HAWAII MEDICAL SERVICE ASSOCIATION

MEDICAL GROUP AGREEMENT

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HAWAII MEDICAL SERVICE ASSOCIATION
MEDICAL GROUP AGREEMENT

THIS AGREEMENT, effective as of _____ , is by and between Hawaii Medical Service Association ("HMSA"), a Hawaii nonprofit mutual benefit society, and

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("Medical Group"), and arises out of the following circumstances:

1. HMSA operates and administers health plans for the benefit of its Members;

2. HMSA desires to contract with Medical Group to provide Covered Services through Medical Group's employed and contracted Participating Providers to Members of HMSA Plans;

3. Medical Group desires to contract with HMSA to provide services as described in Paragraph 2 above; and

4. HMSA and Medical Group wish to promote quality health care, Member satisfaction, Member's choice of physician, and medical decision-making by Member in collaboration with his or her physician.

I. DEFINITIONS

Terms used throughout this Agreement are defined as follows:

1.1 Claim. A complete billing, or an adjustment to such billing, for Covered Services submitted by Medical Group on the CMS 1500 form, another form approved by HMSA, or by electronic transmission accepted by HMSA.

1.2 Copayment. An amount that the Member is required to pay for Covered Services as set forth in the Member's Plan Document.

1.3 Covered Service. A medical service or supply that qualifies for payment under the terms of the Member's Plan Document and meets payment determination requirements set forth in Section 4.2 of this Agreement, or a preventive service that is specifically described as covered in the Member's Plan Document.

1.4 Deductible. The fixed dollar amount a Member must pay each calendar year before benefits subject to the annual deductible become available.

1.5 Eligible Charge. The Eligible Charge for a Covered Service is the lower of either the actual charge as shown on the claim or the charge listed for the service in HMSA's Schedule of Maximum Allowable Charges ("Schedule"). For a Covered Service that does not have a charge listed in the Schedule, HMSA will establish in good faith the Maximum Allowable Charge. HMSA reserves the right to adjust the charges listed in the Schedule upon sixty (60) days' written notice to Medical Group. Factors considered by HMSA in establishing Maximum Allowable Charges or in making adjustments to the charges may include, but are not limited to, changes in the Honolulu Consumer Price Indices (All Items and Medical Care); cost of providing medical care; relative complexity of the service; payments for the service under federal, state and other private insurance programs; and the competitive environment.

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1.6 HMSA Participating Provider. A physician or provider who has entered into a contract with HMSA to provide health care services to Members and who meets HMSA's credentialing or recredentialing criteria, as appropriate, including Participating Physicians providing services pursuant to this Agreement.

1.7 HMSA Participating Provider. A physician or allied health provider who has entered into a contract with HMSA to provide health care services to Members and who meets HMSA's credentialing or recredentialing criteria, as appropriate, including Participating Providers providing services pursuant to this Agreement.

1.8 Member. A person who meets applicable eligibility requirements and is enrolled in a Plan and on whose behalf the applicable Plan premium has been paid.

1.9 Participating Allied Health Provider. A non-physician, including, but not limited to, a psychologist, clinical social worker, certified nurse midwife, certified nurse anesthetist, physical therapist, speech therapist, physician assistant, or advanced practice registered nurse, who is employed by or under contract to Medical Group and who is duly licensed or certified to practice in the State of Hawaii and meets HMSA's credentialing or recredentialing criteria, as appropriate.

1.10 Participating Physician. A physician who is employed by or under contract to Medical Group, and who is a) duly licensed to practice medicine in the State of Hawaii, b) has been determined by HMSA to meet HMSA's credentialing or recredentialing criteria, as appropriate, and, c) if under contract to Medical Group, has also entered into a contract with HMSA as a Participating Physician.

1.11 Participating Provider. A Participating Physician or Participating Allied Health Provider.

1.12 Payor. The party that is financially responsible for payment for Covered Services provided in accordance with this Agreement or an arrangement between HMSA and the applicable Plan. A Payor may be a self-funded employer, an insurance company, a health maintenance organization, a government program or other party which has engaged HMSA to administer the Plan. With respect to certain Plans, HMSA itself may be the Payor or an affiliate of HMSA may be the Payor.

1.13 Plan Document. The document issued by HMSA, an HMSA affiliate, or other Payor that describes Member Benefits.

1.14 Plans. HMSA health plans that provide benefits for services performed by Participating Providers, including, but not limited to, Preferred Provider Plan, State Plan, Federal Plan, Health Maintenance Organization (HMO) Plans, and Drug Riders. Also included are HMSA affiliate Plans, other Blue Cross and/or Blue Shield plans and the plans of their related companies, other health plans in which HMSA has an ownership interest, and plans HMSA has contracted with to provide services contemplated by this Agreement. A complete list of plans is furnished in the Provider E-Library.

1.15 Provider E-Library. The HMSA electronic resource library containing information regarding HMSA's operating policies and procedures concerning providers that is available at http://hhin.hmsa.com. For purposes of this Agreement, the Provider E-Library shall consist of those materials indexed under "Medical."

II. OBLIGATIONS OF MEDICAL GROUP

2.1 Authority to Bind Participating Providers. Medical Group represents and warrants that it is legally authorized to negotiate on behalf of and to bind its Participating Providers to the terms and conditions of

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this Agreement, as it may be amended by the Parties over time pursuant to Section 9.1 below. Upon request by HMSA, Medical Group shall provide to HMSA evidence of Medical Group's authority to so bind its Participating Providers. Medical Group agrees that it is Medical Group's responsibility to assure that the obligations of its Participating Providers as set forth herein are fully satisfied, and Medical Group shall take all steps necessary to cause its Participating Providers to comply with and perform the terms and conditions of this Agreement.

2.2 Provide Covered Services. Medical Group, through its Participating Providers, shall provide Covered Services to Members in accord with the terms and conditions of this Agreement and with the standards prevailing in the professional community at the time of treatment. Medical Group shall provide HMSA with a list of its Participating Providers, and shall update this list whenever Medical Group employs or contracts with a new Participating Provider or an existing Participating Provider is no longer employed by or under contract to Medical Group or no longer meets HMSA's credentialing or recredentialing criteria.

2.3 Credentialing. Medical Group shall require, (a) all its employed and contracted physicians, and (b) allied health providers who provide Covered Services to Members to comply with any and all credentialing and recredentialing requirements and procedures as established by HMSA and amended from time to time. Compliance shall be determined by an HMSA credentialing committee. The members of the credentialing committee will consist of an HMSA Medical Director and other members selected and appointed by HMSA, a majority of whom will be practicing physicians. Failure to meet credentialing or recredentialing requirements may result in termination in accord with Article VII of this Agreement. Medical Group's right to appeal the termination decision is set forth in Section 8.1(b) of this Agreement. Once credentialed, Participating Provider shall inform HMSA of any change to the information provided on the Participating Provider's most current HMSA credentialing application. In the event that HMSA determines that a material misrepresentation or omission has been made with regard to the most current credentialing application, HMSA shall have the right in its sole discretion to withdraw the Participating Provider's credentialed status, initiate a new credentialing review, and/or terminate this Agreement by providing 60 calendar days notice as described in Article VII of this Agreement.

2.4 Compliance With This Agreement. Medical Group shall by contract require its Participating Providers to abide by all applicable terms of this Agreement.

2.5 Individual Providers Not Eligible to Provide Covered Services. Medical Group shall not provide Covered Services to Members through providers employed by or under contract to Medical Group who at the time services are provided: (a) are not Participating Providers; or (b) whose Hawaii license or certification to provide services contemplated by this Agreement is revoked, restricted, suspended, conditioned or expired.

2.6 Licensure. Medical Group warrants and represents that each Participating Provider is and will remain, throughout the term of this Agreement, the holder of a currently valid, unrestricted, and unconditioned (a) license or certificate to practice within the scope of his or her license or certificate in the State of Hawaii; and (b) Drug Enforcement Agency Controlled Substances Registration Certificate and/or Certificate of Registration for Uniform Controlled Substances. HMSA may waive the drug certification requirement if the Medical Group and Participating Physician present evidence acceptable to HMSA that the certification is not required for the Participating Physician to deliver appropriate medical care.

2.7 Required Disclosures. Medical Group shall notify HMSA in writing upon the occurrence of any of the events indicated below:

(a) Any Participating Provider's license to practice in the State of Hawaii is suspended, conditioned, revoked, terminated, expired, or subject to terms of probation or other restriction; or

(b) Any Participating Physician's federal and/or state drug license is suspended, conditioned, revoked, expired, or terminated; or

(c) Any Participating Provider becomes the subject of any disciplinary proceeding or action before the Hawaii Medical Board or the Board of Nursing or a similar agency in any state, or an agency of the federal government; or

(d) Any Participating Provider is convicted of a fraud or felony; or misdemeanor related to the Participating Provider's professional practice or actions evidencing dishonesty, deceit, misrepresentation or other misconduct; or

(e) An act of nature or any event beyond Medical Group's reasonable control occurs that substantially interrupts all or a portion of Medical Group's business or practice, or that has a materially adverse effect on Medical Group's ability to perform its obligations hereunder; or

(f) Medical Group fails to maintain the insurance coverage required under Article VI of this Agreement; or

(g) Any malpractice claim, judgment or settlement in which Medical Group or any Participating Provider is a named defendant; or

(h) There is a change in Medical Group's business address; or

(i) There is a change in Medical Group's federal tax identification number; or

(j) There is a change in the employment status, contractual status, or address of practice locations of any Participating Provider; or

(k) A Participating Provider's privileges at any medical facility or participation in any health plan or network is suspended, limited, revoked or terminated, subject to terms of probation or other restriction, if any such actions are taken due to the Participating Provider's failure to meet credentialing, participation, or staff privilege requirements, or voluntarily surrendered in anticipation of the foregoing; or

(l) There is a change to a Participating Physician's board certification; or

(m) Participating Provider appears on the U.S. Department of Health & Human Services Office of Inspector General's List of Excluded Individuals/Entities (LEIE) or the General Services Administration's Excluded Parties List System (EPLS), or the Office of Personnel Management's Sanction List; or

(n) Participating Provider has a financial interest in any entity which receives payment from HMSA for Covered Services rendered, ordered, or directed by Participating Provider; or

(o) Participating Provider participates in a concierge medicine program that requires a Member to pay for Covered Services; or

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(p) Any other situation arises that could reasonably be expected to affect Medical Group's ability to carry out its obligations under this Agreement.

2.8 Standard of Care. Participating Providers shall provide Covered Services in accord with generally accepted medical practices and prevailing standards applicable to providers practicing in the same field under similar circumstances at the time of treatment.

2.9 Nondiscrimination. Medical Group and Participating Providers shall render services to Members in the same manner, in accordance with the same standards, and within the same time availability, as to their other patients. Neither Medical Group nor any Participating Provider shall refuse to render services to a Member based on the Member's disability, race, color, sex, sexual orientation, national or ethnic origin, age, gender identity or expression, or religion.

2.10 Quality Improvement. As requested by HMSA, Medical Group and Participating Providers shall provide medical records and other data for participation in ongoing HMSA quality improvement activities that may include medical care evaluation studies, clinical practice guidelines, peer review, practice pattern analysis based on claims data, audit of medical records, problem identification and resolution, and priority-setting. Medical Group and Participating Providers agree to work in good faith with HMSA to implement corrective actions recommended in good faith by an HMSA review committee composed of practicing physicians, and to permit this committee to monitor and evaluate such corrective actions. Medical Group's and Participating Providers' right to appeal the corrective action decision is set forth in Section 8.1(a) of this Agreement.

2.11 Continuity of Care. Medical Group and Participating Providers shall provide appropriate medical information to other providers: (a) when referring a Member to another provider, (b) at the Member's request, or (c) at another provider's request in order to ensure continuity of care and to avoid unnecessary duplication of services, unless the Member specifically objects.

2.12 Referral. Each Participating Provider shall use his or her professional judgment when referring Members to other providers, and such referral decisions shall be based on the best interest of the Member. Participating Providers are urged, however, to refer Members to other HMSA Participating Providers whenever appropriate and practical for the financial protection of the Member. When referring Members to non-Participating Providers, Participating Provider shall inform Members that the referral is to a non-Participating Provider and that the Member may have increased out of pocket costs as a result. HMSA shall provide notice in writing to Participating Provider if it becomes aware of a failure to so inform the Member. Participating Provider's subsequent failure to inform the Member after notice from HMSA constitutes cause and may result in termination in accord with Article VII of this Agreement. HMSA shall furnish Medical Group and Participating Providers with a current HMSA Participating Provider Directory or access to such Directory.

2.13 Utilization Management. Medical Group and Participating Providers shall comply with HMSA's utilization management programs. Utilization management requirements are described in the Provider E-Library and Plan Documents. Payments to Medical Group may be reduced or denied (including retroactively denied) if Participating Providers fail to satisfy a utilization management requirement and an HMSA Medical Director or his or her designee determines in good faith that the service does not meet payment determination requirements as described in Section 4.2 of this Agreement. Any recoupment efforts resulting from HMSA's utilization management programs will be conducted in accord with HRS § 431:13-108, which may be amended from time to time. Medical Group or Participating Providers shall not attempt to collect the reduced or denied payment from the Member. Medical Group's or Participating Provider's right to appeal a utilization management program decision is set forth in Sections 8.1(a) and 8.2 of this Agreement.

HMSA's utilization management programs may include, but are not limited to:

(a) pre-certification for a payment determination regarding a proposed service;

(b) concurrent review to determine whether a continued inpatient hospital stay or other treatment protocols meet payment determination requirements set forth in Section 4.2 of this Agreement;

(c) retrospective review to evaluate appropriateness of care and care management; and

(d) focused review of specific procedures and/or specific providers.

2.14 Provider-Patient Relationship.

(a) Medical Group and Participating Providers shall maintain the provider-patient relationship with each Member who is provided with medical care and treatment and shall be responsible for the medical care and treatment of such Members. Nothing contained in this Agreement is intended or shall be interpreted to: (a) interfere with such provider-patient relationship, (b) discourage or prohibit a Participating Provider from discussing preventive or treatment options, including medication, and without regard to what is covered under the Member's Plan, or (c) discourage or prohibit a Participating Provider from providing other medical advice or treatment deemed appropriate by the Participating Provider.

(b) Participating Provider shall not participate in a concierge medicine program that requires Members to pay for Covered Services. Such participation shall constitute cause as that term is used in Section 7.2 of this Agreement.

2.15 Health Information Technology. Medical Group agrees that as it implements, acquires, or upgrades health information technology systems, it shall make reasonable efforts to utilize, where available, certified health information technology systems and products that meet interoperability standards recognized by the Secretary of Health and Human Services, as existing on the date of implementation, acquisition, or upgrade of health information technology systems. HMSA encourages Medical Group to make efforts to demonstrate meaningful use of health information technology in accord with The Health Information Technology for Economic and Clinical Health Act (HITECH Act).

2.16 Provider E-Library. Medical Group and Participating Provider shall comply with all policies, procedures, and requirements contained in the Provider E-Library as described more fully in Section 3.4 below.

III. OBLIGATIONS OF HMSA

3.1 Payment. HMSA shall pay Medical Group directly for Covered Services in accord with Article IV of this Agreement and within the timeliness standards as set forth in the Provider E-Library.

3.2 Membership Cards. HMSA shall issue Plan membership cards to Members. Plan membership cards are for identification only. Possession of a Plan membership card is not a guarantee of eligibility.

3.3 Eligibility Determination. HMSA shall confirm Member eligibility to Medical Group and Participating Providers electronically or telephonically. Medical Group and Participating Provider understand and acknowledge that such verification is not a guarantee of payment.

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3.4 Provider E-Library. HMSA shall make the Provider E-Library available to Medical Group through the HMSA website and shall provide a paper copy of the Provider E-Library to Medical Group upon request. Medical Group and Participating Providers shall comply with all policies, procedures, and requirements contained in the Provider E-Library. Subject to Section 9.1 of this Agreement, HMSA reserves the right to amend policies, procedures and requirements in the E-Library and will provide at least sixty (60) calendar days' written notice of material adverse changes.

3.5 Participating Provider Directories and Websites. HMSA shall: (a) list the name of the Medical Group and the name of each Participating Provider and other information in an HMSA Participating Provider Directory; and (b) distribute the Directory or make it available to Medical Group, Participating Providers, and Members. The same and/or other information may be published on the Blue Cross and Blue Shield Association's website and/or HMSA's website.

3.6 Physician Advisory Committees. HMSA shall establish and maintain physician advisory committees composed of HMSA Participating Physicians. These committees shall provide input to HMSA regarding various physician and clinical issues related to HMSA operations and programs. HMSA will consider recommendations for committee members from individual physicians and physician organizations in the community.

IV. COMPENSATION

4.1 Payment.

(a) Except as otherwise provided in this Article IV, Medical Group shall accept the Eligible Charge as payment in full for Covered Services. HMSA shall pay directly to Medical Group the Eligible Charge minus applicable Copayments, deductibles, and payments from third parties described in Section 4.6 of this Agreement provided that where HMSA is not the Payor, HMSA shall have no obligation to pay claims for which the Payor has not made sufficient funds available for such payment. Covered Services are medical services or supplies that qualify for payment under the terms of the Member's Plan Document and meet payment determination requirements set forth in Section 4.2 of this Agreement or preventive services that are specifically described as covered in the Member's Plan Document. Payment shall be based on the Member's eligibility and HMSA's policies pertaining to the recognition of the service, whether billed alone or in combination with other services. Participating Provider acknowledges and agrees that Participating Provider shall not seek payment from HMSA in the event of nonpayment by a non-HMSA Payor or in the event that a non-HMSA Payor fails to make sufficient funds available for payment regardless of the cause of such nonpayment or failure.

(b) Pay-for-quality payment. HMSA reserves the right to create one or more pay-for-quality programs. In that event, HMSA shall pay Participating Physician a pay-for-quality payment, provided that Participating Physician meets all eligibility, enrollment and award criteria of the program. The determination of whether a Participating Physician is eligible for pay-for-quality programs, amounts to be paid and frequency of payments shall be determined at HMSA's sole discretion. Notwithstanding anything in Section 9.1, HMSA reserves the right to adjust the pay-for-quality program upon at least sixty (60) days' written notice to Participating Physician. The program descriptions, eligibility criteria, and scoring and payment methodologies for such pay-for-quality programs are set forth in the Provider E-Library.

4.2 Payment Determination Criteria.

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(a) A service or supply provided to a Member qualifies for payment under this Agreement if it qualifies for payment under the Payment Determination Criteria in the Member's Plan Document.

(b) Payment determinations are based on policies adopted by HMSA Medical Directors in consultation with practicing physicians as well as HMSA policies, peer reviewed literature and nationally recognized standards. Any determination that a service or supply does not meet the Payment Determination Criteria in the Member's Plan Documents will be made by an HMSA Medical Director.

(c) The fact that a physician may prescribe, order, recommend, or approve a service or supply does not in itself mean that the service or supply meets the Payment Determination Criteria, even if it is specifically described in the Member's Plan Document.

(d) A Medical Group representative or a Participating Provider may contact HMSA for a payment determination regarding a procedure, service, or supply before rendering care.

(e) Medical Group's right to appeal the payment determination decision is set forth in Sections 8.1(a) and 8.2 of this Agreement.

4.3 Services and Supplies That Do Not Meet Payment Determination Criteria. If HMSA determines that any service or supply provided by Medical Group does not meet HMSA's Payment Determination Criteria in the Member's Plan Document, then Medical Group shall not bill or collect from a Member any charges for such service or supply, shall promptly refund the Member any Copayment that Medical Group collected from the Member and shall hold the Member harmless from any charges related to the service or supply, unless a written acknowledgment of financial responsibility specific to the service or supply and signed by the Member or the Member's legal representative is obtained prior to the time the service or supply is rendered.

Medical Group's right to appeal a decision pertaining to services that do not meet HMSA's Payment Determination Criteria is set forth in Sections 8.1(a) and 8.2.

4.4 Services That Are Not Plan Benefits. Except as set forth in Section 4.3, this Agreement does not govern Medical Group's or a Participating Provider's charges to a Member for services that are not Covered Services.

4.5 Prohibition Against Member Billings and Collections. In no event shall Medical Group or a Participating Provider collect or attempt to collect from the Member any amount that HMSA or a Payor is obligated to pay Medical Group under the Member's Plan, whether HMSA's nonpayment results from insolvency, HMSA's breach of this Agreement, or any other cause.

4.6 Coordination of Benefits and Third Party Collections. Medical Group and its Participating Providers shall cooperate with HMSA for the proper coordination of benefits and in the identification and collection of third party payments such as those from workers' compensation, other health insurance, auto insurance, and other third party liability sources.

4.7 Claims. Claims shall only be submitted under this Agreement for services and supplies rendered (a) personally by a Participating Physician, or (b) if the standard of care does not require that the service be provided by a physician, by the Participating Physician's employee or contractor of the Medical Group who meets all required licensure and certification requirements and is qualified to perform the service, incident to a Participating Physician's professional service, and under the Participating Physician's direct supervision. Services are "incident to" if furnished as an integral, although incidental, part of the

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Participating Physician's personal professional services in the course of diagnosis or treatment. "Direct supervision" means that the Participating Physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the employee is performing services.

No payment shall be made on any Claims submitted more than one year after the last day on which the services covered by the Claim were rendered unless the delay was caused by coordination of benefits. Medical Group shall not collect payment from Members for any Covered Services with respect to which the one-year Claim submission period has expired. Medical Group has the right to request a review by HMSA within one year of Medical Group's receipt of HMSA's decision to deny or pay the Claim.

Any recoupment efforts involving such Claims shall be conducted in accord with HRS § 431:13-108, as it may be amended from time to time.

4.8 Refund. Within 60 calendar days ("Notice Period") of Medical Group's receipt of notice from HMSA, Medical Group shall refund to HMSA any overpayment made by HMSA to Medical Group. HMSA shall have the right to offset the amount of any overpayment not refunded against any future payments due to Medical Group from HMSA under this Agreement or any other agreement with HMSA. HMSA has the right of offset under this Section, regardless of whether the Medical Group has assigned the right to receive payments under this Agreement or any other agreement with HMSA, or has otherwise directed HMSA to make payments under this Agreement or any other agreement to a third party. HMSA also has the right to send the matter directly to a collection agency if after providing notice as described above: 1) Medical Group terminates one or more agreements pursuant to which Medical Group receives payment from HMSA, 2) if payments due from HMSA during the Notice Period multiplied by three (3) are insufficient to repay the overpayment, or 3) Medical Group refuses in writing to repay the overpayment. If the matter is sent to a collection agency, Medical Group shall owe HMSA all collection agency fees and costs related to the matter (which HMSA may recoup by offset) and Medical Group's right to arbitration pursuant to Section 8.2 of this Agreement will automatically be waived with respect to the refund at issue. Medical Group shall refund directly to the Member any amounts in excess of Co-payments or Deductibles collected in connection with an overpayment subject to refund under this Agreement.

V. RECORDS

5.1 Member's Medical Record. Medical Group shall ensure that a medical record is established and maintained for each Member that fully documents, in a detailed and comprehensive manner, medical services rendered and billed. Medical Group shall further ensure that such record is legible, signed and dated, in accord with generally accepted medical practices and all applicable federal and state statutory and regulatory requirements and permits effective professional medical review and medical audit processes and facilitates an adequate system for follow-up treatment. All amendments, modifications, updates or any other change made after the initial creation of the electronic medical record shall be clearly identified as an amendment, modification, update or other change, and shall be dated and authenticated by the author.

5.2 Access to Records. "Records" are any and all Member records including, but not limited to, medical records, records relating to submission of claims to HMSA or other insurers, and billings by Medical Group. Medical Group and Participating Providers shall allow HMSA Medical Directors or their designees access to records for the purposes of utilization management, quality assurance, credentialing, recredentialing, claims payment verification, fraud and abuse investigations, and government audits.

Subject to compliance with applicable federal and state laws, professional standards regarding the confidentiality of medical records, and Plan Documents, Medical Group and Participating Providers shall upon HMSA's request:

(a) allow HMSA authorized personnel access to Records on Medical Group's or a Participating Provider's premises in a reasonable manner and at a mutually agreeable time within five working days following notice from HMSA;

(b) transmit Records by telephone or other electronic means to HMSA within two weeks from the date of HMSA's request; or

(c) provide copies of Records to HMSA within two weeks from the date of HMSA's request.

The Parties agree that failure to promptly provide information as required under this Section 5.2 shall constitute a material breach of this Agreement and may result in termination of this Agreement and/or refund to HMSA of payments made for any claim(s) for which records are not provided. Such payments shall be "overpayments" as that term is used in Section 4.8 above.

5.3 Confidentiality. HMSA and Medical Group and Participating Providers agree to keep confidential and to take the usual precautions to prevent the unauthorized disclosure of any and all medical records and information required to be prepared or maintained by Medical Group, a Participating Provider or HMSA under this Agreement. All protected health information ("PHI") used or disclosed by any party under this Agreement is subject to various state and federal statutory privacy standards and laws, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH"), and regulations adopted thereunder by the Department of Health and Human Services (45 C.F.R. Parts 142, 160, 162 and, 164). The Parties shall treat all PHI at all times in accordance with HIPAA standards. This provision shall survive the termination of the Agreement.

VI. INSURANCE

6.1 Insurance Policies. Medical Group, at its sole cost and expense, shall either:

(a) Procure and maintain policies of general liability and professional insurance and other insurance necessary to insure Medical Group and its Participating Providers against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of this Agreement. Policies shall not be less than $1,000,000 per incident and $1,000,000 per policy with an excess liability of $3,000,000; or

(b) As approved by HMSA, procure and maintain a surety bond, proof of qualifications as a self insurer, or other securities affording financial responsibility substantially equivalent to that afforded under general liability and professional liability insurance policies in the amounts described in subsection (a) above.

VII. TERM, TERMINATION AND DISQUALIFICATION

7.1 Term. When executed by both parties, this Agreement shall become effective as of the date noted on page 1 of this Agreement and shall continue in effect for three years unless sooner terminated by either party upon written notice in accord with this Article VII.

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7.2 Termination. Except as set forth in Section 7.3 of this Agreement, either party may only terminate this Agreement, with or without cause, by giving the other party at least 60 calendar days' written notice.

7.3 Immediate Termination. HMSA shall have the right to terminate this Agreement immediately only upon written notice to Medical Group due to 1) revocation, suspension, limitation, condition, or expiration of Participating Physician's license to practice medicine, or 2) if a Participating Provider appears on the U.S. Department of Health & Human Services Office of Inspector General's List of Excluded Individuals/Entities (LEIE) or the General Services Administration's Excluded Parties List System (EPLS). Medical Group's right to appeal the termination decision is set forth in Section 8.1(b).

7.4 Effect of Termination. As of the date of termination, this Agreement shall be considered of no further force or effect except that such termination shall not release Medical Group and its Participating Providers or HMSA from their respective obligations accruing prior to the date of termination, including, without limitation, the following:

(a) HMSA's obligation to pay, in accord with the terms of this Agreement, for Covered Services provided to Members prior to termination;

(b) Medical Group's and Participating Providers' obligation to retain and to provide HMSA access to Records as set forth in Article V of this Agreement;

(c) Medical Group's agreement not to seek compensation from Members for Covered Services provided while this Agreement is in force except for applicable Copayments and deductibles; and

(d) Medical Group's and Participating Providers' and HMSA's obligation to resolve disputes pursuant to Article VIII of this Agreement.

7.5 Participating Provider Immediate Disqualification. HMSA may disqualify any Participating Provider only upon written notice to Participating Provider and Medical Group due to the revocation, suspension, limitation, condition, or expiration of Participating Provider's license to practice or certification to provide Covered Services contemplated by this Agreement. Medical Group's right to appeal the disqualification decision is set forth in Section 8.1(c).

7.6 Effect of Participating Provider Disqualification. As of the date of his or her disqualification, a Participating Provider may not render Covered Services to Members. Except for immediate disqualification, upon HMSA's receipt of the Medical Group's request for appeal, disqualification is suspended until the dispute is resolved. If an immediate disqualification is appealed, the disqualification remains in force until the dispute is resolved.

VIII. DISPUTE RESOLUTION

This Article VIII applies to all sections of this Agreement, notwithstanding reference in selected sections and survives the termination of this Agreement.

8.1 Internal Appeals.

(a) Disputes Other Than Termination (Section 7.2) or Participating Provider Immediate Disqualification (Section 7.4) of this Agreement. If Medical Group or any Participating Provider has any claim, dispute, or cause of action arising out of this Agreement or its performance or breach, or in any way related to this Agreement, including but not limited to any and all claims, disputes or causes of

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action based upon contract, tort, statutory law, or actions in equity, Medical Group, or the Medical Group acting on behalf of the Participating Provider, must submit a written request for review by HMSA within one year after the event giving rise to such claim, dispute or cause of action. HMSA shall issue a decision within sixty (60) calendar days of HMSA's receipt of the request for review or within thirty (30) calendar days if the request is for non-urgent pre-service benefits redetermination. The procedures provided in this Section 8.1 are intended to provide a prompt and inexpensive means of dispute resolution, and are not intended to limit the scope of evidence or witnesses presented in any subsequent arbitration regarding the same claim, dispute, or cause of action.

(b) Participating Provider Immediate Disqualification (Section 7.4). Medical Group, or the Medical Group acting on behalf of the Participating Provider, may appeal HMSA's decision to terminate this Agreement. In order to appeal HMSA's termination of this Agreement, Medical Group, or the Medical Group acting on behalf of the Participating Provider must submit a written request for appeal within sixty (60) calendar days of receipt of a notice of a Participating Provider's disqualification as described in Sections 7.4 and 7.5 above. The basis for the proposed termination shall be provided in the notice of termination or in a separate document provided in advance of the hearing before the review committee. If the termination is pursuant to a recommendation by HMSA's Credentialing Committee, the appeal must conform to HMSA's policies and procedures related to credentialing in addition to this section 8.1(b). An HMSA review committee composed of practicing physicians shall convene within thirty (30) calendar days of the request for appeal. The members of the HMSA review committee shall be selected and appointed by HMSA. A representative of the Medical Group may appear to present evidence or testimony before the committee. Both Medical Group and HMSA may call and cross-examine witnesses who appear to present evidence and testimony before the review committee. HMSA or Medical Group may be represented by counsel or another representative at the appeal. A record shall be made of the proceedings, and a copy shall be provided to Medical Group upon request. Medical Group and HMSA may submit a written statement at the conclusion of the hearing. Medical Group will be notified of the review committee's decision within five working days following the hearing.

(c) Expedited Pre-Service Benefits Redetermination. Medical Group may request an expedited redetermination of any HMSA decision to deny payment for a service that has not yet been provided to a Member if a delay would: (a) seriously jeopardize the Member's life or health; (b) seriously jeopardize the Member's ability to gain maximum functioning; or (c) subject Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the redetermination request. For an appeal under this Section 8.1(c), Medical Group shall request an expedited redetermination and provide any additional information requested by HMSA.

8.2 External Appeals

Arbitration Upon Exhaustion of Internal Appeal. HMSA and Medical Group agree that any and all claims, disputes, or causes of action arising out of this Agreement or its performance, breach or termination, or in any way related to this Agreement, including but not limited to any and all claims, disputes, or causes of action based upon contract, tort, statutory law, or actions in equity, shall be resolved by binding arbitration as set forth in this Agreement, unless arbitration is waived pursuant to Section 4.8 of this Agreement.

If Medical Group or a Participating Provider disagrees with HMSA's decision following exhaustion of internal appeals described in Sections 8.1 above, Medical Group, or Medical Group acting on behalf of the Participating Provider, may submit a written request for arbitration to HMSA's Legal Department in Honolulu, Hawaii, within sixty (60) calendar days following the date of the HMSA review committee's decision.

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Arbitration of disputes between HMSA and Medical Group shall be conducted by an independent arbitration service mutually selected by HMSA and Medical Group. Arbitration shall be conducted in Honolulu, Hawaii, except that if the Medical Group is on a neighbor island, the Medical Group may participate in the arbitration by telephone. If HMSA and Medical Group are unable to agree upon an arbitration service within thirty (30) calendar days of HMSA's receipt of Medical Group's request for arbitration, Dispute Prevention and Resolution, Inc. ("DPR"), or, if DPR is not available, another arbitration service selected by HMSA will conduct the arbitration. If the two parties (HMSA and Medical Group) are unable to agree upon an arbitrator within thirty (30) calendar days following the submission of the claim to the arbitration service, then the two parties shall select an arbitrator in accordance with the arbitration service's arbitrator selection procedures. The arbitration will be conducted pursuant to the Hawaii Uniform Arbitration Act, HRS Chapter 658A, and the arbitration service's arbitration rules (or such other arbitration rules as the parties may mutually agree); to the extent not inconsistent with the arbitration provisions in this Agreement. The arbitrator may hear and determine motions for summary disposition pursuant to HRS 658A-15(b). The arbitrator shall also hear and determine any challenges to the arbitration agreement and any disputes regarding whether a controversy is subject to an agreement to arbitrate. In order to make the arbitration hearing fair, expeditious and cost-effective, discovery by both parties shall be limited to requests for production of documents material to the claims or defenses in the arbitration. Limited depositions for use as evidence at the arbitration hearing may occur as authorized by HRS §658A-17(b). Each party (HMSA and Medical Group) will pay its own attorney and witness fees, provided that the arbitrator shall award attorney fees and costs in an amount authorized by law to a prevailing party related to any claim or contention of a nonprevailing party, that the arbitrator determines was frivolous or wholly without merit. Fees and costs of the arbitrator and the arbitration service may be awarded by the arbitrator as the arbitrator determines is appropriate. If no award is made, fees and costs of the arbitrator and the arbitration service shall be shared equally by both parties. The decision of the arbitrator shall be final and binding on HMSA and Medical Group and judgment shall be entered thereon upon timely motion by either party in a court of competent jurisdiction. No other action may be brought in any court in connection with this decision, except as provided under the Hawaii Uniform Arbitration Act. There shall be no consolidation of parties in the arbitration proceeding. The arbitrator may award any remedy that can be granted by a court in like circumstances, provided that no award of punitive damages or exemplary damages shall be made. The parties shall take appropriate precautions to protect the confidentiality of any personal health information related to the arbitration proceeding.

8.3 Limitations on Appeals. Medical Group may not initiate internal appeal or external appeal of a denied service if:

(a) The Member or his or her authorized representative is currently seeking or has sought review related to the same denied service. In the event both the Member or his or her authorized representative and the Medical Group seek review of the same denied service, the Member's review shall go forward and the Medical Group's request for review will be dismissed.

(b) As to external review only, the Member is covered under a self-insured plan and the Plan sponsor has not agreed by contract to participate in HMSA's external review programs; or

(c) The Member or his or her authorized representative files or has filed suit for the denial of health care services or supplies regarding an adverse determination as to the denied service.

8.4 Review of HMSA's Schedule of Maximum Allowable Charges. Medical Group may submit a written request for a review of a specific Eligible Charge by HMSA staff. If the Medical Group disagrees with the staff's review decision, Medical Group must submit within sixty (60) calendar days of Medical

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Group's receipt of the HMSA staff review decision a written request for review by the HMSA fee review committee. The HMSA fee review committee shall be composed of practicing physicians selected and appointed by HMSA and may submit recommendations for consideration by HMSA. The determination of charges in HMSA's Schedule of Maximum Allowable Charges shall be at HMSA's sole discretion.

IX. MISCELLANEOUS PROVISIONS

9.1 Amendments. Except as set forth in this Agreement, this Agreement may be amended only by mutual agreement of the parties except that HMSA may amend this Agreement as necessary to comply with federal and state law. HMSA may revise the Provider E-Library to make routine changes. Routine changes are defined as any changes other than changes that are both: 1) substantive and 2) inconsistent with the terms of this Agreement. HMSA shall provide at least sixty (60) days' prior written notice of any revisions to the Provider E-Library that are not routine changes, as defined herein.

9.2 Assignment. Neither HMSA nor Medical Group shall assign or transfer rights, duties, or obligations under this Agreement without the prior written consent of the other party. Changes of ownership or changes in majority control of a Medical Group, and assignments of this Agreement by operation of law, are assignments of this Agreement for the purposes of this Section 9.2.

9.3 Captions. The captions contained herein are for reference purposes only and shall not affect the meaning of this Agreement.

9.4 Cooperation of Parties. Medical Group and HMSA agree to meet and confer in good faith on common problems including, but not limited to, those pertaining to Member complaints, customer service, utilization of services, credentialing, authorization, claims and reporting procedures, and information and forms provided to Medical Group for use with Members. A request to meet and confer under this provision shall not relieve either party of their obligations under this Agreement.

9.5 Entire Agreement. This Agreement, together with Plan Documents and the Provider E-Library as amended from time to time, contains the entire agreement between the parties and supersedes all prior agreements and negotiations, either oral or in writing, with respect to the subject matter hereof. One or more attachment(s) or exhibit(s) may be attached to this Agreement, setting forth additional provisions included in this Agreement. By executing this Agreement, the parties acknowledge that these attachments or exhibits are expressly incorporated into this Agreement and are binding on the parties. In the event of any inconsistent or contrary language between an attachment or exhibit and any other part of this Agreement, the attachments or exhibits will control, to the extent applicable. Each attachment(s) or exhibit(s) shall be effective until the effective date of termination of this Agreement unless such attachment(s) or exhibit(s) expires by its terms or is separately terminated by either Party pursuant to the terms of such attachment(s) or exhibit(s).

9.6 Governing Law. This Agreement shall be construed and enforced in accord with the laws of the State of Hawaii.

9.7 Legal Compliance. HMSA, Medical Group and the Participating Providers shall comply with all state and federal laws and regulations in performance of this Agreement and obtain approval of all duly constituted government authorities, including the procurement of all licenses and permits required to provide services hereunder.

9.8 Members' Appeal Rights. Members' appeal rights are outlined in their Plan Documents.

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9.9 Notices. Any notice required to be given pursuant to the amendment or termination of this Agreement shall be in writing and shall be sent, postage prepaid, by certified mail, return receipt requested, to HMSA or to Medical Group at the address below. The notice shall be effective on the date of delivery.

If to HMSA:

Hawaii Medical Service Association
Attention: **PDA (7-PDA)**
P. O. Box 860
Honolulu, HI 96808-0860

If to Medical Group:

Mailing address as reported by Medical Group to HMSA.

9.10 Partial Invalidity. If, for any reason, any provision of this Agreement is held invalid, the remaining provisions shall remain in full force and effect.

9.11 Relationship of Parties. In the performance of the work, duties, and obligations assumed under this Agreement, it is mutually understood and agreed that each party and its agents, employees, or representatives are at all times acting and performing as independent contractors and that neither party shall consider itself or act as the agent, employee, or representative of the other.

Medical Group and Participating Providers expressly acknowledge that this Agreement constitutes a contract between Medical Group and HMSA, that HMSA is an independent plan operating under a license with the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting HMSA to use the Blue Cross and Blue Shield Service Marks in the State of Hawaii, and that HMSA is not contracting as the agent of the Association. Medical Group further acknowledges and agrees that it has not entered into this Agreement based upon representations by any other person or entity other than HMSA and that no person, entity, or organization other than HMSA shall be held accountable or liable to Medical Group for any of HMSA's obligations to Medical Group created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of HMSA other than those obligations created under other provisions of this Agreement.

9.12 Responsibility for Acts. Each party is responsible for its own actions.

This Section 9.12 shall survive termination of this Agreement.

9.13 Waiver. The waiver by either party of any breach of any provision of this Agreement, of any warranty, or of any representation set forth herein shall not constitute a continuing waiver of any subsequent breach of either the same or any other provision, warranty, or representation of this Agreement.

9.14 Execution. This Agreement may be executed by HMSA and Medical Group in counterparts, all of which taken together will be deemed one and the same instrument. Facsimile and photocopy signatures shall have the same binding effect as manual, original signatures.

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IN WITNESS WHEREOF, the undersigned have executed this Agreement as of the date(s) written below.

Hawaii Medical Service Association

By: _____
Paul Schnur

Title: Chief Contract Negotiator

_____
Date of Signature

By: _____
(Signature)

_____
(Print name)

Title: _____

_____
Date of Signature

<Contract.Contract Holder>

By: _____
(Signature)

_____
(Print name)

Title: _____

_____
Date of Signature

THIS CONTRACT IS NOT EFFECTIVE UNTIL SIGNED BY HMSA.

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