HEALTH CARE SERVICES AGREEMENT

BETWEEN

KAISER FOUNDATION HEALTH PLAN

AND

[NAME OF PROVIDER]

HEALTH CARE SERVICES AGREEMENT

Table of Contents

HEALTH CARE SERVICES AGREEMENT

This Health Care Services Agreement ("**Agreement**") is entered into between **Kaiser Foundation Health Plan on behalf of its Hawaii Region**, a California nonprofit public benefit corporation authorized to do business in the State of Hawaii through its Hawaii Region ("**KFHP**"), and _____ [legal name of Provider], a _____ [type of legal entity, such as a corporation, partnership, limited liability company, etc.] ("**Provider**") and is effective _____ [Insert month, day and year] ("**Effective Date**").

RECITALS

A. KFHP operates health care benefit plans and provides or arranges for the provision of medically necessary health care services to Members (as defined below) in its Hawaii Region.

B. KFHP has entered into an agreement with **Kaiser Foundation Hospitals**, a California nonprofit public benefit and charitable corporation authorized to do business in the State of Hawaii through its Hawaii Region ("KFH"), under which KFH agrees to provide or arrange for certain medically necessary hospital or facility services for Members.

C. KFHP has entered into an agreement with the Hawaii Permanente Medical Group, Inc. a Hawaii professional medical corporation ("**HPMG**") under which HPMG agrees to provide or arrange for certain medically necessary professional and outpatient services for Members.

D. Together, KFHP, KFH and HPMG cooperate to form the Kaiser Permanente Medical Care Program in the Hawaii Region.

E. KFHP desires to arrange for the provision of certain health care services to Members by contracting with providers, such as Provider. Provider desires to provide Services (as defined below) to Members in accordance with the terms of this Agreement and using Federal Tax Identification Number _____ in the State of Hawaii.

AGREEMENT

NOW THEREFORE, the parties agree as follows:

ARTICLE 1. DEFINITIONS

Following are definitions of terms used in this Agreement. There may be additional terms defined in the body of the Agreement, the Recitals, and the Exhibits. Defined terms are capitalized.

1.1 **Authorization** means KP's approval for the provision of Covered Benefits to Members (i) by persons designated to provide such approval (ii) pursuant to KP's utilization management and review programs and (iii) in the manner specified (such as prior written approval in many instances), each as described herein, including the Provider Manual and Exhibit 1 (Additional Terms). Further, "**Authorization**" also means the document(s) or electronic documentation indicating KP's approval, as the context requires. "**Authorized**" means provided pursuant to and in compliance with an Authorization.

1.2 **Business Day** means Monday through Friday, excluding recognized federal holidays.

1.3 **Calendar Days** means all days, including holidays and weekends.

1.4 **Claim** means a request for payment for Services rendered to a Member submitted in accordance with the terms of this Agreement, the Provider Manual, and applicable Law.

1.5 **CMS** means the Center for Medicare and Medicaid Services of the US Department of Health and Human Services.

1.6 **Complaint** means any verbal or written expression of a Member's dissatisfaction with a Practitioner or Facility which is not amenable to prompt resolution upon receipt and requires follow-up and investigation (for example, a grievance).

1.7 **Covered Benefit(s)** mean(s) the health care services and benefits that a Member may be entitled to receive under the applicable Membership Agreement, as determined by the applicable Payor.

1.8 **Covered Service(s)** mean(s) those Services rendered by Provider to Members that are (i) Covered Benefits and (ii) Authorized or otherwise approved for payment.

1.9 **Emergency Medical Condition** means any of the following: (i) a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (a) serious jeopardy to the Member's health, or in the case of a pregnant woman, the health of the woman or her unborn child, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part; or (ii) a mental disorder that manifests itself by acute symptoms of sufficient severity such that either the Member is an immediate danger to themselves or others, or the Member is not immediately able to provide for or use food, shelter, or clothing, due to the mental disorder; or (iii) with respect to a pregnant woman who is having contractions (a) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (b) that transfer may pose a threat to the health or safety of the woman or her unborn child; or (iv) as otherwise defined by applicable Law, including Hawaii Law or the federal Emergency Medical Treatment and Active Labor Act (42 USC 1395dd) and its implementing regulations (collectively referred to as "**EMTALA**").

1.10 **Emergency Services** mean those Services necessary to screen, evaluate and stabilize an Emergency Medical Condition in compliance with EMTALA and/or other applicable Law, including Hawaii Law. Emergency Services do not include post-stabilization services and [or observation services after the first twenty-three (23) hour period (unless otherwise required by Law].

1.11 **Facility(ies)** mean(s) those facilities (including hospitals, skilled nursing facilities, and dialysis centers), institutions, locations or any other sites used by Provider (or any Subcontractor) to provide Covered Services to Members pursuant to this Agreement.

1.12 **Financial Responsibility Form** means a form provided to a Member by Provider for the Member's execution, acknowledging that the Member is responsible to pay for those non-Covered Services specifically described on the form. This form shall not be required of a Member prior to the Member's receipt of Emergency Services.

1.13 **Kaiser Administrative Services Organization (or "Kaiser ASO")** means a Kaiser Permanente affiliate that has contracted to perform certain administrative and/or management services on behalf of an Other Payor. Without limitation, a Kaiser ASO includes a Kaiser Permanente regional health plan (where permitted by Law) and Kaiser Permanente Insurance Company.

1.14 **Kaiser Permanente (or "KP")** means KFHP for the Hawaii Region, KFH for the Hawaii Region or HPMG, or any combination of one or more of them, as applicable.

1.15 **Law** means local, state and federal law, regulation or rule, as applicable.

1.16 **Member** means an individual entitled to health care services (at the time such services are rendered) under a Membership Agreement issued by a Payor, or another arrangement with a Kaiser Payor. Members include the following categories:

1.16.1 **Medicare Members** include:

1.16.1.1 **Medicare Advantage Members** who are Medicare Members enrolled under a Medicare Advantage contract between KFHP (or another Kaiser Payor) and CMS.

1.16.1.2 **Medicare Cost Members** who are enrolled under a Medicare Cost contract between KFHP (or another Kaiser Payor) and CMS.

1.16.1.3 **Regular Medicare Members** who are Members (i) entitled to coverage under Part A only or Part B only or Parts A and B of Medicare but (a) are not enrolled under a Medicare Advantage contract or a Medicare Cost contract between KFHP (or another Kaiser Payor) and CMS and (b) for whom the Medicare program is the primary payor for Medicare-covered services under Medicare reimbursement rules, or (ii) enrolled under a Medicare Advantage contract and are hospice patients receiving care from Provider for Services unrelated to the hospice patient's terminal condition.

1.16.2 **Medicaid Members** who are Members, other than QUEST Integration Members (defined below), enrolled in the Medicaid program through contracts between KFHP (or another Kaiser Payor) on the one hand and a state (or organization under contract with a state) on the other hand ("**Medicaid Contracts**"). [The terms "Medicaid" and "QUEST Integration" are interchangeable as they apply to Hawaii Medicaid Members in this Agreement.]

1.16.3 **Commercial Members** who are Members who are not Medicare Members or Medicaid Members or QUEST Integration Members.

1.16.4 **QUEST Integration Members** who are entitled to coverage under the MedQUEST Program (and QUEST-Net Program) (collectively "QUEST Program") of the State of Hawaii.

1.17 **Member Cost Share** means a copayment, deductible, coinsurance or any other charge payable by a Member for Covered Services pursuant to the Member's Membership Agreement.

1.18 **Membership Agreement** means a description of a plan of health benefits covered, issued, sponsored or underwritten by a Payor. The term "Membership Agreement" includes the relevant evidence of coverage, statement of coverage, certificate of insurance, summary plan description, or other description of Covered Benefits issued to a Member, as amended from time to time.

1.19 **Official(s)** mean(s) (i) individuals who represent, in an official capacity, a local, state or federal government agency or regulatory body with jurisdiction over KP or Provider; (ii) representatives of any accreditation agency or organization (such as the National Committee for Quality Assurance ("**NCQA**")) or a peer review or professional organization applicable to KP or Provider; (iii) such other officials entitled by Law or pursuant to government contracts with KP (including Medicare Advantage contracts, Medicare Cost contracts, Federal Employees Health Benefits Program ("**FEHBP**") contracts, QUEST contracts and Medicaid contracts) to monitor health care services to Members; and (iv) the designees of any of the above.

1.20 **Payor(s)** mean(s) any entity(ies), severally, that fall(s) within either category below, as listed in Exhibit 4 (Payors), as amended from time to time:

1.20.1 **Kaiser Payor(s)** means a KP affiliate having responsibility for the provision or arrangement of health care services to Members under a plan regulated by any state insurance commissioner or state director of managed care. A Kaiser Payor includes (i) a corporation or other organization owned or controlled, either directly or through subsidiary corporations, by KFHP (such as Kaiser Permanente Insurance Company) or under common control with KFHP (such as KFH), (ii) Group Health Cooperative, and (iii) any regional Permanente Medical Group; and

1.20.2 **Other Payor(s)** mean(s) any public or private entity that (i) sponsors, administers, and/or funds a plan of health benefits coverage or is otherwise responsible for the arrangement for health care services rendered to Members under a Membership Agreement and (ii) enters into an administrative and/or management service agreement with a Kaiser ASO.

1.21 **Permanente Physician(s)** means any duly licensed physician employee(s) or shareholder(s) of HPMG or such other duly licensed physician(s) as may be designated by HPMG from time to time.

1.22 **Post-Stabilization Services** mean those medically necessary health care services provided after an Emergency Medical Condition has been stabilized or as otherwise defined by applicable Law, including Hawaii Law or EMTALA.

1.23 **Practitioner(s)** mean(s) those health care practitioners (including physicians, nurses, physician assistants, nurse practitioners, and physical therapists) who, by way of ownership of, employment by, or contracts with Provider (or any Subcontractor) provide Covered Services to Members pursuant to this Agreement.

1.24 **Program Requirements** means (i) the Provider Manual and any other applicable policies, procedures, guidelines and formularies of KP, as amended and supplemented by KP from time to time; (ii) all applicable Law, including licensure and certification requirements; (iii) the applicable Membership Agreement; and (iv) NCQA and all other accreditation requirements imposed upon KP in order for KP to maintain accreditation, all as applied to Provider's provision of Covered Services to Members.

1.25 **Provider Manual(s)** mean(s) manual(s) of policies, procedures and guidelines applicable to KP's Hawaii Region, including billing procedures, Authorization and referral policies and procedures, utilization management, quality assurance and improvement, Complaints, and other guidelines and criteria for providing health care services to Members, as updated and supplemented by KP from time to time in accordance with applicable Law.

1.26 **Records** mean books, documents, contracts, subcontracts, and records prepared and/or maintained by a party that relate to this Agreement whether in written or electronic format, including medical records, imaging, prescription files, Member billing and payment records, claims, financial and accounting records (Including relating to the cost of services, payments received from Members, and the financial condition of Provider), policies and procedures, and other books and records that may be required by applicable Law.

1.27 **Services** means those services, supplies and facilities, including as described in Exhibit 1 (Additional Terms), that are ordinary and necessary for the diagnosis and treatment of patients and are customarily provided by Provider or its Subcontractors to its/their patients. Services also include all administrative services provided by Provider (or its Subcontractors) pursuant to this Agreement or the Provider Manual.

1.28 **Subcontract** means a written agreement between Provider and its Subcontractor(s) and/or between two or more Subcontractors for the provision of Covered Services to Members under this Agreement.

1.29 **Subcontractor** means any person or entity that provides or arranges for Covered Services to Members pursuant to a direct or indirect agreement or other arrangement with Provider.

ARTICLE 2. PROVIDER'S RESPONSIBILITIES

2.1 **Provision of Services**. Provider shall provide or arrange for the provision of Covered Services, including those described in Exhibit 1 (Additional Terms), to Members in accordance with this Agreement and the Provider Manual. References to the responsibilities and obligations of Provider in this Agreement and the Provider Manual shall be interpreted to apply (i) to all Provider's Practitioners and at all Facilities of Provider involved in providing Covered Services to Members and (ii) each Subcontractor and its employees, agents and Facilities providing Covered Services to Members.

2.1.1 **Availability.** Provider shall ensure that Covered Services are available (i) during normal business hours, (ii) when medically indicated, on a prompt or same-day basis, and (iii) as otherwise specified in Exhibit 1 (Additional Terms). Provider shall ensure that Covered Services provided under this Agreement are readily available and accessible, provided in a prompt and efficient manner without delays in appointment scheduling and waiting times and consistent with applicable recognized standards of practice and Program Requirements.

2.2 **Practitioners.** Provider shall ensure that all Practitioners providing Covered Services to Members under this Agreement are qualified and competent to provide such Services, meet all requirements specified in Section 7.2 (Licensure, Accreditation and Certification) and Section 7.3 (KP Credentialing), and are approved by KP. Provider shall

ensure that any substitute Practitioner not employed by Provider (or a Subcontractor) and providing Covered Services to Members under this Agreement is a Subcontractor in compliance with Section 2.10 (Subcontracts) and Section 10.1 (Assignment and Delegation). Provider represents and warrants that all Subcontractors have agreed to be bound by all applicable provisions of this Agreement prior to providing any Covered Services to Members. If Provider provides or arranges for the provision of Covered Services through Practitioners, Provider shall identify those Practitioners pursuant to Exhibit 2 (Facilities and Practitioners) and its instructions. If the parties wish to specify certain Practitioners to provide Covered Services to Members, such Practitioners shall be so specified in Exhibit 2 (Facilities and Practitioners).

2.3 **Facilities**. Provider shall ensure that its Facilities are maintained in good repair, meet all applicable requirements specified in Section 7.2 (Licensure, Accreditation and Certification) and Section 7.3 (KP Credentialing), and are approved by KP. If Provider provides or arranges for the provision of Covered Services at a location other than a Member's personal residence, Provider shall identify those Facilities pursuant to Exhibit 2 (Facilities and Practitioners).

2.4 **Quality Assurance, Quality Management and Quality Improvement** (collectively, **"QI"**).

2.4.1 **Cooperation with KP QI.** Provider acknowledges that KP is required by Law and by accreditation standards to monitor the QI activities of Provider, as described in the Provider Manual. With respect to Covered Services provided to Members, Provider shall participate in KP's QI program as established and amended from time to time and described in the Provider Manual and Exhibit 1 (Additional Terms), which includes cooperating with KP's QI activities to monitor and evaluate Covered Services provided to Members (such as tracking and regular reporting of quality indicators), facilitating review of such Covered Services by KP's QI committees and staff, and cooperating with any independent quality review and improvement organization or other external review organization evaluating KP as part of its QI program (including NCQA). Provider shall comply with KP's requests for information necessary to comply with Hawaii law, including, but not limited to, HRS Chapter 432E. Additional Provider obligations regarding KP's QI program, if any, are described in the Provider Manual or Exhibit 1 (Additional Terms). Nothing in this Section shall require a party to provide information or take action that would violate legally required standards to preserve confidentiality and privileges set forth in Law.

2.4.2 **Resolution of Problems.** Provider shall investigate and respond promptly to issues regarding quality of care, accessibility and other Complaints related to Covered Services provided to Members. Provider shall use best efforts to remedy promptly any unsatisfactory condition related to the care of Members at Facilities or by a Practitioner, as determined by KP or any Official. The parties shall work together to resolve promptly problems related to the provision of Covered Services as they arise.

2.4.3 **Provider QI Program.** If required by Officials or Law, Provider shall maintain a QI program that, at all times during the term of this Agreement, meets all state and federal licensing, accreditation and certification requirements applicable to Provider.

2.5 **Utilization Management and Review** (collectively, **"UM"**).

2.5.1 **Cooperation with KP UM**. Provider hereby acknowledges that KP conducts UM programs relating to health care services provided to Members, as described in the Provider Manual. Provider shall participate in KP's UM programs (including prospective, concurrent and retrospective review) and cooperate with KP's UM committees and staff. Upon reasonable notification and to the extent allowable by applicable Law, Provider shall allow KP UM personnel, or their designees, physical, telephonic, and/or electronic access to review, observe and monitor Member care and Provider's performance of its obligations under this Agreement. Additional Provider obligations regarding KP's UM programs, if any, are described in Exhibit 1 (Additional Terms) and the Provider Manual. With respect to Covered Services provided to Members, KP shall have the right, but not the obligation, to participate in Provider's UM program, if any.

2.5.2 **UM Decisions.** Provider acknowledges that UM decision-making is based on the appropriateness of care and service and existence of coverage and that KP does not compensate individuals responsible for UM decision-making with financial incentives that specifically reward them for issuing denials of coverage or service, or that encourage decisions that result in underutilization.

2.6 **Responsibility for Services**. Notwithstanding Section 2.4 (Quality Assurance, Quality Management and Quality Improvement) and Section 2.5 (Utilization Management and Review), Provider shall assume, for each Member to whom Services are rendered by or on behalf of Provider, full responsibility for the manner in which Services are rendered. Provider shall provide Members with Services using the appropriate standard of care.

2.7 **Provider Manual Compliance**. The Provider Manual, as amended from time to time in accordance with Section 10.9 (Amendment), sets forth the procedures for operationalizing many of the requirements of this Agreement. The terms of the Provider Manual are hereby incorporated into, and made a part of, this Agreement. During this Agreement, Provider is responsible for maintaining the Provider Manual and its updates pursuant to directions from KP and for ensuring Provider's compliance with the provisions of the Provider Manual. Provider is also responsible for (i) providing copies of the Provider Manual to its Subcontractors and (ii) assuring that its Practitioners, Facilities and Subcontractors comply with all applicable provisions. The Provider Manual, including all updates, shall remain the property of KP and shall be returned to KP or destroyed upon termination of the obligations under this Agreement. In the event of any inconsistency or conflict between the Provider Manual and this Agreement, the terms of this Agreement shall govern.

2.8 **Operational Responsibilities.**

2.8.1 **Verification.** Prior to the provision of non-Emergency Services, Provider shall verify (i) that a person seeking Services is in fact an eligible Member as of the date of provision of Services, (ii) the Services rendered to such Member are Covered Benefits pursuant to the applicable Membership Agreement, and (iii) the Services (including the scope and duration of Services) are properly Authorized, where required, all in the manner described in this Agreement, the Provider Manual, and the Member's health plan identification card. Provider's receipt of an identification card issued by a Payor from a person claiming to be a Member is indicative but not conclusive of the person's status as a Member. With respect to Services that are not Emergency Services, if Provider is unable to verify (i) through (iii) listed above, Provider may nevertheless provide Services to the person if the person completes a Financial Responsibility Form to the reasonable satisfaction of Provider; and Payor shall only be financially responsible for Services provided to such person if it is subsequently determined that such Services were Covered Services and such person was, in fact, a Member at the time Provider rendered the Services.

2.8.2 **Emergency Services.** If Provider provides to a Member Emergency Services or Covered Services following stabilization of an Emergency Medical Condition, Provider shall (i) notify KP in accordance with Section 8.1.2 (Notice of Emergency Services Provided); (ii) comply with the procedures in the Provider Manual, including those related to Authorization for Post-Stabilization Services; and (iii) assist KP with the transfer of the Member to other Facilities or Practitioners, as directed by KP. To the extent allowable by applicable Law, KP may retrospectively review Claims for Emergency Services to determine whether they meet the criteria for compensation.

2.8.3 **Member Cost Share.** If Member Cost Share is applicable for Covered Services, Provider shall collect Member Cost Share from the Member.

2.8.4 **Transfers.** Provider shall cooperate with KFHP when transferring a Member to or from a facility, including complying with the procedures in the Program Manual related to non-emergency transportation of a Member to or from a facility. Provider shall transfer or refer Members for Covered Services only after obtaining an Authorization and only to providers approved by KP.

2.8.5 **Drugs and Medications.** If Provider prescribes and/or dispenses drugs and medications, Provider shall do so in accordance with applicable Law, this Agreement, and any applicable Program Requirements. Provider shall adhere to the KP formularies for outpatient prescriptions.

2.9 **Relationship with Members.**

2.9.1 **Communication**. Subject to applicable Law and confidentiality requirements, Practitioners may freely communicate with a Member (or his/her authorized representative) about the Member's treatment options, without regard to benefit coverage limitations. Information about health care service and treatment options (including the

option of no treatment) must be provided to Members in a culturally competent manner, and with appropriate access to language assistance as required of KP by applicable Law and Officials. Provider shall ensure that Members with disabilities are able to communicate with health care professionals in making decisions regarding treatment options. Notwithstanding the foregoing, neither Provider nor KFHP shall engage in any conduct that constitutes tortious interference with the other party or the relationships created thereby.

2.9.2 **Notification of Termination.** KP retains the sole right to notify Members of (i) termination of the Agreement under Section 4.2 (Termination of this Agreement) or (ii) suspension or exclusion of participation of a Practitioner or Facility under Section 4.3 (Suspension or Exclusion of Participation), prior to the effective date of termination or suspension/exclusion; and Provider is responsible for providing relevant information to and otherwise assisting KP in making such notifications.

2.10 **Subcontracts.** Subject to Section 10.1 (Assignment and Delegation), if Provider arranges for the provision of Covered Services to a Member by any Subcontractor, Provider shall enter into a Subcontract prior to the provision of any Covered Services to Members by such Subcontractor. Provider warrants that Subcontractors shall be subject to all obligations of Provider under this Agreement. Such Subcontract shall require the Subcontractor (and its Practitioners and Facilities) to comply with all relevant provisions set forth in this Agreement (including all provisions of Article 6 (Records and Confidentiality) and Article 7 (Compliance) and the Provider Manual that would apply to Provider if Provider were providing the subcontracted Covered Services to Members directly. To the extent a Law, a government contract or an Official requires additional provisions to be included in such Subcontracts, Provider shall amend its contracts accordingly or such amendments shall be deemed included in all such Subcontracts. Upon request by KP or an Official, Provider shall provide, within ten (10) Calendar Days of the request, access to and/or copies of Subcontracts (with executed signature page), including for the purpose of (i) meeting legal, regulatory and accreditation requirements applicable to KP or (ii) addressing any inquiry from an Official.

2.11 **Activities Delegated to Provider.** KP may delegate to Provider utilization management, credentialing, medical records review, and/or other activities, upon Provider's agreement to perform such delegated activities, consistent with regulatory and accreditation standards ("**Delegated Activities**"). Upon Provider's agreement to perform such Delegated Activities, such delegated activities shall be described in a separate writing signed by the parties. To the extent that there are any Delegated Activities, KP shall retain the right to audit, monitor, and oversee these Delegated Activities, including implementing a corrective action plan to address any deficiencies identified by Officials or KP, and Provider shall fully cooperate with KP in any such implementation. KP reserves the right to revoke any such delegation (i) at any time by giving notice in accordance with Section 8.2 (Procedure for Giving Notice) and (ii) promptly if KP or an Official determines that any such Delegated Activities have not been performed in a satisfactory manner. In the event that KP has delegated to Provider the responsibility or authority to select Practitioners to provide Services to Members under this Agreement, KP retains the right to approve, suspend or terminate any such responsibility or authority.

ARTICLE 3. BILLING AND PAYMENT

3.1 **Payment of Compensation.** Subject to the terms of this Agreement, the Provider Manual, and applicable Law, Provider shall bill and the responsible Payor shall pay for Covered Services at the rates set forth in Exhibit 3 (Billing and Payment), reduced by the amount of any applicable Member Cost Share. Provider shall accept such Payor's payment and any Member Cost Share as payment in full of Payor's financial obligations. The responsible Payor may delegate its functions under this Article 3 to one or more delegates.

3.1.1 **Submission of Claims.** Unless otherwise specified, Provider shall submit to the responsible Payor a Claim in the format and within the shortest time frames specified in the Provider Manual, Exhibit 3 (Billing and Payment), and/or required by applicable Law ("**Claims Submission Period**") and with such reasonably relevant additional information as may be requested from time to time by the Payor. If Provider fails to comply with the Claims Submission Period requirements, the Payor shall have no obligation to pay for such Claims, and Provider shall be prohibited from billing the Member as set forth in Section 3.3 (Member Hold Harmless). Nothing in this Section shall supersede applicable Law.

3.1.2 **Payment of Claims.** Subject to the terms of this Agreement, the applicable Payor shall pay Provider for Covered Services within the time frame specified in the Provider Manual and/or Exhibit 3 (Billing and Payment) or such other time frame as required by applicable Law after receipt of a properly submitted Claim.

3.1.3 **Authorization.** Except for (i) Emergency Services and (ii) Covered Services that do not require an Authorization and are specifically set forth in the Provider Manual or Exhibit 1 (Additional terms), Authorization is required for payment of Covered Services. The responsible Payor's obligation to compensate Provider is commensurate with the scope and duration of the Authorization. The applicable Payor may terminate an Authorization prior to its expiration date, as specified in the Provider Manual. Compensation for non-Emergency Services provided to Members is payable to Provider only if the Covered Services are covered by an Authorization that has neither expired nor been terminated as of the date(s) of service, and Provider has strictly satisfied its responsibilities in Section 2.8, including those related to verification.

3.1.4 **Denials**. The responsible Payor reserves the right to deny a Provider's Claim for Covered Services if Provider fails to submit it in accordance with this Section 3.1 (Payment of Compensation). To the extent allowable under Law, Payor reserves the right to deny payment of a Claim for Covered Services rendered (i) by a Practitioner or in a Facility that fails to meet the applicable requirements in Section 7.2 (Licensure, Accreditation and Certification), Section 7.3 (KP Credentialing) and Exhibit 2 (Facilities and Practitioners) on the date(s) of service, (ii) to a Medicare Member or Medicaid Member by a Practitioner or a Facility that is sanctioned under or debarred, suspended, or excluded from or has opted out of participation in Medicare or Medicaid, or (iii) in any manner or by any person prohibited by Law or by KP's government contracts.

3.1.5 **Subcontractors.** Unless otherwise required by applicable Law, Provider shall retain responsibility for paying its Subcontractors under this Agreement, and Subcontractor shall not bill, charge, seek compensation, remuneration or reimbursement from, or have any recourse against a Payor for Services provided to Members by such Subcontractor.

3.2 **Adjustments to Payment.** Payors shall each be entitled to conduct reasonable audits of payments under this Agreement, including as described in Exhibit 1 (Additional Terms) and the Provider Manual. A Payor may review and audit any and all Claims, including Records related to Claims, prior to or subsequent to payment, to ensure that coding complies with the Provider Manual and commonly accepted standards, that services rendered are appropriate and medically necessary, and that payment is in accordance with this Agreement and the Provider Manual; and if they are not, Payor reserves the right to deny, reduce or otherwise adjust payment to Provider to the extent permitted by Law. If an audit conducted by a Payor shows that Provider owes money to a Payor, then such Payor will notify Provider, and Provider shall refund such overpayment to such Payor within thirty (30) Calendars Days after Payor's notice.

3.2.1 **Authority to Offset and Recoupment**. To the maximum extent permitted by applicable Law, Payor is hereby authorized to offset and recoup the amount of any debt owed by Provider to KP, including any overpayment to Provider indentified in an uncontested notification of overpayment sent in accordance with applicable Law, whether or not such debt arises from payment for Services provided under this Agreement or otherwise, against any debt or money owed to Provider, whether for Claims for Services provided by Contractor under this Agreement or otherwise.

3.3 **Member Hold Harmless**. Except as expressly provided in Section 3.5 (Billing Members), Provider (and any Subcontractors) shall look solely to the responsible Payor for compensation for Covered Services rendered to Members, and Provider agrees that in no event (including non-payment by Payor, insolvency of Payor or breach of this Agreement) shall Provider (or Subcontractor) bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member, person acting on the Member's behalf, the State of Hawaii, an Official, or any Medicaid or QUEST Integration plans, for Covered Services provided under this Agreement. Without limiting the foregoing, Provider shall not seek payment from Members for reasons including (i) amounts denied by Payor because billed charges were not customary or reasonable, (ii) Provider's failure (a) to obtain Authorization for Services delivered, (b) to submit clinical data promptly, or (c) to submit a Claim in accordance with the appropriate billing procedures or within the appropriate time frame, or in accordance with commonly accepted standard coding practices

3.4 **Surcharges Prohibited.** Provider understands and agrees that surcharges against Members are prohibited by Law, KP contracts with payors, and Membership Agreements, and KP shall take appropriate action if surcharges are imposed. A surcharge is an additional fee that is charged to a Member for Covered Services but is not expressly permitted under the applicable Membership Agreement or, where applicable, is not permitted by Law or an Official.**Billing Members.** Provider may bill a Member for Services and shall have no recourse against Payor in the following circumstances:

3.5.1 **Member Cost Share.** Provider shall collect Member Cost Share from Members, and the responsible Payor's compensation for Covered Services shall be reduced by the amount of such Member Cost Share. Where Member Cost Share is a deductible or based on a percentage calculation (such as for coinsurance), such amount shall be based on or calculated using the negotiated rate specified in Exhibit 3 (Billing and Payment).

3.5.2 **Not a Covered Benefit; After Coverage Exhausted or Denied; Authorization not Sought by Member.** If Provider provides Services to a Member for which the Member has no Covered Benefit or if a Member elects to continue receiving Services from Provider after the Member's Covered Benefits for that Service are exhausted, denied, or not Authorized, Provider may bill the Member for such Services, provided that, before providing the Services (i) Provider has notified the Member that the Services are not Covered Services and (ii) the Member has signed a Financial Responsibility Form.

3.5.3 **Patient Amenities.** Provider shall charge directly to Member, and shall have no recourse against a Payor for, any personal items or services that are customarily charged by Provider (including telephone and television as applicable) but are not Authorized, provided that, before providing the items or services (i) Provider has notified the Member that the services or items are not Covered Services, (ii) Provider has advised the Member whether the Member is financially responsible, and (iii) the Member has signed a Financial Responsibility Form.

3.6 **Billing Other Responsible Payors.**

3.6.1 **Workers' Compensation.** If the Services rendered to a Member are determined to be covered by a state workers' compensation system, Provider shall submit a workers' compensation claim to the applicable workers' compensation carrier according to applicable Law.

3.6.2 **No-Fault Motor Vehicle Coverage**. If the Services rendered to a Member are covered by any no-fault motor vehicle coverage, Provider shall submit a claim for payment to the no-fault insurance carrier according to applicable Law. Provider shall look only to the no-fault insurance carrier for all payments within the personal injury protection amount of such coverage, as provided by applicable Law. After such personal injury protection amount has been exhausted, then any subsequent claims for Services may be submitted to the responsible Payor. **Other Coverage.** If a Member is entitled to other health coverage, including benefits under a health plan issued by an entity or person other than a Payor, Provider shall look to the carrier, entity or person responsible for such health benefits or other coverage.

3.6.3.1 **Primary Coverage.** When a Payor, accessing rates under this Agreement, is primary under applicable Coordination of Benefits ("**COB**") rules, Payor shall pay to Provider, as set forth in Section 3.1 (Payment of Compensation) and Exhibit 3 (Billing and Payment), the amount due for Covered Services rendered to Members.

3.6.3.2 **Secondary Coverage.** When a Payor is secondary under applicable COB rules, Provider shall first bill the other payor(s) to which Payor is secondary and forward to Payor a copy of such other payor's explanation of payment along with the billing information specified in Section 3.1 (Payment of Compensation) and Exhibit 3 (Billing and Payment). Provider's Claims Submission Period shall commence on the date of such other payor's explanation of payment. Payor shall pay for Covered Services in that amount, if any, which, when added to sums owed to Provider from all other payors for Covered Services provided to Members, equals one hundred percent (100%) of the amount payable for Covered Services in accordance with the rates in Exhibit 3 (Billing and Payment). Payor's payment is subject to the receipt of all information reasonably necessary to determine Payor liability. However, if Payor has reserved the right to bill and collect such sums from other payors to which it is secondary, then Provider shall not bill such other

payors for such identified services and shall grant to Payor the sole right to collect any payments due from other payors for such services.

3.6.3.3 **Cooperation with COB Rules.** Provider shall cooperate and comply with the applicable Payor's administration of Coordination of Benefits ("**COB**") rules, as described in Section 3.6.2 (Other Coverage) and in the Provider Manual. Such cooperation shall include the following: (i) Provider shall screen each Member receiving Services to determine if the Member has fee-for-service Medicare coverage, or other health benefits, such as workers' compensation coverage or other coverage as a retiree or as a dependent through the Member's spouse, and shall provide such other coverage information to Payor as soon as it is identified; and (ii) if, following payment by Payor for Services, Provider discovers that Provider is entitled to payment or receives payment for such Services from another payor that is primary to Payor, then Provider shall notify Payor and promptly refund to Payor any amount paid by Payor in excess of the amount set forth in Section 3.6.3.2 (Secondary Coverage).

3.6.4 **Other Payor.** If the entity responsible for payment of Covered Services to a Member is an Other Payor, Provider shall look to such Other Payor for compensation. Each Other Payor has agreed to accept financial responsibility for the payment of providers, including Provider, for the provision of Covered Services to Members who (i) are enrolled in or otherwise entitled to coverage under such Other Payor's Membership Agreement and (ii) receive Services pursuant to this Agreement. Under no circumstance shall KP have any financial responsibility to compensate Provider for Services rendered by Provider to Members covered under an Other Payor's Membership Agreement, notwithstanding the provision of administrative and/or management services by a Kaiser ASO This provision shall not be construed in any manner to (i) create an express, implied or quasi-contractual relationship between any Other Payor and Provider or (ii) impose joint liability on any Payor for the obligations of another Payor.

3.6.5 **Another Kaiser Payor.** If the entity responsible for payment of Covered Services to a Member is a Kaiser Payor other than KP, Provider shall look to such Kaiser Payor for compensation. Each Kaiser Payor has agreed to accept financial liability for the payment of providers, including Provider, for the provision of Covered Services to Members who are enrolled in, or otherwise entitled to coverage under, the health benefits coverage plan of such Kaiser Payor. This provision shall not be construed in any manner to impose joint liability on any Kaiser Payor for the obligations of another Kaiser Payor.

3.7 **Liens and Third Party Claims.** Provider shall not, directly or indirectly through assignment or otherwise, assert any lien claim, subrogation claim, or any other claim against a Member, or any other person or organization against which a Member may hold a potential claim for personal injury, or against the proceeds of a Member's personal injury recovery based on Covered Services that Provider provided to the Member under this Agreement for an injury or illness allegedly caused by a third party. Unless prohibited by applicable Law, KFHP (or the Payor issuing the applicable Membership Agreement) alone shall have the right to pursue and collect such claims for its own account, and Provider agrees to assist these collection efforts by promptly informing KFHP (or the Payor issuing the applicable Membership Agreement) or its designee of Covered Services provided by Provider for which there may be potential third party liability.

ARTICLE 4. TERM AND TERMINATION

4.1 **Term.** This Agreement shall begin on the Effective Date, and unless terminated earlier in accordance with this Article 4, shall continue for **two (2) years** (the "**Initial Term**"). Thereafter, the Agreement shall be automatically renewed for **one (1) year** terms (each of which is referred to as a "Renewal Term") unless either party terminates the Agreement in accordance with this Article 4.

4.2 **Termination of this Agreement**

4.2.1 **Termination Without Cause.** After the completion of the Initial Term, either party may terminate this Agreement at any time and for any reason or no reason by giving at least sixty (60) Calendar Days written notice to the other party.

4.2.2 **Termination With Cause by KFHP.**

4.2.2.1 **With Cure Period.** If Provider fails to comply with a material provision of this Agreement, KFHP may terminate this Agreement effective sixty (60) Calendar Days from the date of KFHP's written notice, if Provider fails to cure the noncompliance to the satisfaction of KFHP within thirty (30) Calendar Days of the notice, which notice shall specify the noncompliance and request that it be cured. Without limitation, the following constitute possible causes for KFHP's termination of this Agreement under this Section: (i) Provider demonstrates conduct (through act or omission) likely to result in revocation, suspension, restriction or nonrenewal of any license, certificate, permit, credential, privilege, accreditation or certification required under this Agreement for Provider to provide Covered Services to Members (including those listed in Section 7.2 (Licensure, Accreditation and Certification) and in Section 7.3 (KP Credentialing) (collectively, "**Essential Permits**"), as determined by KFHP in good faith; or (ii) Provider misrepresents or falsifies information submitted for Essential Permits; or (iii) Provider fails to comply with KP's QI or UM programs; or (iv) Provider fails to comply with the insurance requirements in Section 9.1.1 (Provider Insurance).

4.2.2.2 **Immediately, Without Cure Period.** Notwithstanding Section 4.2.2.1 (With Cure Period), in certain circumstances, KFHP may terminate this Agreement immediately, with written notice. KFHP may so terminate immediately if: (i) any Official revokes, suspends, restricts or fails to renew any Essential Permit; (ii) Provider, a Practitioner listed in Exhibit 2 (Facilities and Practitioners), or any of their employees or Subcontractors is sanctioned under or is debarred, suspended, or excluded from any federal program (including Medicare or Medicaid) or identified in a federal list of excluded entities or excluded individuals, including lists or maintained by the General Services Administration, Office of Inspector General, Department of Health and Human Services, or Office of Foreign Assets Control; or (iii) Provider demonstrates conduct (through act or omission) that threatens the health, safety or privacy of a Member, as determined by KFHP in good faith; or (iv) Provider files a petition in or for bankruptcy, reorganization or an arrangement with creditors, makes a general assignment for the benefit of creditors; is adjudged bankrupt, unable to pay debts as they come due; has a trustee, receiver or other custodian appointed on its behalf; or has a case or proceeding commenced against it under any bankruptcy or insolvency Law (collectively, "Bankrupt"); or (v) Provider undergoes dissolution, merger or consolidation, the sale of all or substantially all of its assets or a direct or indirect change of control, ownership or legal structure.

4.2.3 **Termination With Cause By Provider.**

4.2.3.1 **With Cure Period.** If KFHP fails to comply with a material provision of this Agreement, Provider may terminate this Agreement effective no less than sixty (60) Calendar Days from the date of Provider's written notice, if KFHP fails to cure the noncompliance to the satisfaction of Provider within thirty (30) Calendar Days of the notice, which notice shall specify the noncompliance and request that it be cured. Without limitation, the following constitute possible causes for Provider's termination of this Agreement under this Section: (i) KFHP fails to make payments of undisputed amounts due Provider under the terms of this Agreement; or (ii) any Official revokes, suspends, restricts or fails to renew a license, permit or certification necessary for KFHP to perform its obligations under this Agreement.

4.3 **Suspension or Exclusion of Participation.**

4.3.1 **Suspension or Exclusion With Notice Period.** In accordance with applicable law, KFHP may, at any time and for any reason or no reason, suspend or exclude the participation of a Practitioner or Facility under this Agreement by giving at least sixty (60) Calendar Days prior written notice to Provider, unless patient care or safety requires less or no notice.

4.3.2 **Suspension or Exclusion Without Notice Period.** In accordance with applicable Law, KFHP may immediately suspend or exclude the participation of a Practitioner or Facility under this Agreement (without terminating the Agreement), as specified in a written notice if KFHP determines that: (i) any Official revokes, suspends, restricts or fails to renew any Essential Permit applicable to Practitioner or Facility; or (ii) Practitioner or Facility demonstrates conduct (through act or omission) likely to result in revocation, suspension, restriction or nonrenewal of an Essential Permit applicable to Practitioner or Facility, as determined by KFHP in good faith, including misrepresentation or falsification of information submitted in support of an Essential Permit; or (iii) Practitioner or Facility is sanctioned under or debarred, suspended, or excluded from any federal program (including Medicare or Medicaid) or identified in a

federal list of excluded entities or individuals, including lists maintained by the General Services Administration, Office of Inspector General, Department of Health and Human Services, or Office of Foreign Assets Control, or has opted out of a Medicare or Medicaid program; or (iv) criminal charges are filed against a Practitioner or Facility for any act involving professional misconduct or moral turpitude; or (v) Practitioner or Facility fails to comply with or rectify noncompliance with any material provision of this Agreement or the Provider Manual (including KP's QI and UM Programs) within a time period acceptable to KFHP; or (vi) Practitioner or Facility fails to adequately provide or becomes incapable of adequately providing Covered Services; or (vii) Practitioner or Facility demonstrates conduct (through act or omission) that threatens the health, safety or privacy of a Member, as determined by KFHP in good faith.

4.4 **Effect of Termination.**

4.4.1 **Reserved.**

4.4.2 **Cooperation in Transfer of Members.** Upon termination of this Agreement, Provider shall cooperate, and shall require any Subcontractor to cooperate, with KP in the transfer of Members to other practitioners or facilities contracting with KP.

4.4.3 **Continuation of Care Obligations.** Upon expiration or termination of this Agreement, or suspension or exclusion under this Article 4, Provider shall continue to provide Covered Services pursuant to all of the terms and conditions set forth in this Agreement and the Provider Manual to Members who are under the care of Provider at the time of termination, suspension or exclusion for those specific conditions for which Member is under the care of Provider, and in accordance with the limitations and mandated time period applicable by Law to the Payor issuing the Membership Agreement. As required by Law, in the event of KP insolvency or other cessation of operations, Provider shall continue to provide Covered Services through the period for which dues or premiums have been paid, or if a Member is confined in a Facility on the date of insolvency or other cessation of operations, until the Member can be discharged in accordance with an appropriate professional standard of care.

4.4.4 **All Payors.** Termination of the Agreement with respect to KFHP shall constitute termination of the Agreement with respect to all Payors.

4.5 **Survival of Obligations.** With respect to the provision of Covered Services to Members following the expiration of the Agreement or termination of the Agreement (regardless of the cause giving rise to termination), the following obligations of KFHP and Provider shall survive: Section 2.4 (Quality Assurance, Quality Management and Quality Improvement), Section 2.5 (Utilization Management and Review), Section 2.10 (Subcontracts), Section 2.11 (Activities Delegated to Provider), Section 3.1 (Payment of Compensation), Section 3.2 (Adjustments to Payment), Section 3.3 (Member Hold Harmless), Section 3.5 (Billing Members), Section 3.6 (Billing Other Responsible Payors), Section 4.4 (Effect of Termination), Article 5 (Dispute Resolution), Article 6 (Records and Confidentiality), Article 7 (Compliance), Section 8.1.1 (Notice of Complaints), Section 8.1.5 (Notice of Pending Actions), Article 9 (Insurance and Indemnification), Section 10.1 (Assignment and Delegation), Section 10.4 (Use of Name), Section 10.5 (Publicity), and any other supplemental provision in any exhibit.

ARTICLE 5. DISPUTE RESOLUTION

5.1 **Disputes Between KFHP and Provider, Generally.** The dispute resolution provisions set forth herein shall apply to all claims and disputes between the parties arising from, relating to or in connection with this Agreement, including the performance of or failure to perform any term, condition or covenant herein ("**Dispute(s)**").

5.1.1 **Provider Appeals Process.** KP maintains a provider appeals process described in the Provider Manual to resolve Disputes arising from this Agreement. Except as otherwise set forth herein, Disputes must be submitted in accordance with the procedural requirements set forth in the Provider Manual.

5.1.2 **Meet and Confer.** For any dispute not subject to the provider appeal process or not resolved thereby, or if a party has a Dispute it seeks to address informally, the parties shall use reasonable efforts to informally meet and confer to try and resolve the Dispute. The parties agree to meet and confer within thirty (30) Calendar Days of a

written request submitted as set forth in Section 8.2 (Procedure for Giving Notice) by a party in an effort to settle any Dispute. If the written request specifically references this Section 5.1.2 (Meet and Confer), and either party fails to meet within the thirty (30) day period, that party shall be deemed to have waived the meet and confer requirement, and at the other party's option, the Dispute may proceed immediately to arbitration. At each meet and confer meeting, each party shall be represented by persons with final authority to settle the Dispute.

5.1.3 **Mediation**. If the parties are not able to resolve the Dispute through the meet and confer process, upon mutual agreement, they may submit the Dispute to mediation to be conducted by a retired judge of the Hawaii (Circuit Court or above) or United States District courts of Hawaii (the "**Mediator**") in accordance with the following provisions:

5.1.3.1 **Mediator Selection**. The Mediator shall be selected as soon as reasonably possible but in no event later than thirty (30) Calendar Days following the parties' agreement to mediate. The parties agree that mediation is most likely to be productive if they use an experienced mediator agreeable to both parties and they shall, therefore, use their best efforts to agree on a Mediator as soon as practical after they agree to mediate. If they are unable to agree upon a Mediator during that thirty (30) Calendar Day period, the matter shall be submitted to Dispute Prevention and Resolution, Inc. ("DPR") in Honolulu, Hawaii for selection of a DPR panel Mediator.

5.1.3.2 **Mediation Procedures**. The mediation shall commence as soon as possible after the Mediator is identified but in no event later than thirty (30) Calendar Days after the Mediator is identified, unless the parties mutually agree to a different schedule. The mediation of the Dispute shall be completed in no more than one full day, unless the parties agree otherwise or the Mediator believes that additional time would more likely than not lead to resolution of the Dispute. If, as a result of mediation, a voluntary settlement is reached, the parties agree that such settlement will be reduced to writing and signed by all parties. This signed agreement will be treated the same as, and have the same force and effect as, an arbitration award rendered pursuant to Section 5.1.4 (Arbitration). The parties shall be responsible for their own attorney's fees and costs incurred in preparing for and attending the mediation. The parties shall share equally the costs of the mediation. The mediation shall be conducted in Honolulu, Hawaii, unless the parties mutually agree to another location. The entire mediation process shall be confidential and the privileges and protections of applicable Law shall apply.

5.1.4 **Arbitration**. If the Dispute is not resolved by the parties through the methods described in Section 5.1.1 (Provider Appeals Process), Section 5.1.2 (Meet and Confer) or Section 5.1.3 (Mediation) then it shall be submitted to binding arbitration Honolulu, Hawaii. Notice of the party's demand to arbitrate the Dispute shall be given as set forth in Section 8.2 (Procedure for Giving Notice). The arbitration shall be conducted in Honolulu, Hawaii. The construction, validity and performance of all arbitrations conducted pursuant to this Agreement shall be governed by the Law of the State of Hawaii and Section 2 of the Federal Arbitration Act.

5.1.4.1 **Administration of Arbitration**. Unless otherwise agreed to by the parties, the binding arbitration shall be administered by DPR, except that this Agreement shall control in instances where it conflicts with the DPR Rules. Within thirty (30) days after the service of the demand for arbitration, the parties shall agree on a panel of arbitrators from which to select arbitrators or shall agree on particular arbitrators who shall serve for the case. If the parties cannot agree on any panel of arbitrators or particular arbitrators within the thirty (30) days, then the panel of arbitrators shall be that of DPR. Unless the parties agree to any other arbitration service and rules, DPR shall administer the arbitration and its arbitration rules shall govern the arbitration (including rules for selection of arbitrators from a panel of arbitrators, if the parties have not already agreed upon particular arbitrators to serve). The parties shall be responsible for their own attorney's fees and costs incurred in preparing for and attending the arbitration. The parties shall share equally the fees of the Arbitrator. The parties agree that any and all proper parties may be joined in the arbitration, but the parties agree to proceed with arbitration of all Disputes between them even if other parties refuse to participate. The parties agree that in no event shall a Member be considered a proper party for purposes of this Agreement, and the Arbitrator shall not have the power to join a Member as a party.

5.1.4.2 **Arbitrator's Decision**. The Arbitrator shall issue a written reasoned decision setting forth the parties' contentions, findings of fact and conclusions of law applying Hawaii and applicable federal Law (the "Decision") within thirty (30) Calendar Days of the conclusion of the arbitration of each Dispute. For arbitration awards

of two hundred fifty thousand ($250,000.00) or more, the Arbitrator shall issue a tentative Decision within such thirty (30) day period and the parties may each file a response to the tentative Decision within ten (10) Calendar Days of the date it is issued. In addition, at the request of any party, the Arbitrator shall conduct a hearing on the tentative Decision, which shall be held within thirty (30) days of the date of the tentative decision or the earliest possible date thereafter that is mutually agreed to by the parties and the Arbitrator. The Arbitrator shall then have twenty (20) additional Calendar Days to issue the final Decision. The Arbitrator's final Decision shall be conclusive and binding, and it may be confirmed thereafter as a judgment by the Superior Court of the State of Hawaii. By agreeing to binding arbitration as set forth in Section 5.1.4 (Arbitration), the parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a Dispute between them were determined by litigation in a court, including the right to a jury trial, attorneys' fees and certain rights of appeal.

5.1.5 **Confidential Information**. The parties acknowledge and agree that Disputes based on contract interpretation arise, or are likely to arise, in the ordinary course of business and that this fact creates unusually sensitive issues with respect to the exchange of information related to their Dispute(s). The parties agree that it is not their intent to use the process described herein, regardless of the forum, to obtain the other party's highly confidential and proprietary business information, nor will the parties so use the information except to the extent that such information is critical to the presentation of a party's case or defense. Where appropriate, the parties shall enter into protective orders, and those protective orders shall include creating a category of discovery documents "for attorney's eyes only," which shall provide that counsel, including in-house counsel, to whom such documents are provided shall not participate in, or provide any information to those who participate in, the business negotiations or transactions between the parties. Further, the parties agree to fully cooperate with each other in ensuring that discovery materials which are subject to protective orders are and remain sealed by a court and/or Arbitrator, including, joining in any motion or application for an order the court/Arbitrator accept and seal such documents and/or information. At the conclusion of the Dispute, whenever feasible, each party shall return or destroy all such information, and shall provide to the other party an authorized representative's attestation indicating that all such information has been returned or destroyed.

5.1.6 **Injunctive Relief.** The parties agree that a breach of the confidentiality obligations set forth in this Agreement, including Article 6 (Records and Confidentiality), would cause irreparable injury to the injured party which could not be compensated adequately in damages, and that the injured party shall be entitled, in addition to any other remedies or damages, to injunctive relief to restrain violation of such confidentiality obligations, without the necessity of proving irreparable injury. Such injunctive relief shall be granted without requiring the injured party to post bond or other security. Any party may seek such temporary or preliminary injunctive relief in a court of competent jurisdiction to restrain a violation of the confidentiality obligations, or other provisions of this Agreement, but any permanent injunctive relief, including permanent injunctive relief to restrain the violation of other obligations under this Agreement, shall be resolved by arbitration in accordance with Section 5.1.4 (Arbitration) above. The arbitrator(s) shall have authority to issue final injunctive relief, and any orders necessary to carry out that relief, and such orders shall be confirmed as an enforceable judgment in a court of competent jurisdiction.

5.2 **Disputes Between a Member and Provider.**

5.2.1 **Disputes between Member and Provider (excluding QUEST Integration and Medicaid Members).** Provider shall cooperate with KP in identifying, processing and resolving all Complaints. Provider shall comply with the resolution of any such Complaints by KFHP (or the Payor issuing the applicable Membership Agreement). All decisions regarding Covered Benefits for Members are reserved to KFHP (or the Payor issuing the applicable Membership Agreement), and Provider shall refer Members who have inquiries or disputes regarding Covered Benefits to KFHP (or the Payor issuing the applicable Membership Agreement) for response and resolution. .

5.2.2 **Disputes between Provider and QUEST Integration Member or Medicaid Member.** Notwithstanding Section 5.2.1. above, if any QUEST Integration or Medicaid Member makes any claim against Provider arising out of Covered Services provided hereunder, such claim shall be resolved in accordance with the State of Hawaii MedQUEST program guidelines

5.3 **Claim Disputes Between an Other Payor and Provider.** Claims payment disputes arising from, or related to, Services rendered to Members for which an Other Payor is financially responsible shall be resolved pursuant to the claims dispute resolution process set forth in the applicable Provider Manual and shall not constitute an event giving Provider the right to terminate the Agreement with cause.

ARTICLE 6. RECORDS AND CONFIDENTIALITY

6.1 **Maintenance of Records.** Provider shall maintain Records, regardless of the form of such Records (e.g., paper, film, electronic file, or some other form). Records also include those that are customarily maintained by Provider for purposes of verifying Claims information, reviewing appropriate utilization of Services, and documenting the credentials and privileges of Practitioners. Provider shall maintain accurate Records in accordance with (i) applicable state and federal requirements, including privacy and confidentiality requirements, (ii) general standards applicable to that form of book- or record-keeping, and (iii) KP policies, including those described in the Provider Manual. Provider shall preserve Records for the longest of: (i) one (1) year after the Member reaches the age of majority, if the Member is a minor; (ii) six (6) years from the effective date of termination of this Agreement or from the date of completion of any audit conducted by the Department of Health and Human Services, the Comptroller General or their designees, whichever is longer, or longer if so required by CMS (for example, ten (10) years for Records of Medicare Advantage Members); or (iii) the period of time required by Law, and by the Medicare and Medicaid programs and contracts to which KP is subject.

6.2 **Access to Records**. To the extent permitted by Law and subject to reasonable request and notification, KP, the applicable Payor, and their authorized agents shall have access to and may inspect the Records, including for the purpose of (i) meeting legal, regulatory and accreditation requirements applicable to KP or the applicable Payor or (ii) addressing any inquiry from an Official. In addition, in accordance with Law, Provider shall allow KP and the applicable Payor access to Provider's QI and UM information concerning Covered Services provided to Members and shall provide for timely access by Members to their medical records and other relevant information. .

6.3 **Copies of Records and Other Information**. To the extent permitted by Law and without charge, Provider shall promptly forward to KP and the applicable Payor (i) copies of initial consultation reports upon completion of such consultations and (ii) summaries of patient care or patient results upon completion of such patient care or discharge, both as directed by KP. Upon request and without charge, Provider shall promptly furnish to KP and the applicable Payor copies of Records, including medical records of Members transferred or repatriated following termination of this Agreement pursuant to Section 4.2 (Termination of this Agreement) or following suspension or exclusion of participation of a Practitioner or Facility under Section 4.3 (Suspension or Exclusion of Participation). Upon request and consistent with applicable Law, Provider shall transmit Records to KP and the applicable Payor by facsimile or other electronic means. Subject to reasonable request and notification, KP may arrange for copying of Records to which it/they is/are entitled under this Agreement through a copying service. In addition, Provider shall supply KP with periodic reports and other information (including Provider's policies and procedures, patient care protocols, any mutually agreed upon quality indicators, survey reports, investigations, assessments, formal evaluations or citations) pertaining to Covered Services provided to Members by Provider in such manner and time frames that enable KP to conduct its QI and UM activities and to meet all federal, state, accreditation and contractual reporting requirements (including with respect to QI and UM activities, and Delegated Activities). Upon request, Provider shall provide any data, information and records that KP is required to review for KP's QI and UM programs, licensing, accreditation, or otherwise as required by Law and KP's government contracts.

6.4 **Access for and Disclosure to Officials**. Provider shall comply with all provisions of the Omnibus Reconciliation Act of 1980, the Balanced Budget Act of 1997, the Medicare Prescription Drug Improvement and Modernization Act of 2003, and all other applicable Law regarding access to books, records, documents, and contractual agreements. Without limitation, Provider shall and shall obligate its Subcontractors to maintain, provide access to, and provide copies of Records, this Agreement and other requested information to Officials. Such Records shall be available at all reasonable times at Provider's place of business or at some other mutually agreeable location or as required by such Officials.

6.5 **Inspection**. In addition, at reasonable times and with reasonable notification, Provider shall and shall cause its Subcontractors, Practitioners and Facilities to permit and cooperate with inspections of their sites and Records by KP and/or Officials.

6.6 **Incorporation of Prior Medical Data**. If KP supplies Provider with medically acceptable copies of prior medical histories, tests (such as laboratory, radiology or other diagnostic tests), reports (such as pre-admission and pre-operative reports) and examinations (collectively, "**Medical Data**") for a Member, such Medical Data shall become part of Provider's medical record for that Member to the extent permitted by Law. Provider shall accept such Medical Data and shall not require Members to repeat such Medical Data, unless required by the Member's medical condition, the accreditation organization applicable to Provider, or applicable Law.

6.7 **Confidentiality of Information.**

6.7.1 **Confidential Information Defined**. The parties shall keep in strictest confidence and in compliance with all applicable Law: (i) the terms of this Agreement; (ii) any patient information, including a Member's name, address and health records (including mental health records); (iii) information concerning any matter relating to the business of the other, including the other's employees, products, services, membership, prices, operations, business systems, planning and finance, policies, procedures and practice guidelines; (iv) materials, data, data elements, records or other information obtained from the other during the course of or pursuant to this Agreement; and (v) any information learned while performing obligations under this Agreement, which if provided by the other, would be required to be kept confidential (collectively, "**Confidential Information**") under this Section 6.7 (Confidentiality of Information). Subject to applicable Law and except as provided in Section 6.7.2 (Exceptions), neither party shall disclose Confidential Information to a third party unless authorized in writing in advance by the other, provided however that patient information may be disclosed to the patient, the patient's authorized representative, Practitioners participating in the patient's care, and others as permitted by Law.

6.7.2 **Exceptions**. The prohibitions on disclosure set forth in Section 6.7.1 (Confidential Information Defined) do not apply to information that (i) is required by Law to be disclosed or to be provided to Officials; (ii) is required by accreditation organizations of KP or Provider; (iii) is disclosed in legal or government administrative proceedings; (iv) was publicly known at the time of the disclosure; (v) becomes publicly known through no fault of the disclosing party after the disclosing party's receipt of the Confidential Information; (vi) was developed by the disclosing party independently of and without reference to any of the other party's Confidential Information; (vii) is disclosed as necessary to enforce a party's rights for coordination of benefits, liens, reimbursement or subrogation; or (viii) is disclosed as necessary to a party's agents and affiliates to perform essential corporate activities (including activities delegated in accordance with Section 10.1 (Assignment and Delegation)), as permitted by Law. The prohibitions on disclosure also do not apply to payment information provided to Members with Member Cost Share.

6.8 **Certification of Accuracy of Data**. Provider recognizes that KP is required to certify the accuracy, completeness and truthfulness of data that CMS and other local, state and federal governmental agencies and accrediting organizations request. Such data include encounter data, payment data, and any other information provided to KP by its providers. Provider hereby represents and warrants that any such data submitted to KP by Provider shall be accurate, complete and truthful. Upon KP's request, Provider shall make such certification in the form and manner specified by KP in order to meet KP's legal, regulatory, accreditation and contractual requirements.

6.9 **HIPAA**. Provider understands and agrees that this Agreement and certain data exchanged hereunder may be subject to the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-91), the Health Information Technology and Economic and Clinical Health Act (42 USC 300(j)), and all implementing regulations (collectively, "**HIPAA**"). If Provider is or becomes a "Covered Entity" as defined by HIPAA, Provider shall comply with all relevant HIPAA requirements. If Provider is a "Business Associate" of KFHP as defined by HIPAA, Provider shall execute a Business Associate Agreement with KFHP.

ARTICLE 7. COMPLIANCE

7.1 **Compliance with Laws.**

7.1.1 **Generally**. Provider represents and warrants that it is currently and for the term of the Agreement shall remain in compliance with all applicable Law. Provider shall cooperate with KP in maintaining KFHP's compliance with applicable Law for provision of Covered Services to Members under this Agreement, and when required to maintain KFHP's licenses, comply with the relevant provisions of such Law. KP acknowledges that it is subject to applicable Law, as monitored and enforced by relevant Officials.

7.1.2 **Medicare/Medicaid**. Provider represents and warrants that it is currently and for the term of the Agreement shall remain in compliance with all applicable Laws and CMS instructions necessary for participation in the Medicare and Medicaid programs, the applicable Medicare and Medicaid conditions of participation. Provider further represents and warrants that it is not currently and for the term of the Agreement shall not be sanctioned under or debarred, suspended or excluded from any federal program, including Medicare or Medicaid, or be identified in a federal list of excluded entities or individuals, including lists maintained by the General Services Administration, Office of Inspector General, Department of Health and Human Services, or Office of Foreign Assets Control. With respect to Covered Services provided to Members, Provider shall not knowingly (and shall use best efforts not to) employ or contract with, directly or indirectly, entities or individuals (i) sanctioned by or debarred, suspended, or excluded from participation in Medicare or Medicaid under Sections 1128 or 1128A of the Social Security Act, or (ii) who have opted out of Medicare for the provision of health care services, utilization review, medical social work or administrative services to Members. If Provider becomes aware that it has employed or contracted with a debarred, suspended or excluded person, Provider shall take prompt and appropriate remedial action. With respect to Covered Services provided to Medicaid or Medicare Members, Provider shall comply with (i) Exhibit 3 (Billing and Payment), (ii) all applicable Laws governing the applicable Medicaid or Medicare programs and (iii) the obligations in the contracts between KFHP and CMS (and with respect to Medicaid, between KFHP and State agencies and their subcontractors) governing KP's participation in such programs, including the requirements identified in Exhibit 6 (Federal Program Compliance). Any provision required to be in this Agreement by the Laws governing the Medicaid or Medicare programs shall bind the parties, whether or not provided in this Agreement. With respect to Covered Services provided to Medicaid Members, Provider shall also comply with the applicable policies and procedures regarding identifying, referring and treating special Medicaid Member populations as well as the provisions set forth in Exhibit 5 (QUEST Integration Program Requirements). With respect to Covered Services provided to FEHBP Members, Provider acknowledges the requirements identified in Exhibit 6 (Federal Program Compliance).

7.1.3 **Nondiscrimination**. Provider shall provide Services to Members without discrimination on the basis of race, color, gender, sex, creed, religion, national origin, age, physical or mental disability, genetic information, veteran's status, marital status, sexual orientation, gender identity, income, source of payment, health status (including medical condition, claims experience, receipt of health care, medical history, genetic information), evidence of insurability, and conditions arising out of acts of domestic violence, status as a Member or as a participant in a publicly financed program, whether a Member has filed a Complaint, whether a Member has executed an advance directive, or other status protected by applicable Laws. Provider shall make Services available to all classes of Members, in the same manner, in accordance with the same standards, and with the same availability, as to Provider's other patients. Provider shall not refuse to provide Covered Services to Members participating in a publicly financed health care program. In addition, during the performance of this Agreement, Provider shall comply with Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, and the Rehabilitation Act of 1973, all as amended; shall provide reasonable access and accommodation to persons with disability to the extent required of a health services provider under the Americans with Disabilities Act, or any applicable state Law; and shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment on the basis of any factor prohibited by Law, including for denial of family care leave or any factor already delineated in this Section 7.1.3 (Nondiscrimination).

7.2 **Licensure, Accreditation and Certification**. Provider represents and warrants that it (together with its Practitioners, Facilities and Subcontractors providing Services) shall be and shall remain throughout the term of this Agreement, as applicable: duly licensed by the state(s) where Services are rendered to Members; accredited by the relevant accreditation organization(s) required by KP; certified by the relevant certification organization(s); and be

enrolled in, participate in, meet coverage conditions for and where applicable under CMS rules, be certified by the Medicare and Medicaid programs. Provider shall comply with the standards of any organization accrediting KP, as they apply to the Services provided by Provider under this Agreement. In addition, Provider further represents that each Practitioner through whom it or any Subcontractor provides Services shall, as applicable (i) maintain a current, unrestricted license to practice his/her profession or vocation in the state(s) where Services are provided, (ii) provide Services only within the scope of his/her licensure, certification, training and experience, and (iii) be certified by the appropriate medical specialty board(s) (for physicians) or by the appropriate vocational or professional board(s) or agency(ies) to provide Services, as required by Law or by Program Requirements (including KP credentialing requirements).

7.2.1 **Evidence of Licensure, Accreditation and Certification**. Provider shall promptly provide documentary evidence of its and its Practitioners' Facilities' licensing, certification, accreditation and qualifications (i) upon obtaining them, (ii) upon any material change to them, and (iii) periodically upon KP's request. Upon request, Provider shall provide KP with copies of survey reports, investigations, assessments, formal evaluations or citations of Provider by any regulatory or governmental agency or accreditation organization applicable to Provider and that have more than a minimal likelihood of materially affecting Provider's ability to perform its obligations under this Agreement. Provider shall notify KP of changes to applicable licenses, certifications, accreditations, and qualifications in accordance with Section 8.1 (Provider's Responsibility to Notify KP).

7.2.2 **Approval of Practitioners and Facilities**. With respect to Covered Services to Members, KP retains the right, as part of its QI and UM programs, to approve new Practitioners and Facilities.

7.2.3 **The Joint Commission Standards**. To the extent Provider provides Services in conjunction with KFH, which is accredited by The Joint Commission, Provider agrees to provide such Services in accordance with The Joint Commission standards.

7.3 **KP Credentialing.** Provider and its Facilities, shall be and shall remain throughout the term of this Agreement, credentialed and privileged, as applicable, including its Practitioners consistent with KP's credentialing requirements prior to providing Covered Services to Members, and shall be recredentialed and reprivileged, as applicable, in accordance with KP credentialing and privileging policies. Provider shall be obligated and shall obligate its Subcontractors and its/their Practitioners and Facilities to cooperate with KP's credentialing and privileging processes.

7.4 **Government Contractor**. Provider recognizes that as a government contractor, KP is subject to various Laws and executive orders regarding equal opportunity and affirmative action which also may be applicable to KP's subcontractors, including Provider and its Subcontractors. Provider, therefore, agrees that any and all applicable equal opportunity and affirmative action clauses from the Federal Acquisition Regulations (FAR) at 48 CFR Part 52 shall be incorporated herein by reference as required by federal Laws and executive orders, including the following FAR clauses: (a) Equal Opportunity (April 2002) at FAR 52.222-26; (b) Equal Opportunity for Special Disabled Veterans, Veterans of the Vietnam Era, and Other Eligible Veterans (Sept. 2006) at FAR 52.222-35; (c) Affirmative Action for Workers with Disabilities (June 1998) at FAR 52.222-36, and (d) Utilization of Small Business Concerns (May 2004) at FAR 52.219-8. In addition, Executive Order 13496 (codified at 29 CFR Part 471, Appendix A to Subpart A) concerning the obligations of federal contractors and subcontractors to provide notice to employees about their rights under Federal Labor Laws shall be incorporated herein by reference. If Provider is not otherwise subject to compliance with the Laws and executive orders specified in this Section, the inclusion of this Section shall not be deemed to impose such requirements upon Provider.

7.5 **ERISA**. Notwithstanding any other terms of the Agreement, Other Payors that are the sponsors of self-funded health plans formed pursuant to the requirements of the federal Employee Retirement Income Security Act of 1974 at 29 USC 1001 *et. seq.* ("**ERISA**"), as may be amended and interpreted from time to time, as well as the self-funded health plans formed pursuant to ERISA requirements, shall not be subject to any terms and conditions included in the Agreement solely for the purpose of complying with state Law which is inapplicable (preempted by ERISA) to the sponsor of an ERISA self-funded health benefit plan or to the self-funded health benefit plan itself or which otherwise would be an impermissible direct or indirect regulation of such sponsor or plan in violation of ERISA.

7.6 **Prohibition Against Sending PHI Offshore.** Contractor shall not downstream any obligation of this

Agreement which requires access, use or disclosure of protected health information (PHI), as such term is defined by HIPAA, to any Subcontractor that is not located in the United States, or is not subject to the jurisdiction of a court in the United States, nor shall Contractor fulfill any obligation of this Agreement through such means.

7.7 **No Conflict.** Provider represents and warrants that the requirements of this Agreement do not conflict with the terms of its agreements with Subcontractors or with the terms of Provider's employment of Practitioners. Nonetheless, Provider represents that the terms of this Agreement shall apply in any situation where there is an inconsistency or conflict with the terms of any such agreement, and that Provider shall be responsible to KP for any such inconsistency or conflict of terms. This provision shall supersede any similar provision in any agreement between Provider and a Practitioner or a Subcontractor.]

ARTICLE 8. NOTICE

8.1 **Provider's Responsibility to Notify KFHP**. Provider shall provide notice to KFHP in accordance with Section 8.2 (Procedure for Giving Notice) under all applicable circumstances, including:

8.1.1 **Notice of Complaints**. Provider shall promptly notify KFHP of (i) receipt of any Complaints from or on behalf of Members that have not been, in the reasonable judgment of Provider, resolved within two (2) Business Days; (ii) Complaints to Provider regarding discrimination against Members, including discrimination prohibited in Section 7.1.3 (Nondiscrimination); (iii) contact by an attorney regarding any Complaint; (iv) any Complaints of an alleged violation of HIPAA made to Provider by Members; and (v) any Complaints which, by Law or according to the Member's Membership Agreement, must be addressed by KFHP (or the Payor that issues the applicable Membership Agreement).

8.1.2 **Notice of Emergency Services Provided**. Provider shall promptly notify KP of any Emergency Services provided to a Member upon stabilization of the Member's Emergency Medical Condition, in accordance with the procedures described in the Provider Manual.

8.1.3 **Notice of Changes in Subcontract**. Provider shall notify KFHP within thirty (30) Calendar Days after Provider and any Subcontractor make a material change to their Subcontract that may impact Covered Services provided to Members.

8.1.4 **Notice of Changes in Provider Status**. Provider has an affirmative obligation to be aware of and shall notify KFHP in writing, within five (5) Business Days of Provider's knowledge of the pending occurrence of any of the following events and promptly after the occurrence of any of the following events: (i) there is any material change in the credentialing status of Provider or any Facility; or (ii) there is any incident that may affect any license, certification, or accreditation held by Provider or any Facility, if any, or that may materially affect performance of its/their obligations under this Agreement, or that may be reasonably be interpreted as negatively affecting KP's reputation or operations; (iii) any change in Provider's operations (including termination, suspension or interruption of any Services) that will materially affect the manner in which it provides Covered Services to Members or that will result in cessation or suspension of any Services; (iv) any unusual occurrence that affects any Member receiving Covered Services (including a Member's death or serious physical or psychological injury or risk thereof), or that is required to be reported to any governmental or regulatory body or to an accreditation organization; (v) any change in legal status, tax identification number, Medicare or Medicaid number; (vi) any material change in ownership, control, name, or location; and (vii) any other event or circumstance that materially impairs Provider's ability to provide Covered Services to Members as required by this Agreement or the Provider Manual including Provider's inability to provide Covered Services at a Facility at which KP expects Provider to provide Covered Services.

8.1.5 **Notice of Pending Actions**. Provider shall promptly provide written notification to KFHP (i) of the initiation of any legal action, accreditation organization action, or, regulatory or governmental action that has more than a minimal likelihood of materially affecting Provider's ability to perform its obligations under this Agreement; (ii) of an investigation regarding sanction under or debarment, exclusion or suspension from any federal program, including Medicare or Medicaid; (iii) any inquiry or formal action, proceeding, or investigation is initiated against Provider or any Facility by an accreditation organization; (iv) Provider or any Facility is the subject of any legal or governmental action

concerning qualifications or ability to perform Services; (v) any professional liability claim filed or asserted regarding Services provided to Members by or on behalf of Provider; and (vi) the initiation of any legal action [related to Covered Services] filed by a Member against Provider or a Facility.

8.1.6 **Notice of Changes in Insurance**. Provider shall provide KFHP at least thirty (30) Calendar Days prior written notice before Provider's insurance coverage is cancelled, terminated, not renewed, modified or expired. Provider shall or shall require that its insurance carrier notify KFHP at the time of any material change in insurance carrier, limits or deductibles to the extent that such change may impact Provider's compliance with the terms of the Agreement.

8.1.7 **Notice of Condition for Termination, Suspension or Exclusion**. Provider has an affirmative obligation to be aware of and shall notify KFHP in writing, within five (5) Business Days of Provider's knowledge of the pending occurrence of, and promptly after the occurrence of any condition evoking cause for termination of the Agreement in Section 4.2.2 (Termination With Cause by KFHP) or for suspension or exclusion of participation of a Practitioner or Facility in Section 4.3.2 (Suspension or Exclusion Without Notice Period).

8.2 **Procedure for Giving Notice.** All notices provided under this Agreement shall be in writing, signed by an authorized signatory, and shall be deemed give upon receipt if sent as follows: (i) personally delivered; (ii) sent by confirmed overnight mail by United States Postal Service; (iii) sent by a commercial service with confirmed delivery; (iv) sent by confirmed facsimile; (v) sent by confirmed electronic mail in Adobe PDF or similar format; or (vi) sent by certified mail (return receipt requested). Notices shall be addressed in accordance with the parties' contact information set forth in the Agreement, as may be amended from time to time.

KFHP:

KAISER FOUNDATION HEALTH PLAN

Kaiser Foundation Health Plan, Inc.

2828 Pa'a Street, Suite 3080

Honolulu, Hawaii 96819

Attn: Director, Provider Contracting and Relations

PROVIDER:

[INSERT PROVIDER NAME]

If notice is mailed, delivery is effective at the date and time shown on the confirmation or return receipt. Any party may change its address for notice purposes by written notice to the other party.

8.3 **Identification of Payors**. KFHP shall distribute to Provider periodically, but no less often than annually or as may otherwise be required by Law, a list of Payors. As of the Effective Date, such list is composed of the Payors shown in Exhibit 4 (Payors), which is attached hereto and incorporated herein by this reference. To the extent allowed by applicable Law, KP reserves the right to make additions and deletions to and otherwise to modify such list.

ARTICLE 9. INSURANCE AND INDEMNIFICATION

9.1 **Insurance.**

9.1.1 **Provider Insurance.** Unless otherwise set forth in Exhibit 1 (Additional Terms), Provider shall maintain or cause to be maintained the following insurance coverage, either through insurance coverage or through self-insurance programs that are expressly approved by KFHP, covering itself and each person through whom Provider provides Covered Services to Members under this Agreement at the following levels: (i) commercial general liability and property damage insurance with limits of liability not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) annual aggregate, (ii) a policy of professional liability insurance with limits of liability not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) annual aggregate and (iii) such other insurance or self insurance acceptable to KFHP as shall be necessary to insure it against any claim(s) for damages arising under this Agreement, including claims arising by reason of bodily injury, property damage, personal injury or death in connection with the performance of any Service, or use of any property or location pursuant to this Agreement. Such insurance coverage shall apply to Provider, all Practitioners and Facilities of Provider through which Covered Services are provided to Members under this Agreement and to any other Covered Services provided by Provider (or its Subcontractors) to Members under this Agreement, whether at any KP facility or any other site. Provider shall notify KFHP of changes to insurance in accordance with Section 8.1.6 (Notice of Changes in Insurance).

9.1.1.1 **Standards**. All required insurance under this Section shall be obtained from companies duly licensed to do business in the State of Hawaii, or the state in which Services are delivered and that either (i) has a Best's rating of at least "A" or has a comparable rating from another rating company or (ii) is acceptable to KFHP. Provider shall provide certificates of insurance evidencing such coverage to KFHP upon execution of this Agreement in a form acceptable to KFHP, and from time to time thereafter upon request. KFHP may also accept those self-insurance programs that are deemed appropriate to KFHP.

9.1.1.2 **Tail Coverage**. If Provider obtains one or more claims-made insurance policies to fulfill its obligations under this Section, Provider shall (i) maintain coverage with the same company during the term of this Agreement and for at least five (5) years following termination of this Agreement, or (ii) purchase or provide coverage that assures protection against claims based on acts or omissions that occur during the period of this Agreement but which are asserted after the claims-made insurance policy has expired.

9.2 **Indemnification.**

9.2.1 **Provider Indemnification**. Provider shall indemnify and hold harmless Kaiser Payors, and each of their respective officers, directors, partners, shareholders, agents and employees to the extent allowed by Law, from and against any and all demands, claims, losses, damages, liability, costs, expenses (including the payment of attorneys' fees and costs actually incurred, whether or not litigation is commenced), judgments or obligations, actions or causes of action whatsoever, to the extent arising from or in connection with any acts, failures to act or the performance of or failure to perform obligations hereunder by Provider, its officers, partners, employees, Subcontractors or agents.

9.2.2 **KFHP Indemnification**. KFHP shall indemnify and hold harmless Provider, its officers, directors, partners, shareholders, agents and employees to the extent allowed by Law, from and against any and all demands, claims, losses, damages, liability, costs, expenses (including the payment of attorneys' fees and costs actually incurred, whether or not litigation is commenced), judgments or obligations, actions or causes of action whatsoever, to the extent arising from or in connection with any acts, failures to act or the performance of or failure to perform obligations hereunder by KFHP, its officers, partners, employees, or agents.

9.3 **Cooperation of the Parties**. The parties shall cooperate with each other in the investigation and disposition of any claims arising out of or relating to this Agreement, provided that nothing shall require either party to cooperate to its own legal detriment, disclose any documents, records or communications that are protected from disclosure under the peer review privilege, the attorney-client privilege, the attorney work-product doctrine or other rules governing such privileged materials.

ARTICLE 10. MISCELLANEOUS

10.1 **Assignment and Delegation**. Except as otherwise provided in this Agreement, Provider will not assign this Agreement, or any rights hereunder, or subcontract or delegate any of its duties and obligations under this Agreement without the prior written consent of KFHP. Any material change of ownership or control of Provider or Provider's assets will be deemed an assignment. In any event, all obligations of Provider under this Agreement will be enforceable against any permitted successors and assigns. In the event of a sale, lease or other transfer of Provider's ownership or control, Provider shall, unless KFHP objects, ensure that the buyer, lessee or transferee agrees to enter into a services agreement with KP pursuant to which such buyer, lessee or transferee will provide Covered Services to Members under the same terms and conditions and for the same rates as KFHP is obligated to pay to Provider for such Covered Services hereunder. No transfer of the duties, rights or obligations of this Agreement, nor the change of ownership or transfer of assets shall be deemed to modify, reduce, or limit Provider's duty to either obligate any successor or assignee to provide all Covered Services at the designated Facilities pursuant to the terms and conditions of this Agreement, or to continue performing the full duties and obligations of this Agreement. Further, any succession or assignment without KFHP's express written consent will not relieve or otherwise affect the liability of the predecessor or assignor, who will remain liable, jointly and severally with the successor or assignee. Provider understands and agrees that KFHP may assign this Agreement and its duties under this Agreement and delegate its rights under this Agreement to any KP entity or affiliate. Furthermore, the applicable Payor may delegate the obligations of claims adjudication, claims payment, and other administrative obligations (including medical management, credentialing and network administration) to Kaiser ASO and/or a third party administrator. Delegation of claims adjudication and claims payment obligations does not release the applicable Payor of its financial responsibility for payment.

10.2 **No Third Party Beneficiaries**. Nothing in this Agreement will be construed to give any person other than Provider or KP any benefits, rights or remedies, except that Members will be a third party beneficiary of Section 3.3 (Member Hold Harmless) and Section 4.4.3 (Continuation of Care Obligations), and each Payor, at its option, will have access to rates in Exhibit 3 (Billing and Payment).

10.3 **Force Majeure**. Either party shall be excused from any inability to meet any or all of its obligations under this Agreement due to extraordinary circumstances beyond its reasonable control occasioned by war, acts of government, labor disputes, acts of terrorism, fire, flood, earthquake, extreme weather or other acts of nature provided that the affected party gives prompt written notice to the other party within two (2) Business Days of discovery, or as soon as practicable, of any of the foregoing events or conditions, including a description with the date of occurrence and the anticipated duration. Any party giving such notice must use its best efforts to minimize potential adverse effects to the other party, and the other party shall be entitled to take any necessary measures or actions, including temporarily subcontracting the obligations of the noticing party until the fulfillment of the obligations under the Agreement can be resumed for the balance of the term.

10.4 **Use of Name**. Each party reserves to itself the right to, and the control of the use of, its names, symbols, trademarks and service marks, presently existing or hereafter established, and no party shall use another party's names, symbols, trademarks or service marks in any advertising or promotional materials or communication of any type or otherwise without the latter party's prior written consent. Notwithstanding the foregoing, Provider consents to KP's use of its name, address and telephone number in lists of practitioners and facilities and other marketing materials that KP may publish from time to time during the term of this Agreement.

10.5 **Publicity**. In the interest of presenting accurate information to the general public and Members, and of maintaining good public relations, the parties shall consult with each other regarding any issue relating to this Agreement or the delivery of Covered Services to Members under this Agreement that gives rise to media interest or public relations concern, and shall cooperate in developing any statements or press releases in connection with any such issue.

10.6 **Governing Law**. The validity, enforceability and interpretation of any provision of this Agreement shall be governed by the Law of the State of Hawaii and by any applicable federal Law. Any provision required to be in this Agreement by Law regulating KFHP shall bind the parties whether or not specifically articulated in this Agreement. This Agreement shall be construed and governed in accordance with applicable contractual requirements imposed upon KP by the Medicaid, Medicare, relevant State of Hawaii public employment benefits and FEHBP contracts.

10.7 **Severability**. If any provision is determined invalid, void or unenforceable, in whole or in part, the remaining provisions shall remain in full force and effect.

10.8 **Waiver**. A failure of any party to exercise any provision of this Agreement shall not be deemed a waiver. Any waiver of any provision of this Agreement shall be in writing and signed by the party against whom the waiver is sought to be enforced. Any such waiver shall not operate or be construed as a waiver of any other provision of this Agreement or a future waiver of the same provision.

10.9 **Amendment.**

10.9.1 **Amendment by Mutual Consent**. Except as otherwise set forth in this Agreement, amendments to this Agreement may be adopted by mutual consent in a written amendment signed by the parties.

10.9.2 **Legally Required Modification**. Notwithstanding any other provision of this Agreement, if KP reasonably determines that a modification of this Agreement is necessary to cause it to conform with Law, or the requirements imposed upon KP by an accrediting or regulatory agency, or in order for KP to participate in government-funded health plan products (a "**Legally Required Modification**"), then KP shall give Provider written notice of the proposed Legally Required Modification and the date on which it is to go into effect, which shall not be less than thirty (30) Business Days following the date of the notice, unless a different period is required by Law or Officials, and the legally required modification shall be effective on that date specified in the notice.

10.9.3 **Change to Provider Manual**. Where permissible by Law, KP retains the unilateral right to amend the Provider Manual, provided such amendment is effective not less than thirty (30) Business Days from the date of notice from KP to Provider.

10.10 **Interpretation of the Agreement**. This Agreement shall be interpreted according to its fair intent and not for or against any one party on the basis of whether such party drafted the Agreement. The captions or section headings are for convenience of reference only and shall not affect in any way the meaning or interpretation of this Agreement. All references to "including" or "include(s)" shall mean "including, without limitation" and "includes(s) without limitation," respectively. The omission of a particular example or the inclusion of any examples shall not be construed to broaden or limit the effect of the language herein.

10.11 **Statutory and Other References**. Any reference to a statute, regulation, executive order, government agency or regulatory body, accreditation standard, or accreditation organization refers to the statute, regulation, executive order, government agency or regulatory body, accreditation standard, or accreditation organization as amended from time to time, and to any successor statute, regulation, executive order, government agency or regulatory body, accreditation standard, or accreditation organization.

10.12 **Counterparts.** This Agreement may be executed in separate counterparts, none of which need contain the signatures of all parties, and each of which, when so executed, shall be deemed an original. Such counterparts shall together constitute and be one of the same instrument. This Agreement may be executed by the exchange of faxed executed copies, certified electronic signatures, or copies delivered by electronic mail in Adobe PDF or similar format, and any signature transmitted by such means for the purpose of executing this Agreement shall be deemed an original signature for purposes of this Agreement.

10.13 **Non-Exclusivity**. Unless otherwise specified in Exhibit 1 (Additional Terms), this is not an exclusive Agreement; Provider and KFHP may enter into similar agreements with other parties; and KFHP reserves the right to arrange for any Services for Members from any other provider.

10.14 **No Volume Guarantee**. Unless otherwise specified in Exhibit 1 (Additional Terms), KFHP does not represent, warrant or covenant any minimum volume of patients or Members that will be referred to Provider under this Agreement.

10.15 **Independent Contractor**. Provider enters into this Agreement, and shall remain throughout the term of this Agreement, as an independent contractor. Nothing in this Agreement is intended to create nor shall it be construed to create between KP and Provider a relationship of principal, agent, employee, partnership, joint venture or association. Neither KP nor Provider has authorization to enter into any contracts, assume any obligations or make any warranties or representations on behalf of the other. No individual through whom Provider renders Services shall be entitled to or shall receive from KP compensation for employment, employee welfare and pension benefits, fringe benefits, or workers' compensation, life or disability insurance or any other benefits of employment, in connection with providing Services. Provider represents and warrants that it shall be responsible for all legally required tax withholding for itself and its employees. References to Provider include reference to Provider, Practitioners and Subcontractors.

10.16 **Remedies Cumulative**. The rights and remedies provided for in this Agreement shall not be exclusive and are in addition to any other rights and remedies that exist in Law or equity.

10.17 **Entire Agreement**. This Agreement, together with all exhibits and sub-exhibits attached hereto and incorporated by reference herein, contains all the terms and conditions between the parties and supersedes any prior contracts, agreements, negotiations, proposals or understandings relating to the subject matter of this Agreement.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their respective duly authorized representatives as of the dates set forth below.

KAISER FOUNDATION HEALTH PLAN for the Hawaii Region	**[INSERT LEGAL NAME OF PROVIDER]**
By: _____	By: _____
Rudy R. Marilla	[Insert full Name of Person Authorized to Sign]
Vice President, Clinical Operations, Contracting, and Community Benefit	[Insert title of Person Authorized to Sign]
Date: _____	Date: _____

EXHIBIT 1

ADDITIONAL TERMS

[INSERT BASED ON FACILITY TYPE: HOSPITAL, SNF, HOSPICE, HOME HEALTH, ETC.]

EXHIBIT 2

PRACTITIONERS AND FACILITIES

This Exhibit 2 incorporates by reference, as applicable, a listing of (i) the Practitioners providing Services to Members under this Agreement, (ii) the name, location, and address of each Facility at which Provider provides Services to Members under this Agreement (including Facilities used by Subcontractors), and (iii) related Provider information as reasonably requested by KP from time to time to administer this Agreement.

Provider shall not use any Practitioner or Facility to deliver Services to a Member under this Agreement unless and until KP (i) approves such Practitioner and/or Facility and (ii) such Practitioner and/or Facility meets the conditions specified in Article 7 (Compliance) of the Agreement.

Whether or not Provider has properly notified KP about the Practitioners (including Subcontractors) providing Services to Members and the Facilities at which Provider provides Services to Members under this Agreement, this Agreement shall be deemed to apply to all Practitioners providing Services to Members and all Facilities where Services are provided to Members.

The following Practitioners and/or Facilities shall be used to deliver Services to Members under this Agreement and may not be removed, as applicable, from this Exhibit 2 except by amendment of the Agreement according to its Section 10.9 (Amendments): **[NAME OF PROVIDER]**

EXHIBIT 3

BILLING AND PAYMENT
FOR FACILITY SERVICES

In accordance with the provisions of Article III (Billing and Payment) and this Exhibit 3, the responsible Payor shall pay compensation to Provider for Covered Services rendered to Members.

I. DESCRIPTION OF SERVICES

For purposes of this Agreement, "Services" are defined as _____

II. INSTRUCTIONS RELATING TO CLAIMS

A. **Billing KP or Third Party Administrator ("TPA").** Provider agrees to bill KP within three hundred sixty five (365) calendar days of the date of Member's treatment or discharge for care received by Members from Provider under the terms and conditions set forth in this Agreement. KP or TPA reserves the right, on a case-by-case basis, to deny payment for any invoices submitted by Provider after three hundred sixty five (365) calendar days from the latter of either: (i) the date of treatment or discharge or (ii) the date of Provider's receipt of an Explanation of Benefits from an alternate insurer. Provider shall waive its right to seek payment from Kaiser Permanente or from Member for any such denied invoices.

B. **Payment by KP.**

1. For those cases for which KFHP coverage is primary, KP shall pay for Services or provide notice of denial within thirty (30) calendar days of receipt of a properly completed Provider bill and any other necessary forms as required by KP.

2. For cases where other insurance is primary, KP liability shall be determined and paid within thirty (30) calendar days of determination of payment by the other carrier (i.e., receipt of bill copy and payment statement or Explanation of Benefits statement).

3. Any disputed invoices will be approved or denied by KP within sixty (60) calendar days of receipt of said notice of dispute.

4. Provider agrees to notify KP in writing if Provider believes it has been incorrectly paid. KP has the right to deny payment for any disputed claim submitted by Provider after three hundred sixty five (365) calendar days from the latter of either (i) the date of treatment or discharge or (ii) the date of Provider's Explanation of Benefits from an alternate insurer Provider shall waive its right to seek payment from Kaiser Permanente or from Member for any such denied disputed claim.

C. **Claim Submission to KP Payors.** Provider shall submit all Claims for Services rendered to Medicaid Members and Commercial Members to KP. Claims shall be submitted in accordance with this Agreement and the billing procedures set forth in the Provider Manual, as a condition for payment.

III. REIMBURSEMENT

When the Services described above are provided to Members in accordance with the terms and conditions of this Agreement, KP will pay, and Provider will accept as payment in full the rates listed below minus any copayments, deductibles or coinsurance payable by Member. For purposes of this Agreement, Provider's billed charges are its usual and customary community charges in effect at the time Services are provided. KFHP, TPA, or Members shall not be responsible to pay any taxes.

A. **Regular Health Plan Members (Commercial Members):** [ENTER PAYMENT TERMS] / REMOVE FOR QI

B. **Medicare Advantage Members**: The responsible Payor shall pay Provider for Covered Services provided to Medicare Advantage Members the lesser of (i) covered billed charges, or (ii) an amount equal to Medicare rates of reimbursement that are current at the time Services are provided.

C. **Medicaid Members (QUEST Integration and QUEST-Net Members).** The responsible Payor shall pay Provider for Covered Services provided to Medicaid Members the least of (i) covered billed charges, or (ii) an amount equal to Medicaid rates of reimbursement that are current at the time Services are provided.

D. **Medicare Cost Members and Medicare FFS Members.** The responsible Payor shall pay Provider for Covered Services provided to Medicare Cost Members (following receipt from Provider of a copy of the Medicare Summary Notice and a Claim): (i) any applicable Member Cost Share for which Payor is responsible unless Provider is directed to collect same, and (ii) any amounts due for Covered Services that are not covered by Medicare, according to the lesser of (a) covered billed charges or (b) the applicable rates set forth below.

E. **Other Primary Insurance:** When another carrier or party (such as Medicare, Medicaid, No-Fault or Workers' Compensation) has primary financial responsibility for payment of Services provided to a Member, Provider will bill such other carriers or parties directly.

Upon Provider's receipt of a Statement of Reimbursement or Explanation of Benefits from the other carrier or party, Provider will submit to KP a copy of such Statement of Reimbursement or Explanation of Benefits from the other carrier or party indicating the applicable copayments or deductibles, within thirty (30) calendar days. Eligible charges payable by KP or TPA shall be determined by KP in accordance with Member's healthcare benefits. In no case will KP pay more in total than what KP would have paid if it were the primary payor, less amounts payable by the primary payor.

When emergency services are provided to Members who have dual insurance coverage, primary coverage will be determined using the National Association of Insurance Commissioners (NAIC) model and the birthday rule.

F. **Other Primary Insurance for Clinic Based Services:** When Services are rendered by Provider in a facility that is owned, rented, managed or leased by Kaiser Permanente, if another carrier or party (such as Medicare, Medicaid, No-Fault or Workers' Compensation) has primary financial responsibility for payment of Services provided to a Member, KP will bill such carriers or parties directly, and retain such charges as an offset for any pre-payments made by KP to Provider for Services rendered.

To avoid duplicative billings, Provider waives his right to receive any reimbursement benefits from a primary financially responsible party and agrees not to bill such party directly, without prior written authorization from KP, after the effective date of this amendment. Provider agrees to cooperate with KP by providing any necessary information for the purpose of billing such primary party for Provider's Services.

When emergency services are provided to Members who have dual insurance coverage, primary coverage will be determined using the National Association of Insurance Commissioners (NAIC) model and the birthday rule.

G. **Non-Members:** KP is not financially responsible for any Services provided to non-Members. Provider may bill either the non-Member's primary health insurance, or the non-Member, whichever is applicable.

IV. **Future Rate Changes.**

A. All requests for rate increases shall be made to KP in writing, and shall be accompanied by appropriate financial information to justify the requested increase amount. In no event shall any rate increase agreed to by the parties exceed the most recently published year-end percentage change in the Consumer Price Index, All Urban Consumers (CPI-U) for the Honolulu area for All Items. Rates shall not be increased more frequently than once per twelve-month period and only upon mutual written agreement of the parties.

B. Provider agrees to provide KP with at least thirty (30) calendar days prior written notice of any changes to Provider's aggregate charge master. In the event KP is billed and pays Provider's increased charge master rate without thirty (30) calendar days prior written notice, KP reserves the right to recover by requesting reimbursement from Provider of such amounts.

V. **Charge Master Increase Offset & Notification Language**

If Provider increases its charge master after the effective date of the Agreement, then all inpatient and outpatient services reimbursed at percentage of charge will be adjusted to offset the charge master increase so that percentage of charge remains at the agreed to percentage of charge(s) shown in Section III of this Exhibit 3.

Example

(a)	Annual aggregate charge master increase:	7.0%
(b)	Current percentage of billed charges:	70% of billed charges
(c)	Offset calculation:	0.70 / 1.07 = 0.65
(d)	Restated % of billed charge	65% of billed charges

Provider will provide written notice to KP of its annual aggregate charge master increase. Such written notification shall be provided by Provider at least sixty (60) days in advance to KP and no later than May 1st of each fiscal year for the change increase to become effective July 1st of the subsequent fiscal year. The applicable percentage of charges payment rate(s) shall be adjusted by an amount sufficient to offset and cap (as computed in the sample calculation provided above) the reported annual aggregate charge master increase. Such adjustments will be implemented, if necessary, on July 1st each year of this Agreement, and will be formally documented as an amendment(s) to this Agreement.

VI. **Billing and Reimbursement Related to "Do Not Bill Events"**

A. Do Not Bill Events ("DNBEs") mean

1. with respect to general acute care hospitals billing for institutional services:

(a) the eleven Hospital Acquired Conditions identified by CMS in final regulations set forth in the Federal Register (see 73 Federal Register 48433, pages 48471-48491 from August 19, 2008) and summarized at https://www.cms.gov/HospitalAcqCond/Downloads/HACFactsheet.pdf ("HACs"), when such HACs are not identified and documented as having been present upon admission; and

(b) the three surgical errors described in the CMS National Coverage Determination dated June 12, 2009 and documented at https://www.cms.gov/transmittals/downloads/R101NCD.pdf, which include surgery on the wrong patient, surgery on the wrong body part, and wrong surgery performed on a patient ("Sentinel Events" or "SEs").

2. with respect to general acute care hospitals billing for professional services:

(a) the one Hospital Acquired Condition addressing foreign objects retained after surgery identified by CMS in final regulations set forth in the Federal Register (see 73 Federal Register 48433, pages 48471-48491 from August 19, 2008) and summarized at https://www.cms.gov/HospitalAcqCond/Downloads/HACFactsheet.pdf ("RFOs"), when such RFO is not identified and documented as having been present upon admission; and

(b) Sentinel Events.

B. In the event any Member experiences a DNBE while receiving Covered Services under the Agreement, Provider agrees to the following:

1. Report the DNBE. Provider shall report the DNBE to the applicable Payor: for Kaiser Payors, to Kaiser Risk Management at (808) 432-7163. However, Provider shall not be required to waive any privilege or confidentiality rights under law in order to comply with this subsection.

2. Waive or Reimburse Fees. Provider shall waive fees otherwise owed by Payors and Members (or reimburse such fees that may have already been paid by Payors or Members) that are directly related to the DNBE, whether the DNBE is reported by the Provider or later discovered by Kaiser.

3. Claims Submission.

Where Provider submits Claims on a UB-04 to Payors, Provider shall (a) include on all inpatient Claims to Payors for Covered Services to Members, present on admission ("POA") indicators in the manner required by CMS for Medicare fee-for-service claims and (b) for any DNBEs recognized prior to submitting a Claim, include on all Claims to Payors for Covered Services to Members, the applicable International Classification of Diseases ("ICD") codes and all applicable standard modifiers (including CMS National Coverage Determination ("NCD") modifiers for SEs) in the manner required by CMS for Medicare fee-for-service claims.

If Provider submits Claims on a CMS 1500 to Payors and recognizes that a DNBE has occurred prior to submitting a Claim, Provider shall include on all Claims to Payors for Covered Services to Members, the applicable ICD codes and all applicable standard modifiers (including CMS NCD modifiers for SEs) for any DNBE in the manner required by CMS for Medicare fee-for-service claims.

Where Provider recognizes that a DNBE has occurred prior to submitting a Claim to a Payor, Provider's Claim to the Payor shall reflect all services provided (including those related to the DNBE) and all associated fees (including those related to the DNBE), with an adjustment in fees to reflect the waiver of fees directly related to the DNBE.

4. Process for Resolving DNBE Reimbursement Issues.

4.1 Kaiser Payors

Kaiser Payors and Provider shall work collaboratively to resolve promptly DNBE determinations and corresponding reimbursement issues. Any disputes related to DNBE reimbursement shall be resolved according to the dispute resolution process in the Agreement.

5. Reimbursement

Reimbursement by Provider to Payors or Members for fees directly related to a DNBE that were already paid to Provider, shall be deemed an overpayment subject to Section 3.2 of the Agreement, unless otherwise required by law.

C. The parties acknowledge that this Section VI. is solely for the purpose of determining compensation to Provider and shall not constitute or imply any admission of liability.

EXHIBIT 4

PAYORS

The following list of Payors may be modified from time to time without Provider consent.

Kaiser Payors

Kaiser Foundation Health Plan of Georgia, Inc.
Nine Piedmont Center
3495 Piedmont Road, Northeast
Atlanta, GA 30305-1736
(404) 364-7000

Kaiser Foundation Health Plan of Colorado
10350 East Dakota Avenue
Denver, CO 80231-1314
(303) 344-7200

Kaiser Foundation Health Plan, Inc.
Northern California Service Area
1950 Franklin Street
Oakland, CA 94612
(510) 987-1000

Kaiser Foundation Health Plan, Inc.
Southern California Service Area
Walnut Center
393 East Walnut Street
Pasadena, CA 91188
(626) 405-3289

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah Street, Suite 100
Portland, OR 97232-2099
(503) 813-2800

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street
Rockville, MD 20852
(301) 816-2424

Group Health Cooperative of Puget Sound
521 Wall Street
Seattle, WA 98121
(206) 448-5600

Group Health Northwest
5615 West Sunset Highway
Spokane, WA 99224
(509) 838-9100

Other Payors

[None]

EXHIBIT 5

QUEST INTEGRATION PROGRAM REQUIRED PROVISIONS

This Exhibit shall only apply to medical services for Medicaid members. In case of conflict between the Agreement and this Exhibit, this Exhibit shall control as to the Medicaid program only. To the extent that any greater rights or obligations between the parties are created under this Exhibit that are in the Agreement, such rights and obligations shall only apply to medical services provided under the Medicaid programs.

DEFINITIONS

Covered Benefit(s) mean(s) the health care services and benefits that a Member may be entitled to receive under Kaiser Permanente QUEST Integration (see Attachment A, QUEST Integration Covered Benefits).

Covered Service(s) mean(s) those Services rendered by Provider to Members that are (i) Covered Benefits and (ii) Authorized or otherwise approved for payment.

Emergency Medical Condition is defined as a medical condition manifesting itself by a sudden onset of symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition shall not be defined based on lists of diagnoses or symptoms.

Medical Necessity is defined by Hawaii Revised Statutes §432E-1.4 as, (a) For contractual purposes, a health intervention shall be covered if it is an otherwise covered category of service, not specifically excluded, recommended by the treating licensed health care provider, and determined by the health plan's medical director to be medically necessary as defined in subsection (b). A health intervention may be medically indicated and not qualify as a covered benefit or meet the definition of medical necessity. A managed care plan may choose to cover health interventions that do not meet the definition of medical necessity.

(b) A health intervention is medically necessary if it is recommended by the treating physician or treating licensed health care provider, is approved by the health plan's medical director or physician designee, and is:

(1) For the purpose of treating a medical condition;

(2) The most appropriate delivery or level of service, considering potential benefits and harms to the patient;

(3) Known to be effective in improving health outcomes; provided that:

(A) Effectiveness is determined first by scientific evidence;

(B) If no scientific evidence exists, then by professional standards of care; and

(C) If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and

(4) Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price.

(c) When the treating licensed health care provider and the health plan's medical director or physician designee do not agree on whether a health intervention is medically necessary, a reviewing body, whether internal to the plan or external, shall give consideration to, but shall not be bound by, the recommendations of the treating licensed health care provider and the health plan's medical director or physician designee.

(d) For the purposes of this section:

"Cost-effective" means a health intervention where the benefits and harms relative to the costs represent an economically efficient use of resources for patients with the medical condition being treated through the health intervention; provided that the characteristics of the individual patient shall be determinative when applying this criterion to an individual case.

"Effective" means a health intervention that may reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

"Health intervention" means an item or service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. A health intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied. New interventions for which clinical trials have not been conducted and effectiveness has not been scientifically established shall be evaluated on the basis of professional standards of care or expert opinion. For existing interventions, scientific evidence shall be considered first and, to the greatest extent possible, shall be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care shall be considered. If professional standards of care do not exist or are outdated or contradictory, decisions about existing interventions shall be based on expert opinion. Giving priority to scientific evidence shall not mean that coverage of existing interventions shall be denied in the absence of conclusive scientific evidence. Existing interventions may meet the definition of medical necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or in the absence of such standards, convincing expert opinion.

"Health outcomes" mean outcomes that affect health status as measured by the length or quality of a patient's life, primarily as perceived by the patient.

"Medical condition" means a disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

"Physician designee" means a physician or other health care practitioner designated to assist in the decision-making process who has training and credentials at least equal to the treating licensed health care provider.

"Scientific evidence" means controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and the health outcomes may be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases. Scientific evidence may be found in the following and similar sources:

(1) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that

submit most of their published articles for review by experts who are not part of the editorial staff;

(2) Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database Health Services Technology Assessment Research (HSTAR);

(3) Medical journals recognized by the Secretary of Health and Human Services under section 1861(t)(2) of the Social Security Act, as amended;

(4) Standard reference compendia including the American Hospital Formulary Service-Drug Information, American Medical Association Drug Evaluation, American Dental Association Accepted Dental Therapeutics, and United States Pharmacopoeia-Drug Information;

(5) Findings, studies, or research conducted by or under the auspices of federal agencies and nationally recognized federal research institutes including but not limited to the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and

(6) Peer-reviewed abstracts accepted for presentation at major medical association meetings.

"Treat" means to prevent, diagnose, detect, provide medical care, or palliate.

"Treating licensed health care provider" means a licensed health care provider who has personally evaluated the patient.

A. <u>Prohibit Billing Member</u>

Except as expressly provided in this Agreement in addition to the exception of cost sharing pursuant to the Hawaii Medicaid State Plan, Provider (and any Subcontractors) shall look solely to the responsible Payor for compensation for Covered Services rendered to Medicaid/QUEST Integration Members, and Provider agrees that in no event (including non-payment by Payor, insolvency of Payor or breach of the Agreement) shall Provider (or Subcontractor) bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member, person acting on the Member's behalf, Official, State or any Medicaid plans, for Covered Services provided under the Agreement. Without limiting the foregoing, Provider shall not seek payment from Members for reasons including (i) amounts denied by Payor because billed charges were not customary or reasonable, (ii) Provider's failure to obtain Authorization for Services delivered, (iii) clinical data that was not submitted promptly, or (iv) Provider's failure to submit a Claim in accordance with the appropriate billing procedures or within the appropriate time frame, or in accordance with commonly accepted standard coding practices.

The provider will comply with all requirements regarding when billing a member or assessing charges is allowable, as described below:

- Health Plan may collect fees directly from members for non-covered services or for services from unauthorized non-health plan providers.
- Health Plan may deny payment to the provider when a member self-refers to a specialist or other provider without following the Health Plan's prior authorization procedures.
- Health Plan has described the process for the provider on how to bill a member when non-covered or unauthorized services are provided as described below:

  - ✓ If a member self-refers to a specialist or other provider within the network without following the Health Plan's prior authorization procedures and the Health Plan does deny

payment to the provider, the provider may bill the member if the provider provided the member with an Advance Beneficiary Notice of non-coverage;

- ✓ If a provider fails to follow Health Plan procedures which results in nonpayment, the provider may not bill the member; and

If a provider bills the member for non-covered services or for self-referrals, he or she shall inform the member and obtain prior agreement from the member regarding the cost of the procedure and the payment terms at time of service.

B. Cooperate with QI Activities

Provider acknowledges that Kaiser Permanente is required by Law and by accreditation standards to monitor the quality improvement (QI) activities of Provider, as described in the Provider Manual. With respect to Covered Services provided to Members, Provider shall participate in Kaiser Permanente's QI program as established and amended from time to time, which includes cooperating with Kaiser Permanente's QI activities to monitor and evaluate Covered Services provided to Members, facilitating review of such Covered Services by Kaiser Permanente's QI committees and staff, and cooperating with any independent quality review and improvement organization or other external review organization evaluating Kaiser Permanente as part of its QI program.

C. Member Transfer to Another Health Plan

Provider shall cooperate with Kaiser Permanente to refer or transfer Members to any other facility or another primary care provider if a reasonably prudent person may determine that the member's health or safety is in jeopardy. Provider shall immediately notify Kaiser Permanente and the attending Permanente Physician of any indication of an emergency or other significant change in a Member's condition that may require the Member's transfer to another facility. Except in emergency cases, any change in hospital must be agreed to by the attending Permanente Physician and Provider. In emergency cases, Provider will obtain authorization for admission to any acute care facility from Kaiser Permanente as soon as reasonably practicable.

D. Communications with Members

Subject to applicable confidentiality requirements, Provider may freely communicate with a Member (or his/her authorized representative) about the Member's treatment options, without regard to benefit coverage limitations or which may not reflect the health plan's position. Information about health care service and treatment options (including the option of no treatment) must be provided to Members in a culturally competent manner, as required of Kaiser Permanente under applicable Law and by Government Officials.

E. Provision of Services

This Agreement does not prohibit, or otherwise restrict, Provider from (1) providing health care services to Members in a manner consistent with all laws, rules and regulations, customs and ethics relating to Provider's medical profession, (2) advising or advocating on behalf of a Member for the Member's health status, medical care, or treatment or non-treatment options, including any alternative treatments that may be self-administered, and (3) advocating on behalf of a Member to obtain necessary health care services in any grievance system or utilization review process, or individual authorization process.

F. Availability/Waiting Time

Provider shall accept all Members for treatment, unless the Provider requests and Kaiser Permanente allows for a waiver from this requirement. Provider's hours of operation shall be no less than the hours of operation offered to commercial members or comparable FFS Medicaid members.

Provider shall ensure that Covered Services provided under the Agreement are readily available and accessible, provided in a prompt and efficient manner, meeting the appointment waiting time standards set forth below, and consistent with applicable recognized standards of practice and Program Requirements. The acceptable appointment waiting times are:

- Immediate care (twenty-four (24) hours a day, seven (7) days a week) and without prior authorization for emergency medical situations;
- Appointments within twenty-four (24) hours for urgent care and for PCP pediatric sick visits;
- Appointments within seventy-two (72) hours for PCP adult sick visits;
- Appointments within twenty-one (21) days for PCPs (routine visits for adults and children);
- Appointments within twenty-one (21) days for behavioral health (routine visits for adults and children); and
- Appointments within four (4) weeks for visits with a specialist or for non-emergency hospital stays.

G. Continuation of Treatment

Upon termination of this Agreement, except in the case of adverse reasons on the part of the Provider, Provider shall continue to provide Covered Services pursuant to all of the terms and conditions set forth in the Agreement and the Provider Manual to Members who are under the care of Provider at the time of termination for those specific conditions for which Member is under the care of Provider, and in accordance with the limitations and mandated time period applicable by Law to Health Plan to preserve the continuity of care for those Members. As required by Law, in the event of Kaiser Permanente insolvency or other cessation of operations, Provider shall continue to provide Covered Services through the period for which dues or premiums have been paid, or if a Member is confined in a Facility on the date of insolvency or other cessation of operations, until the Member can be discharged in accord with an appropriate professional standard of care or Member's benefits expire.

H. HIPAA Confidentiality

HIPAA. Provider understands and agrees that the Agreement and certain data exchanged hereunder may be subject to the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-91) and all regulations and provisions issued thereunder, including but not limited to 45 CFR parts 2, 160, 162, 164 and 431 (subpart F), HAR Chapter 17-1702, HRS Sections 334-5, 346-10 and Chapter 577A (collectively, "HIPAA"). If Provider is or becomes a "Covered Entity" as defined by HIPAA, Provider shall comply with all relevant HIPAA requirements.

I. Provider Compliance with Laws, Regulations, and Rules

Provider shall comply with the provisions of (1) 42 CFR 434, 42 CFR 438.6, and 42 CFR 438.114, (2) Title IX of the Education Amendments Act of 1972 (regarding education programs and activities), (3) all corrective action plans initiated by the health plan, (4) all EPSDT requirements, (5) Kaiser Permanente's compliance plan, including all fraud and abuse requirements and activities, and all other applicable laws, regulations and rules.

J. Maintenance of Records

Medical records shall be retained in accordance with Sections 622-51 and 622-58, HRS, for a minimum of seven (7) years after the last date of entry in the records. For minors, records must be preserved and maintained during the period of minority plus a minimum of seven (7) years after the age of majority.

Provider shall coordinate with the health plan in transferring member's medical records (or copies) when a member changes PCPs.

K. Access for and Disclosure to DHS

Provider shall provide record access to CMS, State Medicaid Fraud Control Unit or any authorized DHS personnel contracted by the DHS, without member consent so long as the access to the records is required to perform the duties of the contract with the State and to administer the QUEST Integration program. Provider shall comply with health plan standards that provide the DHS or its designee(s) prompt access to members' medical records whether electronic or paper.

L. Submission Encounter Data Provision

Providers (if compensated by capitation payments) shall submit encounter data on a monthly basis, as well as any and all medical records to support such encounter data as requested by Kaiser Permanente, with or without the specific consent of the Member, DHS or its designee for the purpose of validating encounters.

M. Access to Medical Records

Provider will, within sixty (60) days of a request, provide Kaiser Permanente and the DHS or its designee, with copies of Member's medical records, or access to such medical records. Any refusal to provide medical records, access to medical records, or inability to produce medical records to support the claim/encounter shall result in recovery of payment from Provider.

N. Certification of Accuracy of Data

Provider hereby represents and warrants that any data submitted to Kaiser Permanente by Provider shall be accurate, complete and truthful. Upon Kaiser Permanente's request, Provider shall make such certification in the form and manner specified by Kaiser Permanente in order to meet Kaiser Permanente's legal, regulatory, accreditation and contractual requirements.

O. Cultural Competency Plan

Provider shall comply with the Kaiser Permanente's cultural competency plan to ensure that all Services are provided in a culturally competent manner. Information about health care service and treatment options (including the option of no treatment) must be provided to Members in a culturally competent manner, as required of Kaiser Permanente under applicable Law and by Government Officials.

P. Marketing Materials Submitted to DHS for Approval

If Provider desires to distribute any marketing material relating to the Medicaid program covered under

this Agreement, Provider must submit such proposed material to Health Plan to submit to DHS for approval prior to its distribution. Provider will cooperate with Kaiser Permanente in an effort to obtain DHS's approval of such material, and agrees that no such material shall be disseminated until DHS has agreed in writing to its contents.

Q. Medicaid Eligible Newborn Services

Kaiser Permanente shall pay for Medicaid eligible newborn services provided if such services are authorized under this Agreement.

R. Individuals on the State or Federal Exclusion List

Provider shall not employ or contract with directly or indirectly, any individual or entity who is identified as "ineligible", as defined by the Department of Health and Human Services (HHS) Office of Inspector General (OIG), or who has opted out of Medicare for the provision of healthcare services, utilization review, medical social work or administrative services with respect to Members. "Ineligible" is defined by the OIG as an individual or entity who is currently excluded, debarred, suspended, or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or nonprocurement programs; or has been convicted of a criminal offense that falls within the ambit of 42 U.S.C. 1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible. Provider shall: (i) screen all persons or entities whom it employs or contracts and/or provides Services under this Agreement against the HHS/OIG List of Excluded Individuals/Entities (available through the Internet at http://oig.hhs.gov) and General Services Administration (GSA) excluded provider listing found on the GSA's List of Parties Excluded from Federal Programs (available through the Internet at http://epls.arnet.gov) (collectively, the "Exclusion Lists") prior to engaging their services; and (ii) require, as part of the hiring or contracting process, that such persons disclose whether they are an "ineligible" person.

S. Prohibit Financial Relationship Referrals

Provider represents and warrants that it is currently and for the term of the Agreement shall remain in compliance with all applicable Laws and CMS instructions necessary for participation in the Medicare and Medicaid programs, including fraud and abuse and Stark Laws, the patient self-determination amendments of the Omnibus Budget Reconciliation Act of 1990 (regarding advance directives), and the applicable Medicare and Medicaid conditions of participation. Provider is prohibited from making referrals for designated health services to healthcare entities with which the Provider or a member of the Provider's family has a financial relationship, defined as a direct or indirect ownership or investment interest (including an option or nonvested interest) in any entity. This direct or indirect interest may be in the form of equity, debt or other means and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest, or a compensation management with an entity.

T. Transitioning Members

Provider shall fully cooperate with other health plans to assure maximum health outcomes for transitioning Members. Where a member is receiving transition services from Provider, Provider shall, at the option of Kaiser Permanente, continue to render Services in accordance with the terms and conditions of this Agreement until member is transitioned to another source.

U. No-Show Fee

Provider is prohibited from imposing a no-show fee for QUEST Integration Members who were scheduled to receive a Medicaid covered service.

V. Liens and Third Party Claims

Provider shall not, directly or indirectly through assignment or otherwise, assert any lien claim, subrogation claim, or any other claim against a Member, or any other person or organization against which a Member may hold a potential claim for personal injury, or against the proceeds of a Member's personal injury recovery based on Services that Provider provided to the Member under this Agreement for an injury or illness allegedly caused by a third party. Unless prohibited by applicable Law, Health Plan (or the Payor that issues the applicable Membership Agreement) alone shall have the right to pursue and collect such claims for its own account, and Provider agrees to assist these collection efforts by promptly informing Health Plan (or the applicable Payor) or its designee of Services provided by Provider for which there may be potential third party liability.

W. State and Member Hold Harmless

Except as expressly provided in this Agreement, the State and Members shall bear no liability (1) for health plan's failure or refusal to pay valid claims of subcontractors or providers for covered services, (2) for services provided to a member for whom the State does not pay the health plan, and (3) for services provided to a member for which the plan or State does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangements to the extent that the payments are in excess of the amount that the member would owe if the health plan provided the services directly.

X. Interpretive Services

Provider shall offer access (and document such offer) to interpretation services for Members that have a Limited English Proficiency (LEP) at no cost to the Member.

Y. Member Access to PHI

Provider has the responsibility under HIPAA and the Privacy Rule to provide the patient with access to his or her PHI (45 CFR Section 164.524); to allow that patient to request an amendment of his or her PHI (45 CFR Section164.526) and to provide an accounting of those disclosures identified under the Privacy Rule as reportable disclosures (45 CFR Section 164.528). Provider will extend these same rights to its Kaiser Permanente patients. If Provider amends, allows a Kaiser Permanente patient to amend or includes in its records any statement of a Kaiser Permanente patient pursuant to 45 CFR Section 164.526, it will give a copy of such to Kaiser Permanente.

Z. Overpayments

Provider shall be required to refund any payment from a Member or member's family (in excess of Member's share of cost) for the prior coverage period.

AA. Vaccines For Children Program

If Provider will be providing vaccines to children, he/she shall enroll and complete appropriate forms for the Vaccines For Children program.

BB. Alternate Providers

A Provider with an ambulatory practice shall have admitting and treating privileges with at least one general acute care hospital within the health plan's network and on the island of services. If a Provider does not have admitting and treating privileges, the Provider shall have a written agreement with at least one other provider with admitting and treatment privilege with an acute care hospital within the health plan's network on the island of service.

CC. Advanced Directive Requirements

In addition to advance directive requirements specified in the Agreement, Provider shall comply with the required regulations as specified in 42 CFR Part 49 subpart I and 42 CFR Section 417.436 (d).

DD. Provider Qualifications

In addition to the qualification requirements specified in the Agreement, Provider shall also comply with all applicable Hawaii Administrative Rules ("HAR") sections and Medicaid requirements for licensing, certification and recertification.

EE. Quality Assurance and Utilization Review

Provider shall participate in and cooperate with Health Plan's utilization review program and its quality assurance and improvement programs, including the timely submission of requested data and participating in the interpretation of performance data, instituting needed change, and cooperating with appropriate remedial action.

FF. Disclosure Requirements

Provider shall comply with disclosure requirements identified in accordance with 42 CFR Part 455.104-106. Disclosure requirements include:

- **§455.104 Disclosure by Medicaid providers and fiscal agents: Information on ownership and control.**

  What disclosures must be provided. The Medicaid agency must require that disclosing entities, fiscal agents, and managed care entities provide the following disclosures:

  (1)(i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

  (ii) Date of birth and Social Security Number (in the case of an individual).

(iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.

(2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

(3) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

(4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

When the disclosures must be provided.

(1) *Disclosures from providers or disclosing entities.* Disclosure from any provider or disclosing entity is due at any of the following times:

(i) Upon the provider or disclosing entity submitting the provider application.

(ii) Upon the provider or disclosing entity executing the provider agreement.

(iii) Upon request of the Medicaid agency during the re-validation of enrollment process under §455.414.

(iv) Within 35 days after any change in ownership of the disclosing entity.

- **§455.105 Disclosure by providers: Information related to business transactions.**

Information that must be submitted. A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about—

(1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of

the request; and

(2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

- **§455.106 Disclosure by providers: Information on persons convicted of crimes.**

Information that must be disclosed. Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who:

(1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

(2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

GG. Auxiliary Aids and Services

Providers shall offer access to auxiliary aid and services at no cost to QUEST Integration Members living with disabilities and to document the offer and provision of auxiliary aids to the same extent as Kaiser Permanente.

HH. Annual Cost Reports

If applicable, Provider shall submit annual cost reports to the State's Med-QUEST Division.

II. Breach of Confidentiality

Provider shall immediately notify the health plan in writing of all privacy and security breaches (as such term is defined in Federal and State law or rules) of confidential information related to Medicaid recipients within two business days of discovery and to provide a written report of investigation and mitigation of the breach within 10 calendar days of discovery.

EXHIBIT 6

FEDERAL PROGRAM COMPLIANCE

A. Medicare Advantage Program

Kaiser Foundation Health Plan in its Hawaii Region ("Health Plan") has entered into a Medicare Advantage Organization contract with the Centers for Medicare and Medicaid Services ("CMS"). Health Plan has contracted with KFH to provide certain services under such Medicare Advantage contract. CMS and Health Plan require KFH to include the provisions in this Section A in any subcontracts. Section A of this Exhibit is incorporated by reference into and made part of the Agreement with respect to Services rendered to Members enrolled in the Medicare Advantage program ("MA Members"). In the event of a conflict or inconsistency with any term or condition in the Agreement relating to Services rendered to MA Members, Section A of this Exhibit shall control. KFH shall itself, or shall cause Health Plan to, satisfy the obligations of Health Plan under this Exhibit.

1. **Records.** [42 CFR §422.118, §422.504(d), §422.504(a)(13), MMCM Ch. 11, §100.4] Provider shall (a) abide by all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information; (b) ensure that medical information is released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas; (c) maintain medical records and related information in an accurate and timely manner and for ten years after termination or expiration of this Agreement or the date of completion of any audit, whichever is later; and (d) ensure timely access by MA Members to the records and information that pertain to them.

2. **Prompt Payment.** [42 CFR §422.520(b)(1), §422.504(c), MMCM Ch. 11, §100.4] Provider shall be paid for Covered Services rendered to MA Members within the lesser of 30 days of receipt of a properly submitted, supported and undisputed claim or the time period set forth elsewhere in this Agreement.

3. **Member Hold Harmless.** [42 CFR §§422.504(g)(1)(i)&(iii), §422.504(i)(3)(i), §422.105(a), §422.100(g), MMCM Ch. 11, §100.4] Provider agrees that in no event including, without limitation, nonpayment by or insolvency of Health Plan or KFH or breach of this Agreement, shall Provider bill; charge; collect a deposit from; seek compensation, reimbursement, or remuneration from; impose surcharges; or have any recourse against a MA Member or a person acting on behalf of a MA Member for fees that are the legal obligation of Health Plan or KFH. This Agreement does not prohibit Provider from collecting Member Cost Share or fees for non-Covered Services to the extent permitted by the applicable health benefit plan; however, Member Cost Share may not be imposed for influenza and pneumococcal vaccines that are Covered Services. If a person who correctly identifies himself as a MA Member seeks Services from Provider without an applicable authorization or referral, Provider may only charge the MA Member for customary in-plan Member Cost Share unless Provider notified the MA Member that the Services would be Covered Services only if further action is taken by the MA Member per applicable health benefit plan rules. If a MA Member is also enrolled in Medicaid and Medicaid is responsible for the Member Cost Share, Provider shall not hold MA Member liable for such Member Cost Share, and Provider shall accept payment pursuant to this Agreement as payment in full or bill Medicaid for such Member Cost Share. Sections A.3 and A.4 shall be construed in favor of the MA Member as an intended third party beneficiary, shall survive the termination of the Agreement, the insolvency of Health Plan or [KFH/HPMG], and shall supersede any oral or written agreement between Provider and a MA Member.

4. **Continuation of Benefit.** [42 CFR §422.504(g)(2), MMCM Ch. 11, §100.4] In the event of the termination or expiration of this Agreement, Health Plan's or KFH's insolvency, or other cessation of business, Provider shall continue to provide Covered Services for all MA Members through the period for which premium was paid and, for MA Members who are confined in an inpatient facility on the date of insolvency or other cessation of business, through the date of discharge.

5. **Audit and Inspection.** [42 CFR §§422.504(e)(1)(iii),(e)(4)&(i)(2), MMCM Ch. 11, §100.4] The Department of Health and Human Services, the U.S. Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent facilities, contracts, books, documents, papers, and records of Provider involving transactions related to the Health Plan's Medicare Advantage contract during the period of this Agreement and for ten years after termination or expiration of this Agreement or the date of completion of any audit, whichever is later. Provider shall retain such contracts, books, documents, papers, and records for this period.

6. **Accountability and Delegation.** [42 CFR §§422.504(i)(1),(3),(4)&(5)] Health Plan shall only delegate activities or functions to Provider pursuant to a written delegation agreement in compliance with CMS rules, which require, among other things, a covenant of Provider that it will comply with all applicable Medicare laws, regulations, and CMS instructions. To the extent Health Plan delegates any functions for which it is responsible, Health Plan is ultimately responsible to CMS for oversight and compliance and shall retain the right to monitor performance of the delegated functions and to revoke such delegation if Health Plan or CMS determines that performance is unsatisfactory. If Health Plan delegates the selection of providers, Health Plan retains the right to approve, suspend or terminate any such selection.

7. **Exclusion/Sanction.** [42 CFR §422.752(a)(8), §422.204(b)(4), 42 USC §1320a-7 & §1320a-7a] Provider represents that (a) it is not excluded, debarred, sanctioned, suspended or otherwise ineligible from, by or for participation in any federal or state program, including Medicare and Medicaid, (b) with respect to Covered Services provided to MA Members, it does not knowingly employ or contract with an individual or entity so excluded, debarred, sanctioned, suspended, or otherwise ineligible, and (c) no practitioner providing Covered Services to a MA Member has opted out of Medicare. This representation shall be continuing throughout the term of this Agreement, and Provider shall promptly notify Health Plan if such representation can no longer be made.

8. **Certification of Data.** [42 CFR §422.504(l)(3), MMCM Ch. 11, §100.4] The chief executive officer of Provider, the chief financial officer, or an individual delegated the authority to sign on behalf of one of these officers, shall certify from time to time, as requested by Health Plan or KFH, that the encounter data and other data supplied by Provider (based on its best knowledge, information, and belief) are accurate, complete and truthful.

9. **Termination.** [42 CFR §422.202(d)(4), §422.506(b), §422.510, §422.111(e), MMCM Ch. 6, §60.4, MMCM Ch. 11, §100.4] If this Agreement may be terminated without cause, the minimum period of notice shall be at least 60 days, but shall be greater if provided in this Agreement. If the Medicare Advantage contract between Health Plan and CMS is terminated or not renewed, this Agreement will be terminated as to MA Members, except to the extent Health Plan enters into a different form of contract with CMS, in which case Provider agrees to cooperate with Health Plan in meeting its requirements under the new contract until such time as this Agreement may be amended. If Provider provides primary care services to MA Members, Provider shall provide at least 30 days notice before terminating the Agreement.

10. **Access to Books and Records.** [42 USC §1395x(v)(1)(I), 42 CFR §420.302(b)] If this Agreement is determined to be subject to the provisions of 42 USC §1395x(v)(1)(I), which governs access to books and records of contractors of Covered Services to MA Members, Provider agrees to permit representatives of the Secretary of the U.S. Department of Health and Human Services and the U.S. Comptroller General to have access to this Agreement and to the books, documents, and records of Provider, as necessary to verify the costs of this Agreement in accordance with criteria and procedures contained in applicable federal law.

11. **Advance Directives.** [42 CFR §§422.128(b)(1)(ii)(E)&(F)] The MA Member's medical record shall reflect, in a prominent part, whether or not the MA Member has executed an advance directive. Provider may not condition the provision of care or otherwise discriminate against a MA Member based on whether or not the MA Member has executed an advance directive.

12. **Compliance.** [42 CFR §422.2, §§422.504(h),(i)&(j), §422.562(a), §422.516, §422.503(b)(4)(vi), §422.2268, MMCM Ch. 11, §100.4 and 120] Provider shall comply and shall require any subcontractors providing services to MA Members, to comply with all applicable Medicare laws and regulations (including without limitation those designed to prevent or ameliorate fraud, waste and abuse), state and federal laws (including criminal laws, the False Claims Act, Anti-Kickback statute, Health Insurance Portability and Accountability Act or HIPAA, Civil Rights Act of 1964, Age Discrimination Act of 1975, Rehabilitation Act of 1973, Americans with Disabilities Act, Genetic Information Nondiscrimination Act of 2008), with CMS instructions, with Health Plan's policies and procedures, with applicable elements of Health Plan's compliance plan (including, without limitation, reporting of compliance issues, cooperation with Health Plan's routine monitoring and auditing of providers, and annual training and education, e.g., related to fraud, waste and abuse), and with applicable contractual obligations under Health Plan's Medicare Advantage contract, as amended from time to time. Failure to comply with Health Plan's compliance program may result in a corrective action or other appropriate action under the Agreement. In the event of changes to the governing laws, regulations, or CMS requirements applicable to the Medicare Advantage program, this Exhibit shall be amended to the extent required by any such later required changes. Provider shall cooperate, assist and provide records, data and information, as requested by Health Plan or KFH, for Health Plan's compliance with Medicare requirements.

A. Provider shall provide information to Health Plan about disclosure of MA Members' Protected Health Information ("PHI," as defined by HIPAA) to entities outside the United States so that Health Plan may complete CMS's required Offshore Subcontractor Information and Attestation form; and if Provider discloses MA Members' PHI to entities outside the United States, Provider shall inform Health Plan of the fact of such disclosures within 15 days of contract execution or amendment, shall implement reasonable security policies and procedures auditable by Health Plan to protect such PHI, and shall report actual or suspected security breaches to Health Plan.

B. Provider acknowledges that funds received from Health Plan and/or KFH are in whole or in part derived from federal funds.

C. Provider shall also cooperate with Health Plan's grievance and appeals procedures for MA Members.

D. If Provider engages in any marketing activities related to MA Members or the Medicare Advantage program (including distribution of any materials related to the Medicare Advantage program), Provider shall comply with all applicable Medicare Advantage marketing rules.

13. **Credentialing.** [42 CFR §422.204, §422.112(a)(5)] Provider agrees to cooperate with Health Plan's credentialing process for providers rendering Covered Services to MA Members (including recredentialing at least every 3 years). Provider agrees that Health Plan will review the credentials of Provider and (as applicable) its medical professionals or allow Health Plan to review, approve and audit Provider's credentialing process.

14. **Access to Services.** [42 CFR §§422.100(b)&(g), §§422.112(a)(1),(3),(6),(7),(8), §422.110(a), §422.206(a)(2), MMCM Ch. 11, §100.4] Covered Services shall be available and accessible in a timely manner, during hours of operation convenient to the population served, and in a manner that does not discriminate against MA Members. Provider shall not discriminate against MA Members on the basis of health status (including medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, conditions arising out of acts of domestic violence and disability), race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, or source of payment. Services and information about treatment options shall be provided to MA Members in a culturally competent manner, including the option of no treatment, and with appropriate assistance for MA Members with limited communication skills and disabilities. Provider shall allow direct access (a) for all MA Members to influenza vaccines and (b) for women MA Members to screening mammography and women's health specialists for women's routine and preventive health

care services. Health Plan shall assume financial responsibility for emergency and urgently needed services to MA Members in accordance with applicable law and health benefit plan rules, regardless of whether there is a prior authorization for the services.

15. **Quality Assurance.** [42 CFR §422.112(b)(5), §422.152, §§422.504(a)(3)(iii)&(5), MMCM Ch. 11, §100.4] Provider shall participate in and cooperate with Health Plan's quality assurance and improvement programs, including cooperating with any independent or external review organization retained by Health Plan as part of its quality assurance and improvement programs. Provider shall render Covered Services in a manner consistent with professionally recognized standards of care. Provider shall inform MA Members of specific health care needs that require follow-up and shall provide, as appropriate, training in self-care and other measures for MA Members to promote their own health.

16. **Subcontractors.** [42 CFR §422.504(i)(3)(iii)] If Provider provides Covered Services to MA Members through a subcontractor, Provider shall require such subcontractor to provide Services to MA Members consistent with Health Plan's contractual obligations.

17. **Encounter Reporting.** [42 CFR §422.310] In the event Provider does not submit standard claims for payment, Provider shall provide the information necessary for Health Plan to report to CMS all encounters for MA Members on a standard CMS 1500 or UB-04 form.

18. **Hospital Provisions.** [42 CFR §422.620] If Provider is a hospital, Provider shall provide MA Members with advance notice of hospital discharge appeal rights and cooperate with Health Plan and/or the applicable Quality Improvement Organization regarding appeals or grievances related to the discharge.

19. **Physician Provisions.** [42 CFR §422.208(c), §422.202(d)(1), MMCM Ch. 11, §100.4] Where Provider is a physician or physician group: (a) if the compensation arrangement places physician(s) at "substantial financial risk" as defined under the Physician Incentive Plan rules, the parties shall comply with such rules; and (b) if this Agreement is suspended or terminated, physician(s) shall be given written notice of the reasons for suspension or termination and, if applicable, the right to appeal.

B. Medicare Cost Program

Health Plan has entered into a Medicare Cost contract with CMS. Health Plan has contracted with KFH to provide certain services under such Medicare Cost contract. CMS and Health Plan require KFH to include the provisions in this Section B in any subcontracts. Section B of this Exhibit is incorporated by reference into and made part of the Agreement with respect to Services rendered to Members enrolled in the Medicare Cost program ("MC Members"). In the event of a conflict or inconsistency with any term or condition in the Agreement relating to Services rendered to MC Members, Section B of this Exhibit shall control. KFH shall itself, or shall cause Health Plan to, satisfy the obligations of Health Plan under this Exhibit.

1. **Records.** [42 CFR §417.486(c) and (d)] Provider shall maintain the confidentiality of medical records of MC Members and abide by all federal and state laws regarding confidentiality and disclosure.

2. **Member Hold Harmless.** [42 CFR §417.122, §417.407(f)] Provider agrees that in no event including, without limitation, nonpayment by or insolvency of or cessation of operations by Health Plan or KFH, or breach of this Agreement, shall Provider bill, charge, collect from, or have any recourse against a MC Member or a person acting on behalf of a MC Member for fees that are the legal obligation of Health Plan or KFH. This Agreement does not prohibit Provider from collecting Member Cost Share or fees for non-Covered Services to the extent permitted by the applicable health benefit plan. Sections B.2 and B.3 shall be construed in favor of the MC Member as an intended third party beneficiary, shall survive the termination of the Agreement, the insolvency of Health Plan or KFH, and shall supersede any oral or written agreement between Provider and a MC Member.

3. **Continuation of Benefit.** [42 CFR §417.122(b)] In the event of the termination or expiration of this Agreement, Health Plan's or KFH insolvency or other cessation of business, Provider shall continue to provide Covered Services for all MC Members through the period for which premium was paid and, for MC Members who are confined in an inpatient facility on the date of insolvency or other cessation of business, through discharge.

4. **Audit and Inspection.** [42 CFR §417.482] Provider agrees that CMS or its designees shall have the right to inspect, evaluate, and audit the quality, appropriateness, and timeliness of Covered Services and reconciliation of benefit liabilities as well as any books and records (including medical records) maintained by Provider related to Health Plan's CMS contract. This right shall extend through three years from the date of final settlement for any Medicare Cost contract period, or longer in the case of fraud.

5. **Exclusion/Sanction.** [42 CFR §417.500, which incorporates by reference 42 CFR §422.752] Provider represents that (a) it is not excluded, debarred, sanctioned, suspended or otherwise ineligible from, by or for participation in any federal or state program, including Medicare and Medicaid, (b) with respect to Covered Services provided to MC Members, it does not knowingly employ or contract with an individual or entity so excluded, debarred, sanctioned, suspended, or otherwise ineligible, and (c) no practitioner providing Covered Services to a MC Member has opted out of Medicare. This representation shall be continuing throughout the term of this Agreement, and Provider shall promptly notify Health Plan if such representation can no longer be made.

6. **Termination.** [Medicare Managed Care Manual, Chapter 17F, §120.3, 42 CFR §417.464(c)] If this Agreement may be terminated without cause, the minimum period of notice shall be at least 60 days, but shall be greater if provided in this Agreement. If the Medicare Cost contract between Health Plan and CMS is terminated or not renewed, this Agreement will be terminated as to MC Members, except to the extent Health Plan enters into a different form of contract with CMS, in which case Provider agrees to cooperate with Health Plan in meeting its requirements under the new contract until such time as this Agreement may be amended.

7. **Advance Directives.** [42 CFR §417.436(d), §417.472(f)] The MC Member's medical record shall reflect whether or not the MC Member has executed an advance directive. Provider may not condition the provision of care or otherwise discriminate against a MC Member based on whether or not the MC Member has executed an advance directive. Provider shall cooperate with Health Plan and KFH to ensure that MC Members receive written information regarding advance directives.

8. **Compliance.** [42 CFR §417.126(a), §417.472(e), §417.478, §417.600(b)] Provider shall comply and shall require any subcontractors providing services to MC Members, to comply with all applicable Medicare laws and regulations, with all applicable other federal laws (including Title VI of the Civil Rights Act of 1964, Age Discrimination Act of 1975, and the Rehabilitation Act of 1973), with Health Plan's policies and procedures (including applicable elements of Health Plan's compliance plan), and with applicable contractual obligations under Health Plan's Medicare Cost contract (including references to CMS instructions), as amended from time to time. In the event of changes to the governing laws, regulations, or CMS requirements applicable to the Medicare Cost program, this Exhibit shall be amended to the extent required by any such later required changes. Provider shall cooperate, assist and provide records, data and information (including, without limitation, the cost of operations, the patterns of utilization of Covered Services, the availability, accessibility, and acceptability of Covered Services, and developments in MC Member health status), as requested by Health Plan or KFH, for Health Plan's compliance with Medicare requirements. Provider shall cooperate with Health Plan's grievance and appeals procedures for MA Members.

9. **Credentialing.** [42 CFR §§417.416(b) & (c)] If Provider renders institutional services, Provider shall meet all applicable Medicare conditions of participation and be appropriately accredited or certified

according to CMS rules. If Covered Services are provided by health care practitioners other than physicians, such practitioners shall be appropriately supervised by a physician according to CMS rules.

10. **Access to Services.** [42 CFR §417.414(b), §§417.416(a) & (e)] Provider shall make Covered Services available and accessible with reasonable promptness to MC Members in a manner that ensures continuity, all with respect to geographic location, hours of operation, and provision of after-hours services. If Provider renders emergency services, medically necessary emergency services shall be available 24 hours a day, seven days a week.

11. **Quality Assurance and Utilization Review.** [42 CFR §417.106(a) and §417.418] Provider shall participate in and cooperate with Health Plan's utilization review program and its quality assurance and improvement programs, including the timely submission of requested data and participating in the interpretation of performance data, instituting needed change, and cooperating with appropriate remedial action.

12. **Physician Provisions.** [42 CFR §417.479] Where Provider is a physician or physician group, if the compensation arrangement places physician(s) at "substantial financial risk" as defined under the Physician Incentive Plan rules, the parties shall comply with such rules.

13. **Delegation.** [42 CFR §417.472(b) & (c)] Health Plan shall only delegate activities or functions to Provider pursuant to a written delegation agreement in compliance with CMS rules. To the extent Health Plan delegates any functions for which it is responsible, Health Plan is ultimately responsible to CMS for oversight and compliance and shall retain the right to monitor performance of the delegated functions and to revoke such delegation if Health Plan or CMS determines that performance is unsatisfactory.

C. Federal Employee Health Benefits Program

Health Plan has entered into a contract with the U.S. Office of Personnel Management ("OPM") to provide or arrange health care services for persons enrolled in the Federal Employees Health Benefits Program ("FEHBP"). Health Plan has contracted with KFH to provide certain services under such FEHBP contract. OPM and Health Plan require KFH to include the provisions of this Section C in any subcontracts. Section C of this Exhibit is incorporated by reference into and made part of the Agreement with respect to Services rendered to Members enrolled in FEHBP ("FEHBP Members"). In the event of a conflict or inconsistency with any term or condition in the Agreement relating to Services rendered to FEHBP Members, Section C of this Exhibit shall control. KFH shall itself, or shall cause Health Plan to, satisfy the obligations of Health Plan under this Exhibit.

1. **Service Obligations.** [FEHBP contract §§1.9, 1.11, 1.20, and 1.27] Provider and its health care providers shall cooperate with Health Plan quality standards, implementation of patient safety improvement programs and disaster recovery plans, and assist Health Plan with collection of data for quality assurance records.

2. **Hold Harmless.** [FEHBP contract §2.9] In the event of (a) insolvency of Health Plan, KFH or of Provider, or (b) Health Plan's, KFH's or Provider's inability to pay expenses for any reason, Provider shall not look to FEHBP Members for payment, and shall prohibit health care providers from looking to FEHBP Members for payment.

3. **Billing and Payment.** [FEHBP contract §§2.3(g), 2.6(b), and 2.11] Provider shall cooperate with Health Plan and KFH in the performance of its obligations under the FEHBP contract to administer and coordinate benefits, pay claims and recoup erroneous payments (for which no time limit applies to

such recoupments). Provider shall submit claims on the appropriate CMS 1500 form or UB-04 form and shall make all reasonable efforts to submit claims electronically.

4. **Termination of FEHBP Contract.** [FEHBP contract §4.59] If the FEHBP contract is terminated by OPM, the Agreement and all subcontracts shall be terminated with respect to FEHBP Members, and the parties shall assign to the government, as directed by OPM, all right, title, and interest of Health Plan under the Agreement and subcontracts terminated.

5. **Continuation of Care.** [FEHBP contract §1.24] In the event Health Plan terminates its FEHBP contract with OPM or terminates this Agreement other than for cause, Provider, Health Plan, and KFH agree that specialized care shall continue to be rendered and paid under the terms of this Agreement for those FEHBP Members who are undergoing treatment for a chronic or disabling condition or who are in the second or third trimester of pregnancy for up to 90 days, or through their postpartum period, whichever is later. Provider shall also promptly transfer all medical records to the designated new provider during or upon completion of the transition period, as authorized by the FEHBP Member and shall give all necessary information to Health Plan and KFH for quality assurance purposes.

6. **Confidentiality.** [FEHBP contract §1.6(b)] Provider shall hold confidential all medical records of FEHBP Members, and information relating thereto, except (a) as may be reasonably necessary for administration of the FEHBP contract, (b) as authorized by the FEHBP Member or his or her guardian, (c) as disclosure is necessary to permit government officials having authority to investigate and prosecute alleged civil or criminal actions, (d) as necessary to audit the FEHBP contract, (e) as necessary to carry out the coordination of benefit provisions of the FEHBP contract, or (f) for bona fide medical research or educational purposes (only if aggregated).

7. **Maintenance and Audit of Records.** [FEHBP contract §§5.7 and 48 CFR §§2.101, 52.215-2] OPM and other government officials have the right to inspect and evaluate the work performed or being performed under the FEHBP contract, records involving work or transactions related to the FEHBP contract, and the premises where the work is being performed, at all reasonable times and in a manner that will not unduly delay the work. If government officials or their authorized representatives request access, inspection or evaluation of such Provider records or premises, Provider shall cooperate by providing access to records and facilities until six years after final payment or settlement under the FEHBP contract.

8. **Notice of Significant Events.** [FEHBP contract §1.10 and 48 CFR §1652.222-70] Provider agrees to notify Health Plan and KFH of any Significant Event within seven business days after the Provider becomes aware of it. A "Significant Event" is any occurrence or anticipated occurrence that might reasonably be expected to have a material effect upon Provider's ability to meet its obligations under the Agreement.

9. **Compliance.** [FEHBP contract §§1.20, 5.5, 5.47, and 5.56 and 48 CFR §52.203.7] Provider and Health Plan shall comply with the Health Care Consumer Bill of Rights (at http://www.opm.gov/insure/archive/health/cbrr.htm), as amended from time to time. Provider and its health care providers shall comply with the Anti-Kickback Act and its implementing regulations and shall not pay any person for influencing or attempting to influence a government entity or employee. Neither Health Plan nor KFH shall be liable for payment to Provider for services rendered by a provider debarred, excluded or suspended from participation in any federal program. In addition, as requested, Provider shall cooperate with, assist, and provide information to Health Plan as needed for Health Plan's compliance with all FEHBP contract requirements.

A. [FEHBP contract §§ 5.19, 5.22, 5.23, 5.14, 5.59, 5.56, 5.61] This section constitutes notice to Provider that Provider may be required to comply with the following Federal Acquisition Regulations (each a "FAR") at 48 CFR Part 52, which are incorporated herein by reference: (a) Equal Opportunity at FAR 52.222-26; (b) Equal Opportunity for Veterans at FAR 52.222-35 and -37; (c) Affirmative Action for Workers with Disabilities at FAR 52.222-36; (d) Utilization of Small Business Concerns at FAR 52.219-8; (e) Certification of Non-Segregated Facilities at FAR 52.222-21; and (f) Use of Patented

Inventions at FAR 52.227-1 and -2. In addition, Executive Order 11246 regarding nondiscrimination in employment decisions and Executive Order 13496 (codified at 29 CFR Part 471, Appendix A to Subpart A) concerning the obligations of federal contractors and subcontractors to provide notice to employees about their rights under Federal labor laws, or its successor, shall be incorporated by reference. If Provider is not otherwise subject to compliance with the laws and executive orders specified in this Section 9.A., the inclusion of this Section 9.A. shall not be deemed to impose such requirements upon Provider.

10. **Health Information Technology.** [FEHBP contract §1.27] As Provider implements, acquires, or upgrades health information technology systems, it shall use 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 ("Interoperability Standards"), have already been pilot-tested in a variety of live settings, and demonstrate meaningful use of health information technology in accordance with the HITECH ACT. Provider shall also encourage its subcontracted providers to comply with applicable Interoperability Standards.

11. **Licensure and Other Credentials.** [FEHBP contract §1.9(f)] Provider shall require that all physicians providing Services to FEHBP Members comply with Health Plan's credentialing requirements.