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HAWAI'I PACIFIC HEALTH
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Policy Name: Health Clinic Services Agreement - Payor Policy (HHP-16)

Effective Date:

Approved by the Board: [November 20,2013]

Previous Versions: None

Approval Signature: _____

Name: Douglas Kwock, M.D. **Title:** President/Chair

Definitions:

"**Claim**" means a complete billing, or an adjustment to such billing, for Covered Services submitted by an HHP Provider on the CMS 1500 claim form, or by electronic transmission accepted by HMSA.

"**Co-payment**" means a specified dollar amount or percentage of Eligible Charge paid by the Member for a service. Co-payments are specified in the Member's HMO Plan Document.

"**Covered Service**" means a professional medical service or supply that is: (i) in compliance with Payment Determination Criteria (as described in Section XVII); (ii) a covered benefit under the terms of the applicable Member's HMO Plan Document; and (iii) a service or supply of the type that HHP Providers are licensed and qualified to provide.

"**Eligible Charge**" for a Covered Service is the lower of either the actual charge as shown on the Claim or the charge listed for the service in HMSA's Schedule of Maximum Allowable Charges (the "MAC Schedule"). HMSA will establish in good faith, and may amend from time to time, the Maximum Allowable Charge for any service that does not have a charge listed on the MAC Schedule. Factors considered by HMSA in establishing Maximum Allowable Charges or in making adjustments to such charges may include, but are not limited to, changes in the Honolulu Consumer Price Indices (All Items and Medical Care); the cost of providing medical care; the relative complexity of the service; payments for the service under federal, state, and private insurance programs; and the competitive environment. The Eligible Charge does not include the general excise tax or any other tax.

"**Health Clinic Services Agreement**" means the agreement entered into by HMSA and HHP, effective January 1, 2014, as may be amended from time to time.

"**HHP**" means Hawai'i Health Partners, LLC.

"**HHP Health Center Patient(s)**" means any Member who has designated or been assigned to HHP or an HHP Provider as a Personal Care Provider and for the provision of Covered Services.

"**Hawai'i Health Partners Provider**" or "**HHP Provider**" means either, as applicable, (i) a Hawaii licensed physician who has individually entered into a Hawai'i Health Partners Physician Participation Agreement to provide, along with its AHPs, if any, Covered Medical Services to Patients, including Covered Services to HHP Health Center Patients as a Hawai'i Health Partners Network Provider; or (ii) a medical group entity that has entered into a Hawai'i Health Partners Physician Participation Agreement for its Physicians

and AHPs, if any, to provide Covered Medical Services to Patients, including Covered Services to HHP Health Center Patients as a Hawai'i Health Partners Network Provider.

"**HMO Plan Document**" means the document issued by an HMO Program that describes the health care benefits available to Members enrolled in that HMO Program.

"**HMO Program**" means a health care plan offered or administered by HMSA whose Members designate or are assigned to a PCP for primary care services, health maintenance, and the ongoing coordination and management of health care services, and who receive Covered Services through a designated health center.

"**HMSA**" means Hawaii Medical Service Association.

"**HMSA Participating Provider**" means a physician, hospital or other health care provider who has entered into a contract with HMSA, or on whose behalf a contract has been entered into with HMSA, for the provision of Covered Services to Members.

"**Member**" means a person who meets applicable eligibility requirements and is enrolled in an HMO Program.

"**Payment Determination Criteria**" means the criteria for determining whether a service or supply qualifies for payment under Section XVII.

"**Payor**" means HMSA or the HMSA affiliate that is financially responsible for payment for Covered Services provided in accordance with this Agreement under the Away from Home Program.

"**Participation Agreement**" means the written agreement between an HHP Provider and HHP to provide covered services to HHP Patients.

"**Personal Care Provider**" or "**PCP**" means an HHP Provider who meets HMSA's criteria for serving as a PCP and is responsible for managing the health care of HHP Health Center Patients who have been assigned to or have chosen such HHP Provider as the Member's PCP.

"**Provider E-Library**" means the HMSA Provider electronic resource library available at www.hmsa.com/portal/provider!index.htm, which contains HMSA administrative programs, policies, and procedures.

Purpose:

This policy is intended to implement the requirements of the Health Clinic Services Agreement that are applicable to HHP Providers.

Policy / Procedure:

I. Covered Services. HHP Providers shall provide Covered Services to Members in accordance with HHP policies and procedures, the Provider E-Library, and medical professional standards and practices applicable to similarly licensed or certified health care practitioners and facilities providing services under similar circumstances at the time of treatment. The Covered Services to be provided by each HHP Provider shall include all services provided by such HHP Provider in the provider's normal scope of practice. HHP Providers must provide HHP with at least ninety (90) calendar days' written notice prior to the HHP Provider's termination of his or her practice or the closure of his or her practice to additional patients. In the event HHP Provider is a medical group, this notice requirement shall extend to each individual physician or other professional who is party to an HHP Joinder Agreement and is credentialed as an HMSA Participating Provider.

II. Compliance with Policies and Procedures. HHP Providers shall comply in all material respects with all applicable policies and procedures of HMSA as defined in the Provider E-Library or otherwise communicated to HHP Providers, including HMSA policies and procedures regarding credentialing and re-credentialing processes, utilization management processes, quality improvement programs, Member complaint procedures, concurrent review procedures, and other similar programs.

III. Availability. HHP Providers shall make appropriate and necessary arrangements to ensure that Covered Services are available twenty-four (24) ours per day, seven (7) days per week.

IV. Nondiscrimination. HHP Providers shall render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability, as such services are offered to the HHP Providers' non-Member patients. HHP Providers shall not refuse to render services, or differentiate or discriminate in its provision of services to, a Member based on the Member's race, color, ancestry, national origin, sex, gender identity or expression, age, marital or familial status, sexual orientation, ethnicity, religion, genetic information, mental or physical disability, handicap, health status, health insurance coverage, source of payment, by reason of the patient's status as a Member, or on any other basis deemed unlawful under federal, state or local law.

V. Credentialing and Disqualification. HHP Providers shall: (i) complete an HMSA application to become an HMSA Participating Provider; and (ii) provide HMSA with all information necessary to complete HMSA's credentialing and recredentialing process. Only HHP Providers whose applications to become HMSA Participating Providers have been accepted by HMSA and who are in current compliance with all HMSA credentialing and re-credentialing requirements shall provide services to Members. All HHP Providers shall comply with any and all credentialing and re-credentialing procedures as established by HMSA or the applicable HMO Program and as set forth in the Provider E-Library or otherwise communicated by HMSA to HHP Providers.

Except as set forth in Section XXVII below, HMSA may disqualify from participation any HHP Provider who violates applicable state or federal law or does not meet HMSA credentialing requirements (other than licensure) as set forth herein by providing at least sixty (60) calendar days written notice to the HHP Provider.

VI. Eligibility to Provide Covered Services. Each HHP Provider shall ensure he or she has not been:

A. Excluded, suspended or debarred from participation in a Federal health care program as defined in 42 U.S.C. § 1320a-7b(f);

B. Convicted, under federal or state law (including without limitation, having entered a plea of nolo contendere or been admitted to participation in a first offender deferred adjudication or other arrangement whereby a judgment or conviction has been withheld), of a criminal offense related to:

1. The neglect or abuse of a patient;

2. The delivery of an item or service, including the performance of management or administrative services related to the delivery of an item or service, under a Federal health care program, as defined by 42 U.S.C. § 1320a-7b(f);

3. Fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a health care item or service or with respect to any act or omission in any program operated by or financed in whole or in part by any federal, state or local government agency;

4. The unlawful manufacture, distribution, prescription or dispensing of a controlled substance; or

5. Interference with or obstruction of any investigation into any criminal offense described in (1) through (4) above.

C. In the event that the HHP Provider becomes aware that any of the conditions set forth in this section are no longer accurate, the HHP Provider shall promptly notify HHP in writing and HHP Provider shall no longer provide Covered Services until reinstatement of the HHP Provider is approved in writing by HMSA.

VII. Required Notification. Each HHP Provider shall notify HMSA and HHP in writing within two (2) business days after HHP Provider becomes aware of the occurrence of, and shall upon request provide HMSA and HHP with additional documentation or information regarding, any of the events indicated below:

A. Any action to suspend, condition, revoke, terminate, or subject to terms of probation or other restriction, the HHP Provider's: (i) privileges at any medical facility; (ii) license, certification or accreditation necessary for the provision of Covered Services, or (iii) Drug Enforcement Administration Controlled Substances registration and/or Uniform Controlled Substances registration;

B. If the HHP Provider voluntarily surrenders or terminates any license, certification, accreditation or privilege in anticipation of an action described in paragraph (a) above;

C. If the HHP Provider is convicted of a fraud or felony or is suspended, debarred or excluded from participation in a Federal health care program as defined in 42 U.S.C. § 1320a-7b(f);

D. If an act of nature or any event beyond the HHP Provider's reasonable control occurs that substantially interrupts all or a portion of HHP Provider's business or practice, or that has a materially adverse effect on HHP Provider's ability to provide Covered Services consistent with applicable HHP policies and procedures;

E. If the HHP Provider fails to maintain compliance with all applicable HHP Provider credentialing or recredentialing requirements;

F. If any HHP Provider fails to maintain compliance with required insurance coverage;

G. Any malpractice judgment in which HHP Provider is a named defendant;

H. If there is a change in HHP Provider's business address, business telephone or facsimile number, practice location, tax identification number, board certification or scope of practice; or

I. Any other occurrence that could reasonably be expected to have a material adverse effect on HHP Provider's ability to carry out its obligations to provide Covered Services consistent with applicable HHP policies and procedures.

VIII. Referral. HHP Providers shall follow HMO Program referral management processes described in the Provider E-Library for Covered Services which cannot be appropriately provided by HHP Providers and shall submit required referral information to HMSA. Members are assigned by island for the purposes of the HMO health center arrangement. For example, although belonging to the same legal entity, HHP on Oahu and HHP on Kauai are separate health centers for the purpose of the HMO Program. All Covered Services provided on an island other than the island where the Member's PCP is located are subject to HMSA's referral management process and require a referral. As medically appropriate, HHP Providers shall refer Members to other

providers in the following order of preference: (i) other HHP Providers; (ii) HMSA Participating Providers affiliated with other health centers that have contracted with HMSA to provide services to HMO Members; (iii) non-HHP HMSA Participating Providers who have contracted to provide services to HMO Members; (iv) other HMSA Participating Providers; and (v) all other providers. Subject to applicable law, HHP Providers who refer a Member to another provider shall provide appropriate medical information regarding the Member to such provider to facilitate continuity of care and to avoid unnecessary duplication of services, unless the Member specifically objects. HHP Providers shall obtain administrative approval from HMSA in accordance with the Provider E-Library prior to referring a Member to a non-HMSA Participating Provider.

IX. Personal Care Provider ("PCP"). HHP Providers who practice in General Practice, Family Practice, General Internal Medicine, and Pediatrics, as well as Advanced Practice Registered Nurses and Physician Assistants shall be eligible to serve as PCPs. In addition, solely for purposes of compliance with the Health Clinic Services Agreement and for no other purposes under the Participation Agreement, obstetricians who elect in writing to HHP and to HMSA shall be considered PCPs. Subject to the practice capacity of the individual HHP Provider, HHP Providers shall accept all Members who designate or are assigned to the provider as their PCP without regard to medical condition; provided, however, that pediatricians may restrict their patients to children. In conjunction with HHP, the role of the PCP with respect to HHP Health Center Patients includes:

A. Managing the health care of and arranging all Covered Services for HHP Health Center Patient;

B. Providing initial care and, assuming ongoing responsibility for health maintenance and treatment of illness. In addition, as the need for specialized services is determined, managing referrals to appropriate health care providers in accordance with the Provider E-Library and Section VIII above;

C. Telephonically or electronically verifying the eligibility and assignment of the HHP Health Center Patient prior to providing Covered Services;

D. Following HMO Program referral reporting procedures in referring HHP Health Center Patients for Covered Services which are not available from HHP Providers in accordance with Section VIII above;

E. Reviewing the out-of-network services obtained by HHP Health Center Patients to confirm whether those services were requested or arranged by the PCP or other HHP Providers;

F. Making available to HHP Health Center Patients up-to-date preventive services such as immunizations and other screening tests, and reporting to the HHP Health Center Patient, when appropriate, the findings of such tests; and

G. Identifying and referring HHP Health Center Patients to appropriate patient education and disease management programs that HMSA sponsors.

X. Utilization Management. HHP Providers shall participate in and comply with HMSA's utilization management programs and requirements as described in the Provider E-Library or as otherwise communicated to HHP Providers in writing. Such cooperation and compliance shall include, but not be limited to, the provision of any information reasonably requested by HMSA related to Covered Services provided to Members for use in HMSA utilization management programs. HMSA's utilization management programs may include, but are not limited to:

A. Pre-certification requirements to determine whether a proposed service complies with the Payment Determination Criteria;

B. Concurrent review to determine whether a continued in-patient hospital stay or other treatment protocol meets the Payment Determination Criteria;

C. Retrospective review to evaluate the appropriateness of care and care management;

D. As applicable, concurrent review by case managers under HMSA's disease management programs, to determine that the Member is receiving appropriate care and services in coordination with the Member's disease;

E. Case management programs to identify other less costly treatment alternatives without compromising quality of care; and

F. Review of records in conjunction with credentialing of HHP Providers.

XI. Pre-Certification. HHP Providers shall use best efforts to obtain pre-certification from HMSA for Covered Services in accordance with the pre-certification policies and procedures set forth in the Provider E-Library or otherwise communicated to HHP Providers. HHP Providers may not be paid by HMSA in the event a HHP Provider provides Covered Services without having verified the required pre-certification. No HHP Provider shall bill or collect from a Member for such services provided without the required pre-certification, unless the HHP Provider obtains a written acknowledgment of financial responsibility prior to the time services are rendered.

XII. Continuation of Care in the Event of Insolvency. To the extent required by law or the Hawaii Commissioner of Insurance, in the event that HMSA or a Payor becomes insolvent, HHP Providers shall continue to provide, Covered Services to Members for the duration of the period after such insolvency for which premium payment has been made.

XIII. Member Complaints. HHP Providers shall reasonably comply with the Member complaint procedures as set forth in the Provider E-Library or otherwise communicated to HHP Providers. The HHP Provider shall notify HHP of any material Member complaints made to the HHP Provider regarding the quality of care provided or allegations of professional incompetence or professional misconduct in connection with Covered Services provided by a HHP Provider.

XIV. Recordkeeping. HHP Providers shall prepare and maintain, and protect the confidentiality, security, accuracy and integrity of, all appropriate medical and other records related to the provision of Covered Services to Members, including, but not limited to, medical, financial, accounting, administrative, and billing records ("Records"), in accordance with:

A. Federal, state and local law;

B. Industry standards related to quality; and

C. Reasonable HMSA billing, reimbursement, and administrative procedures as set forth in the Provider E-Library or otherwise communicated to HHP Providers.

XV. Retention. HHP Providers shall preserve Records for the longer of:

A. The period of time required by federal, state or local law or by contract, including the period required by state and federal contracts to which HMSA is subject; or

B. Seven (7) years from the date such Records are created or the date the Health Clinic Services Agreement ends, whichever is later.

XVI. Payment. In the event that a HHP Provider is aware of a third party payor that is primary to HMSA, such HHP Provider shall not seek payment from HMSA prior to obtaining payment from such third party payor. HHP Providers shall accept as payment in full from HMSA or the

applicable Payor and the Member no more than the applicable amount indicated in Schedule I to this policy. HHP Providers shall use commercially reasonable efforts to collect any Copayments required for Covered Services directly from Members and shall not routinely waive, discount or rebate any such Co-payments.

XVII. Payment Determination.

A. A Covered Service qualifies for payment under the Health Clinic Services Agreement if it meets the criteria for medical necessity under H.R.S. §432E-1.4 or, in the case of Federal Employee Health Benefits Program ("FEHBP") Members, as set forth in the Member's Plan Document.

B. Payment determinations are based on policies adopted by HMSA Medical Directors in consultation with practicing physicians as well as HMSA policies, peer reviewed literature and nationally recognized standards. Any determination that a service or supply does not meet the Payment Determination Criteria will be made by an HMSA Medical Director. The fact that a physician may prescribe, order, recommend, or approve a service or supply does not in itself mean that the service or supply meets the Payment Determination Criteria, even if it is specifically described in the Member's HMO Plan Document.

C. HHP Providers may contact HMSA for a payment determination regarding a procedure, service, or supply before rendering care. HMSA will provide a response to HHP Provider in accord with the timeliness standards set forth in the Provider E-Library. Such determinations are not a guarantee of payment by HMSA.

XVIII. Claims.

A. HHP Providers shall submit Claims to HMSA, either electronically or using HMSA-approved claim forms, in accordance with HMSA procedures, guidelines, specifications and requirements, including but not limited to the provisions of the Provider E-Library.

B. No payment shall be made for Claims submitted more than one (1) year after the last day on which the services covered by the Claim were rendered, unless required by coordination of benefits or waived by HMSA on a case-by-case basis. HHP Providers shall not collect payment from Members for any Covered Services with respect to which the one (1) year Claims submission period has expired. An HHP Provider may request a review by HMSA of any Claim, and HMSA may independently initiate a retrospective review of any Claim, within twenty-four (24) months of an HHP Provider's submission of the Claim.

C. HHP Providers shall submit Claims only for Covered Services rendered personally by the (i) HHP Provider or (ii) non-physician employee of the HHP Provider incident to the HHP Provider's professional services under the HHP Provider's direct supervision.

XIX. Member Hold Harmless. In no event, including but not limited to non-payment by HMSA or a Payor, or HMSA's or a Payor's insolvency or breach of the Health Clinic Services Agreement, shall HHP Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or persons acting on a Member's behalf for Covered Services.

XX. Non-Covered Services. HHP Providers shall use good faith efforts to clearly inform Members of their financial responsibility for services that are not Covered Services, including using best efforts to obtain a written acknowledgment of financial responsibility signed by the Member or the Member's legal representative prior to the time services are rendered, to the extent practicable. HHP Providers shall assert no claim against HMSA for services rendered to a Member which are not Covered Services.

XXI. Coordination of Benefits and Third Party Collections. HHP Providers shall cooperate with HMSA for the proper coordination of benefits and in the identification and collection of third party payments such as those from workers' compensation, other health insurance, auto insurance, and other third party liability sources in accordance with HMSA policies and procedures.

XXII. Payment Audits. HHP Providers shall cooperate and comply with such audits as are required by HMSA to ensure the accuracy of payments made to HHP Providers, provided that, such audits shall be limited to a period of two (2) years from the date of submission of such Claim by a HHP Provider. Notwithstanding the foregoing, the two (2) year limitation shall not apply to audits of Claims for services rendered to a Member enrolled in any plan offered pursuant to the FEHBP and conducted in accordance with HMSA's contract with, or pursuant to applicable regulations promulgated by, the federal Office of Personnel Management, nor shall such limitation bar an audit initiated in good faith and arising from reasonably credible allegations of fraud or abuse communicated to HMSA by, a third party, such as a regulatory or enforcement agency with jurisdiction over HMSA, HHP or a HHP Provider, a Member, another provider, or a non-HMSA Payor.

XXIII. Overpayments and Underpayments. HHP Providers shall promptly notify HMSA in writing in the event that the HHP Provider becomes aware, through an audit, review, applicable utilization management processes or otherwise, of an overpayment or underpayment by HMSA or a non-HMSA Payor to a HHP Provider for Covered Services provided to a Member pursuant to the Health Clinic Services Agreement. HHP Providers shall refund the amount of any undisputed overpayment to HMSA or the applicable payor within sixty (60) calendar days after receipt of notice with supporting documentation of such overpayment or underpayment. Except where a HHP Provider has credible evidence of fraud or abuse by HMSA in connection with such an overpayment or underpayment, the right of a HHP Provider to request the return or payment of any amounts due the requesting HHP Provider as a result of an overpayment or underpayment as described above shall be limited to a period of eighteen (18) months from the date of the submission of a final Claim by the HHP Provider.

XXIV. Performance Measurement and Data Reporting Standards. HHP Providers shall provide HMSA with any information reasonably requested by HMSA for compliance with HMSA's performance measurement and data reporting obligations under Haw. Rev. Stat. Ann. § 432E-1 0, including, but not necessarily limited to, information related to the quality, effectiveness and appropriateness of care; access to and availability of Covered Services; Member satisfaction; and the utilization and cost of services.

XXV. Insurance and Indemnification. Each HHP Provider, at its sole cost and expense, shall secure and maintain insurance coverage from reputable insurance company(s) or indemnity trust(s) which must have not less than a Standard and Poor's Insurer Financial Enhancement Rating of "A" or an A.M. Best Rating of "A-", such professional liability, comprehensive general liability, and other insurance as shall be necessary to insure such HHP Provider and his/her/its officers, directors, agents and employees, against any claim for damages, whether arising by reason of personal injuries or death occasioned directly or indirectly in connection with the provision of any Covered Services to Members or arising by reason of the use of its property, equipment or facilities or by reason of its other activities in connection with the provision of Covered Services to Members. HHP Providers shall maintain such professional liability insurance in an amount not less than one million dollars ($1,000,000) per occurrence and not less than one million dollars ($1,000,000) in the aggregate annually. In addition, HHP Provider's liability insurance for any facility owned or controlled by HHP Provider and through which Covered Services are provided pursuant to the Health Clinic Services Agreement shall have limits of not less than one million dollars ($1,000,000) per occurrence, and not less than five million dollars ($5,000,000) in the aggregate annually. HHP Providers shall provide HMSA with certificates of coverage upon request, and shall obligate the carrier of each such insurance policy to give HMSA written notice by certified mail at least thirty (30) days prior to cancellation or other termination of such policy.

XXVI. Immediate Disqualification of a HHP Provider. HMSA may disqualify any HHP Provider from providing Covered Services to Members immediately upon written notice to the HHP Provider in the event that (i) the HHP Provider's license to provide Covered Services is revoked, suspended, terminated, limited, conditioned or expires, (ii) if such HHP Provider appears on the U.S. Department of Health & Human Services Office of Inspector General's LEIE or the General Services Administration's Excluded Parties List System ("EPLS"), or (iii) if HHP Provider poses an immediate threat of harm to a Member, as reasonably determined by an HMSA Medical Director.

XXVII. Effect of HHP Provider Disqualification. HHP Providers who are disqualified pursuant to Sections V and XXVI above shall not render Covered Services to Members as of the effective date of the disqualification. Except for immediate disqualification, the HHP Provider's disqualification shall be suspended upon HMSA's receipt of a request for arbitration of the disqualification determination and shall remain so until the dispute is resolved. The arbitration of an immediate disqualification shall not suspend the disqualification, and such disqualification shall remain in full force and effect unless or until the disqualification is overturned.

XXVIII. Post-Termination Continuation of Care.

A. In the event that the Health Clinic Services Agreement is terminated for any reason, as a whole or with respect to a particular non-HMSA Payor, HHP Providers shall:

1. Continue to provide Covered Services to Members who were receiving treatment from the HHP Provider as of the date of termination pending clinically appropriate discharge or transfer of the Member to another provider, or as otherwise required by law.

2. Continue to care for Members undergoing an active course of treatment, as defined in the Provider E-Library, for the shorter of a period of up to ninety (90) calendar days post-termination or until the course of treatment is completed. HHP Providers shall continue to treat pregnant Members in their second or third trimester through the postpartum period.

3. In accordance with the Health Care Consumers Bill of Rights and Responsibilities, continue to: (i) provide Covered Services to 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 ninety (90) calendar days, or through the postpartum period, whichever is later, under the same terms and conditions of this Agreement; (ii) promptly transfer all medical records to the designated new provider during or upon completion of the continuation period, as authorized by the Member; and (iii) give all necessary information to HMSA for quality assurance purposes.

B. If the terms of an agreement pursuant to which HMSA has agreed to arrange for the provision of Covered Services to Members of a particular HMO Program require that HMSA's provider network remain intact for a specified period of time, HHP Providers shall continue to provide Covered Services in accordance with the terms of the Health Clinic and Services Agreement to Members of that HMO Program until such time as a change to HMSA's network is permitted under such HMO Program agreement, provided that in no event shall such period exceed twelve (12) months from the effective date of the termination. HMSA shall pay HHP Providers for services rendered pursuant to this Section XXVIII.B at the rate equal to one hundred percent (100%) of the Eligible Charge as of the date of termination or expiration of the Health Center Services Agreement.

XXIX. Reimbursement Rates for HHP Providers. HMSA or the applicable Payor shall pay HHP Providers as set forth in Schedule I to this policy.

Related Documents:

Health Clinic Services Agreement

Distribution:

SCHEDULE I

REIMBURSEMENT RATES FOR HHP PROVIDERS

Except as specifically provided otherwise in the Health Clinic Services Agreement, as HMSA may amend from time to time, HMSA or the applicable Payor shall pay, and HHP Providers shall accept, the following amounts, less any applicable Co-payments or other amounts due from third parties, as payment in full for Covered Services rendered to Members:

1. Ninety percent (90%) of the Eligible Charge for Covered Services provided to HHP Health Center Patients.

2. Eighty-five percent (85%) of the Eligible Charge for Covered Services provided to Members who have designated or been assigned to an HMO Program participating clinic other than HHP, when those Members have been referred to HHP in accordance with HMSA's policies and procedures.

3. Eighty-five percent (85%) of the Eligible Charge for Covered Services rendered to Members pursuant to the Away From Home Care Program.