) business days notice.

5.2 Additional Insurance and Tax Obligations. Provider shall maintain general and comprehensive insurance covering its place of business against any loss, liability or damage arising out of the alleged condition of the premises or the furniture, fixtures, appliances or equipment located therein, together with standard liability protection against any loss, liability or damage as a result of either its agents', sub-contractors' or employees' negligence including, but not limited to, negligence in the operation of a motor vehicle for business purposes. All such policies, or self-insurance programs satisfactory to Plan, shall be in a minimum amount of $500,000 per claim and $1,000,000 in the annual aggregate, or, if applicable, the amount required by the MSP, whichever is more. Provider shall maintain such other insurance in amounts necessary to insure itself and its employees, agents and subcontractors against any claim, event or loss that would impair Provider's ability to carry out the terms of this Agreement. Provider shall be fully responsible for all of Provider's federal, state, county and municipal tax obligations, including excise taxes and workers' compensation insurance, and all other applicable insurance coverage obligations which arise under this Agreement for Provider and its employees. Plan and the MSP shall have no responsibility or liability for any such taxes or obligations, and Provider hereby agrees to hold Plan and the MSP harmless from and indemnifies them against any such liability. Plan shall maintain general liability insurance to insure the Plan and its

premises as required by the MSP. Provider shall secure and maintain automobile insurance when transporting Members, if applicable. Any amounts of insurance required by the MSP shall be communicated by Plan to Provider.

5.3 Evidence of Insurance. At the request of Plan, Provider shall furnish to Plan written evidence that the policies of insurance or self-insurance programs required under this Agreement are in full force and effect. Provider shall immediately notify Plan of any loss of, suspension of or reduction in the insurance coverage of Provider.

5.4 Indemnification. Each party agrees to indemnify and hold harmless the other party and its officers, employees and agents from and against all fines, claims, demands, suits, actions, or costs, including reasonable attorneys' fees, of any kind and nature, to the extent they arise by reason of the indemnitor's acts or omissions.

## ARTICLE VI

## TERMS AND TERMINATION OF AGREEMENT

6.1 Term and Renewal of Agreement. Unless terminated sooner pursuant to this Article, the initial term of this Agreement shall be one (1) year, commencing on the effective date set forth on the first page of this Agreement, and the Agreement shall automatically renew for additional one-year terms unless a party provides sixty (60) days written notice prior to the renewal date to the other party. Following a notice of termination, and extending to the date of actual termination, all obligations of both parties set forth in this Agreement shall remain in force without change or diminishment.

6.2 Termination by Mutual Agreement. This Agreement may be terminated at any time upon the written mutual agreement of both parties.

6.3 Termination for Cause.

6.3.1 Termination without Right to Arbitration. Notwithstanding any other provision, attachment or amendment of this Agreement, Plan may immediately terminate this Agreement or may terminate an individual provider within a Medical Group Practice for cause, without any right to arbitration as provided by Section 8.12 of this Agreement, upon the occurrence of any of the following events: (i) Plan's agreement with a MSP is terminated, in which case any termination shall coincide with the MSP agreement termination date; (ii) Provider or an individual provider within a Medical Group Practice is excluded from federal health care programs such as Medicare or Medicaid; (iii) Provider or an individual provider within a Medical Group Practice is indicted, charged by information for, or convicted of a felony; (iv) Provider fails to fully and accurately submit required ownership, criminal conviction, or business transaction disclosures in accordance with 42 CFR Part 455, Subpart B; or (v) Provider's or an individual provider's license to practice medicine or DEA or CSC license is revoked, suspended, conditioned or limited in any way or affects Provider's or the individual provider's ability to deliver Covered Services, or if such license expires.

6.3.2 Termination Following Peer Review. Plan may terminate this Agreement or may terminate an individual provider within a Medical Group Practice if Plan has

determined, consistent with the standards for professional review actions enumerated in § 671D-11 of the Hawaii Revised Statutes, that the health, safety or welfare of a Member is jeopardized as a result of acts or omissions of Provider. Plan may transfer Member to another PCP or health plan if the Member's health or safety is in imminent danger, subject to the standards for professional review actions enumerated in § 671D-11 of the Hawaii Revised Statutes.

6.3.3 Termination with Right to Arbitration. Plan may terminate this Agreement or may terminate an individual provider within a Medical Group Practice, subject to Provider's right to arbitration as provided by Section 8.12 of this Agreement, upon occurrence of any of the following events: (i) Provider or an individual provider within a Medical Group Practice furnished false, incomplete or materially inaccurate information to Plan before or during the term of this Agreement; (ii) Provider or an individual provider within a Medical Group Practice fails to maintain any insurance policy required by this Agreement; (iii) Provider or an individual provider within a Medical Group Practice fails to comply with Plan's Quality Improvement and Utilization Management Programs, policies, procedures or its bylaws and regulations; (iv) Plan or Provider becomes insolvent; (v) Provider or an individual provider within a Medical Group Practice fails to adhere to Plan's credentialing and re-credentialing standards or fails to cooperate in the credentialing or re-credentialing process; (vi) Provider or an individual provider within a Medical Group Practice loses his or her admitting privileges at a Participating Provider facility; (vii) Provider or an individual provider within a Medical Group Practice breaches the confidentiality of Member Medical Records; (viii) the MSP directs Plan to terminate Provider or an individual provider within a Medical Group Practice for failure to meet or violation of any applicable state or federal laws, rules, or regulations, or if the provider's performance is deemed inadequate by the MSP based upon accepted community or professional standards; or (ix) Provider or an individual provider within a Medical Group Practice breaches a contract requirement or obligation.

6.4 Obligations Following Termination. In the event of termination of this Agreement, Provider shall continue to provide, coordinate or assist in the transition of care until Plan makes reasonable and medically appropriate arrangements for the assumption of such Covered Services by another provider, except when termination occurs due to adverse conduct on the part of Provider. If Provider has already received compensation for future services, Provider shall continue to provide Covered Services to any Member assigned to Provider on the effective termination date of this Agreement until the end of the period for which Provider has received advanced payment, unless otherwise instructed by Plan. Plan shall compensate Provider during this period for Covered Services provided to a Member in accordance with the rates established in this Agreement. Termination of this Agreement shall not affect the rights, duties and obligations of the parties arising out of services provided prior to the effective date of termination.

## ARTICLE VII

## GOVERNING LAW

7.1 Governance of This Agreement. This Agreement shall be governed by and construed in accordance with the laws of State of Hawaii and the contract between the MSP and Plan.

7.2 Compliance with Federal and State Laws and Regulations. Provider and Plan shall meet state and federal laws and regulations, as applicable, including, but not limited to: physician incentive plans, 42 CFR § 434 and § 438.6; fraud and abuse laws and rules; Title XVIII and XIX of the Social Security Act; the Americans with Disabilities Act, including the provision of sign language interpretation services when necessary and not an undue burden; or any applicable rule or regulation promulgated pursuant thereto.

7.3 Fraud and Abuse. Provider shall notify Plan immediately upon discovery of fraud or suspected fraud and abuse involving a Member, Provider, Plan, or an employee, agent, contractor or affiliate thereof.

7.4 Nondiscrimination. Provider and Plan shall abide by the Civil Rights Act of 1964 (as amended), the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, Title IX of the Education Amendments Act of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975 and all other federal and state laws, regulations or orders (including Executive Orders 11246 and 11375, "Equal Employment Opportunity") which prohibit unlawful discrimination because of race, color, creed, religion, sex, including gender identity or expression, national origin, ancestry, age, health status, income status, sexual orientation, and physical or mental disability. Provider shall not differentiate or discriminate in the provision of Covered Services to Members for any reason, including but not limited to, the frequency or extent of Covered Services needed by a Member nor the source of payment for Covered Services. Plan shall not discriminate with regard to the participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. This shall not preclude Plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty or interfere with measures established by Plan that are designed to maintain quality and control costs. Plan shall not discriminate against Providers that serve high-risk populations or conditions that require costly treatment.

7.5 Compliance with MSP Policies and Procedures. Provider and Plan shall provide all services and perform their duties under this Agreement in accordance with, and subject to, MSP policies as may be set forth in existing provider notices, provider manuals, minimum subcontract provisions and rules and regulations which may be issued or promulgated by the MSP from time to time during the term of this Agreement. MSP policies and procedures are available at www.med-quest.us and www.cms.hhs.gov.

7.6 Waiver. The waiver, by either party, of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, all waivers must be in writing and signed by the party to be charged.

7.7 Invalid Provisions. If any provision of this Agreement shall be held to be illegal, invalid, or unenforceable in whole or in part for any reason, the remaining provisions shall continue in force and effect. The parties shall negotiate in good faith a substitute clause for the provision declared illegal, invalid, or unenforceable, which shall most nearly approximate the original intent of the parties in entering this Agreement. The invalidity or non-enforceability of any term or provision hereof shall in no way affect the validity or enforceability of any other terms or provisions.

## ARTICLE VIII

## GENERAL PROVISIONS

8.1 Amending Agreement. This Agreement may be amended at any time upon mutual consent of both parties. If Plan submits an amendment to Provider, such amendment shall automatically become effective 45 days from the date the notice of amendment is given to Provider unless written notice of non-acceptance of the amendment is received by Plan within 30 days of receipt of such amendment. Amendments necessitated to conform to MSP requirements or to comply with state or federal laws or regulations do not require an amendment but shall automatically amend this Agreement. Plan shall notify Provider in a timely manner upon learning of such regulatory changes.

8.2 Assignment and Delegation. This Agreement and/or any rights or duties hereunder may not be assigned, subcontracted or delegated by Provider without the prior written consent of Plan. Any such assignment, delegation or subcontract shall, if required, be subject to prior written approval of the MSP. In the event that Provider obtains written consent of both Plan and, if required, of the MSP, to enter into a contract of assignment and/or subcontracts with other persons or entities to perform any of Provider's obligations hereunder, Provider shall submit the contract of assignment or subcontract to the MSP and Plan for approval and such assignment or subcontract shall not be effective until written approval of such contract by both entities is given. Provider shall not eliminate or limit its duties or liabilities hereunder in such contract and shall remain fully responsible for its duties and responsibilities hereunder notwithstanding such contract and for assuring performance by its contractors or subcontractors. Any responsibility assigned, subcontracted or delegated by Provider pursuant to a subcontract (i.e. credentialing, Quality Improvement, utilization management, etc.) does not release Provider from ensuring all assigned, subcontracted or delegated responsibilities are performed according to appropriate performance standards. Failure to comply with any performance standard and any resulting penalty incurred, either by Provider or its subcontractor, remains the responsibility of Provider. A breach or default by a contractor or subcontractor under such contract shall be a breach or default by Provider hereunder. Plan shall notify Provider 60 days prior to an assignment of this Agreement.

8.3 Indemnification. Plan shall indemnify Provider from all liability arising out of Provider's involvement on any Plan committee; provided however, that Plan shall not indemnify Provider if Provider, while serving on such committee, acted in bad faith or with gross negligence or engaged in willful misconduct.

8.4 Severability. The invalidity or unenforceability of any term or provision hereof shall in no way affect the validity or enforceability of any other term or provision of this Agreement.

8.5 Entire Agreement. This Agreement, together with the Exhibits, Attachments, and Amendments hereto, is the entire Agreement between the parties and supersedes any prior Agreement or understanding, whether oral or written, to the contrary. No representations, warranties or covenants not set forth herein, whether written or oral, shall be binding upon the parties.

8.6 Advertising / Use of Name. Plan may use Provider's name, address, telephone number and description of specialty areas in any roster or list of Participating Providers published by Plan in advertising and other marketing materials. Plan and Provider shall strictly comply

with any applicable MSP rules and regulations with regard to marketing materials. Any advertisements or marketing materials developed or produced by Provider that refer to Plan, this Agreement or the MSP shall be forwarded to Plan for submission to the MSP for review and approval prior to distribution. Provider shall not use the names, photographs or likenesses of or information about any Member in its promotional material or for any other purpose except in the delivery of Covered Services or with the expressed written consent of the Member or their responsible party.

8.7 Merger, Reorganization or Change of Ownership. Provider shall notify Plan in writing of a merger, reorganization or change in Provider's ownership at least 60 days prior to the effective date of the change. If such change is related to or affiliated with Plan, this Agreement shall require an amendment and prior approval of the MSP.

8.8 Confidentiality. Each party acknowledges that the other party may disclose to it information, data, procedures, manuals, forms or processes that are highly confidential and proprietary and that, in some cases, may be trade secrets. Each party agrees to take every measure necessary to protect and preserve the confidentiality of information or materials that are designated as confidential. Such information and data include, but are not limited to, payment rates and fee schedules, eligibility lists, policies and procedures and reports.

8.9 Headings. The titles and headings used in this Agreement are for convenience only and shall have no effect on the legal interpretation of the terms of the Agreement.

8.10 Notification of Changes. In addition to notices required elsewhere in this Agreement, Provider shall provide Plan with written notice of changes in any of the following information at least 60 days prior to the effective date of the change: Provider's address, addresses of any other Provider service sites, telephone number, professional liability insurance coverage, ownership relationships, tax I.D. number or credentialing / licensure status.

8.11 Notices. Notices required under this Agreement shall be deemed delivered upon receipt by the party to whom the notice was sent. Notice by mail shall be mailed first class postage prepaid and addressed as indicated below or in accordance with a notice of a change. Notices delivered personally shall be deemed delivered upon receipt.

(A) Notice to Plan:
Chief Executive Officer
AlohaCare
1357 Kapiolani Blvd., Ste. 1250
Honolulu, Hawaii 96814

(B) Notice to Provider: _____
_____
_____
_____

8.12 Dispute Resolution/Arbitration. Disputes related to denial of payment for claims by Plan, or related to issues regarding the quality of care or access to care provided by Provider, shall be handled initially through Plan's internal appeals process, as set forth in Plan's Provider Manual. Notwithstanding any other provision of this Agreement, if there is any dispute, claim or controversy between Plan and Provider, and the informal dispute resolution process is not successful, Provider or Plan may submit the matter to arbitration

by sending written notice to the opposing party setting forth the basis of the dispute and the party's desire to arbitrate. The arbitration shall be conducted in Hawaii before a mutually agreed upon arbitrator. If Plan and Provider are unable to agree on an arbitrator within sixty (60) days from the written request for arbitration, either party may apply to the First Circuit Court of Hawaii for an appointment of an arbitrator. The arbitrator shall be bound by the terms and conditions set forth in the Agreement when such terms and conditions are set forth clearly and without ambiguity. The judgment upon the award rendered in such arbitration may be entered in any court with jurisdiction and the parties hereby submit to the jurisdiction of the applicable court in Hawaii for the purpose of confirming the award and entering judgment thereon. The arbitrator may not award consequential, special, punitive, or exemplary damages. The arbitrator may award costs of the arbitration and the arbitrator's services, but not attorneys' fees, against a party. If the arbitrator makes no award, each party shall pay its own costs, including attorneys' fees, and the parties shall equally share the costs of the arbitration. Unless otherwise agreed to by Plan, arbitration shall be completed within sixty (60) days from the date the matter comes before the arbitrator.

8.13 Regulatory Approval. This Agreement shall not take effect and shall not be binding upon either party until:

8.13.1 Plan executes a contract with the MSP; and,
8.13.2 the terms of this Agreement are approved by the MSP.