ANCILLARY PROVIDER PARTICIPATION AGREEMENT

This Ancillary Provider Participation Agreement ("**Agreement**") is made and entered into by and between ______________________________, a __________ licensed and/or organized under the laws of the State of Hawaii, and the Principals of such entity all as listed in Attachment "A"(collectively "**Provider**") and WellCare Health Insurance of Arizona, Inc. d/b/a 'Ohana Health Plan and those Affiliates that underwrite or administer health plans and are identified in one or more of the program attachments appended hereto (severally and collectively, as the context may require, "**Health Plan**").

RECITALS

WHEREAS, Provider is a ________________ licensed under the laws of the State of Hawaii, operating in accordance with state and federal laws, rules and regulations, and that wishes to provide medical and related health care services to Health Plan Members (as defined below); AND

WHEREAS, Provider represents and warrants that Provider has authority to negotiate and execute provider agreements, including without limitation this Agreement, and has authority to bind itself and all of its Health Care Providers to the terms and conditions of this Agreement. Whenever in this Agreement the term "Provider" is used to describe an obligation or duty, such duty or obligation shall also be the responsibility of each individual Health Care Provider, as the context may require; AND

WHEREAS, Health Plan offers plans of health benefits coverage for individuals eligible for and enrolled in government sponsored health plans and desires to include Provider in selected provider network(s) for the provision of medical and related health care service by Provider to Members.

NOW THEREFORE, in consideration of their mutual promises and consideration herein, the sufficiencies of which are hereby acknowledged, the parties agree as follows:

Article I
Definitions

As used in this Agreement, unless otherwise defined in a program attachment all capitalized terms shall have the following meanings:

1.1 "**Affiliate**" means an entity that directly or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, Health Plan. An entity "controls" any entity in which it has the power to vote, directly or indirectly, 50% or more of the voting interests in such entity or, in the case of a partnership, if it is a general partner, or the power to direct or cause direction of management and policies of such entity, whether through the ownership of voting shares, by contract or otherwise.

1.2 "**Benefit Contract(s)**" means those health insurance coverage contracts, policies or other coverage documents issued or administered by Health Plan. For purposes of this Agreement, Benefit Contract means only those coverage contracts for plans offered or administered by Health Plan and which plans are referenced in one of the program attachments hereto.

1.3 "**Claim**" means a claim that has no defect, impropriety, lack of substantiating documentation, including the information necessary to meet the requirements for encounter data, and using a completed UB-04 or CMS-1500 form or their respective successor forms or alternative electronic equivalents (which electronic equivalents must comport with all HIPAA Administrative Simplification Act requirements for electronic transactions), for Covered Services received timely by Health Plan and which complies with standard CMS coding guidelines, and/or other government program requirements where applicable, and requires no further documentation, information or alteration in order to be processed and paid timely by Health Plan.

1.4 "**CLIA**" means the Clinical Laboratory Improvement Amendments of 1988, as may be amended.

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1.5 "**Covered Services**" means those Medically Necessary medical, related health care and other services covered under and defined in accordance with the applicable Member Benefit Contract.

1.6 "**Designated Provider**" means those Health Plan subcontracted arrangements, capitated or otherwise, whereby certain specialty service or ancillary vendors and/or providers have assumed financial risk for the provision of certain Designated Services rendered to Members.

1.7 "**Designated Services**" means that certain category or set of Covered Services within a certain medical specialty that are made available by a Designated Provider.

1.8 "**Encounter Data**" means information, data and/or reports about clinical encounters and Covered Services rendered to Members as supported with documentation in the Member medical record and in a format that comports with the HIPAA 837 requirements.

1.9 "**Health Care Provider(s)**" means those physicians, health care professionals, practitioners, and/or other providers licensed and/or authorized under the laws of the state or states in which services are provided that are employed by or contracted with Provider and identified in Attachment "B" of this Agreement.

1.10 "**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, including without limitation its privacy, security and administrative simplification provisions, and the rules and regulations promulgated thereunder, each as may be amended from time to time.

1.11 "**Medically Necessary**" means those Covered Services and/or supplies that are: (a) appropriate and consistent with the diagnosis and treatment of the Member's medical condition; (b) required for the care and treatment of Member's medical condition directly except when care is preventive in nature; (c) compatible with the standards of acceptable medical practice in the community; (d) provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and severity of symptoms; and (e) are not experimental nor provided solely for the convenience of the Member or the health care provider.

1.12 "**Member**" means an individual who is enrolled with Health Plan and eligible to receive Covered Services under a Benefit Contract.

1.13 "**Member Expenses**" means copayments, coinsurance, deductibles and/or other cost-share amounts due from the Member for Covered Services pursuant to their Benefit Contract.

1.14 "**Participating Provider**" means a designated physician, practitioner, ancillary provider, hospital, facility or other provider contracted with and credentialed by Health Plan, or Health Plan's designee, for participation in certain Health Plan provider network(s). Listings of Participating Providers generally are available on Health Plan's website.

1.15 "**Principal**" means any owner of Provider and/or owners of a majority interest, officer, directors and key management of the Provider (or Provider's professional association, partnership or corporation).

1.16 "**Proprietary Information**" means information related to Health Plan: (a) which derives economic value, actual or potential, from not being generally known to or readily ascertainable by other persons who can obtain economic value from its disclosure or use; and (b) which is the subject of efforts that are reasonable under the circumstances to maintain its secrecy or proprietary status, including all tangible reproductions or embodiments of such information. Proprietary Information includes, but is not limited to, technical and non-technical data related to the formulas, patterns, designs, compilations, programs, inventions, methods, techniques, drawings, processes, finances, actual or potential customers and suppliers, existing and future products, manuals, policies and procedures, software, information and operational systems of Health Plan, Health Plan affiliates, subsidiaries or Health Plan's parent company. Proprietary Information also includes information that has been disclosed to Health Plan or Health Plan's affiliates by a third party and which Health Plan or any Health Plan affiliate, subsidiary or Health Plan's parent company is obligated to treat as confidential.

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1.17 "**Provider Manual**" means the Health Plan's operating policies, standards, and procedures for Participating Providers including, but not limited to, Health Plan's requirements for claims submission and payment, credentialing/re-credentialing, utilization review/management, disease and case management, quality assurance/improvement, advance directives, Member rights, grievances and appeals.

Article II
Relationship

2.1 Relationship of the Parties. In the performance of their respective duties and obligations hereunder, the relationship between the parties and their respective employees and agents is that of independent parties contracting with each other solely for the purpose of carrying out the terms of this Agreement. Nothing in this Agreement or otherwise should be construed or is deemed to create any other relationship, including one of employment, agency or joint venture. Except as specifically provided for herein, the parties agree that neither Provider nor Health Plan will be liable for the activities of the other nor their respective agents or employees, including without limitation, any liabilities, losses, damages, injunctions, lawsuits, fines, penalties, claims or demands of any kind or nature by or on behalf of any person, party or government agency arising out of or related to this Agreement.

2.1.1 Provider acknowledges that: (a) there is no guarantee: (i) Health Plan will participate in any given government payor sponsored health benefit program; (ii) any Health Plan contract with any given government payor will remain in effect; or (iii) Members will be maintained through referral or assignment to Provider; and (b) this is not an exclusive arrangement.

2.1.2 Provider acknowledges that Health Plan, through Health Plan's parent company, WellCare Health Plans, Inc. has a corporate ethics and compliance program ("**The Trust Program**"), as may be amended from time to time, which includes information regarding Health Plan's policies and procedures related to fraud, waste and abuse and which provides guidance and oversight as to the performance of work by Health Plan, Health Plan employees, contractors and business partners in an ethical and legal manner. Participating Providers and other contractors of Health Plan are encouraged to report compliance concerns and any suspected or actual misconduct. Details of The Trust Program may be found under 'Corporate Governance' at the 'Investor Relations' section of Health Plan's web site www.wellcare.com.

2.2 Provider Information.

2.2.1 Provider: (a) shall provide Health Plan with a complete list of all Health Care Providers prior to execution of this Agreement and shall provide notice to Health Plan prior to the addition of any new Health Care Providers under this Agreement consistent with the provisions of Attachment "B"; (b) represents and warrants that all Health Care Providers: (i) are appropriately licensed under the laws of the State of Hawaii; and (ii) contract with managed care organizations and health insurance companies only through Provider negotiated contracts; and (c) agrees that it is Provider's responsibility to assure the compliance of Health Care Providers with the terms and conditions of this Agreement.

2.2.2 Provider: (a) represents and warrants that all employed Health Care Providers shall comply with the terms and conditions of this Agreement; and (b) that to the extent Provider maintains written agreements with employed physicians and other Health Care Providers, such agreements contain similar provisions to this Agreement.

2.2.3 Provider: (a) represents that Provider maintains written agreements with all contracted Health Care Providers, which agreements contain similar provisions to this Agreement; (b) shall provide Health Plan with a sample of Provider's form agreements used with Provider's contracted Health Care Providers; (c) shall provide Health Plan with a copy of the first page (including the names of the contracting parties and the effective date) and the signature page of all contracted Health Care Providers who are or will be providing Covered Services to Members under this Agreement prior to execution of this Agreement or contracting with Provider, as applicable; (d) shall obtain signatures from each contracted Health Care Provider who is or will be providing Covered Services to Members under this Agreement on a separate Individual Letter Agreement & Joinder in the form set forth in Exhibit "B-1" within thirty (30) days of execution of this Agreement; and (e) hereby waives any non-compete provisions contained in arrangements with such contracted Health Care Providers as related to their contracting directly with Health Plan.

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Provider and Health Care Providers contracted with Provider who do not execute such Individual Letter Agreement & Joinder shall not be entitled to participate under this Agreement and will not be identified as a Participating Provider.

2.2.4 In the event of any conflict between Provider agreements with Health Care Providers rendering services under this Agreement and the terms of this Agreement, this Agreement shall control with respect to Covered Services rendered to Members. Upon reasonable request and where necessary to meet regulatory and/or government payor requirements and/or where necessary to confirm payment obligations, Provider agrees to provide Health Plan, and/or an authorized government agency, with access to copies of Provider's written agreements with Health Care Providers. To the extent not otherwise required by Health Plan for payment purposes and/or an authorized government agency, Provider may redact fees paid by Provider thereunder prior to giving access to such agreements.

2.2.5 Provider understands that Provider and each Health Care Provider is required to be credentialed and/or re-credentialed under Health Plan's policies must be individually credentialed by Health Plan, or Health Plan's designee, before providing Covered Services to Members as a Participating Provider. Subsequent to execution of this Agreement, Provider understands and agrees that should Provider employ or contract with a new Health Care Provider during the term of this Agreement, such new Health Care Provider shall not be added as a Participating Provider under this Agreement and payment for any Health Plan authorized Covered Services rendered to Members shall be as a non-participating provider until successful completion of credentialing by Health Plan, or Health Plan's designee. As part of the credentialing/re-credentialing process, Provider hereby consents to and will cooperate with any requested in-office or site reviews.

2.2.6 Subject to any applicable regulatory requirements regarding provider-to-patient ratios, Provider agrees that Provider will accept new Members for as long as Provider is accepting any new patients. If Provider is no longer available to prospective Members under the above requirements, Provider shall provide Health Plan with sixty (60) days prior written notice.

2.2.7 Regardless of any provision to the contrary and with respect to participation under this Agreement and designation as a Participating Provider, Health Plan reserves the right to approve the participation under this Agreement of any new Health Care Provider who is required to be credentialed by Health Plan, or Health Plan's designee, or to terminate or suspend any Health Care Provider who is or will be providing services to Members under this Agreement and who does not meet or fails to maintain Health Plan credentialing and/or re-credentialing standards.

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2.3 Member Communications. The parties acknowledge and agree that nothing contained in this Agreement is intended to interfere with or hinder communications between physicians and Members regarding a Member's medical condition or available treatment options. Provider acknowledges and agrees that all patient care and related decisions are the responsibility of the treating physician and that, regardless of any coverage determination(s) made or to be made by Health Plan, Health Plan does not dictate or control clinical decisions with respect to the medical care or treatment of Members.

2.4 Health Plan Information.

2.4.1 Provider acknowledges and agrees that all rights and responsibilities arising in respect to individual Members shall be applicable only to Health Plan or Affiliate, as applicable, that issued the Benefit Contract covering the respective Member and may not be imposed or enforced upon any other Affiliate. The joinder of Health Plan entities under the designation "Health Plan" shall not be construed as imposing joint responsibility or cross guarantee between or among Health Plan entities.

2.4.2 Provider agrees that all Proprietary Information and any other non-publicly available information given or transmitted by Health Plan are the confidential and proprietary information of Health Plan, and constitute Health Plan's trade secrets. Provider agrees not to disclose any Proprietary Information to any person or entity without Health Plan's prior written consent, except as may be required by law or government agency.

(a) Provider understands that Health Plan has developed, at a substantial investment, certain assets, including without limitation Health Plan membership, provider networks, contracts, manuals, advertising and marketing materials, and other beneficial property, are a part thereof. In recognition of this, Provider agrees that during the term of this Agreement and for the one (1) year period following any expiration or termination of this Agreement, whether directly or indirectly, without the prior written consent of Health Plan, Provider shall not: (i) disclose the names, addresses, or phone or identification numbers of any Member to any third party, except as required by process of law or regulation; or (ii) use any of Health Plan's materials, including, but not limited to, Member lists or other assets, directly or indirectly, to further the business purposes of Provider or any Principal of Provider. Regardless of any provision to the contrary, in the event of a violation of threatened violation of this section, Health Plan is entitled to seek all available remedies at law or equity including an injunction enjoining and restraining Provider from violating this section. Provider acknowledges that the provisions of this section are a separate and independent covenant and the enforcement of this section is not subject to any claims of defense, offset or breach of this Agreement by Health Plan.

2.5 Third Party Beneficiaries. Except as specifically provided herein, the terms and conditions of this Agreement shall be for the sole and exclusive benefit of the Provider and Health Plan. Nothing herein, express or implied, is intended to be construed or deemed to create any rights or remedies in any third party, including without limitation a Member.

2.6 Administrative Services. Health Plan, or Health Plan's designee, shall perform those administrative functions and/or activities as are necessary for the administration of Benefit Contracts, including without limitation provider network development, credentialing/re-credentialing, claims processing/adjudication, marketing, quality assurance/improvement, and utilization review/management. Any delegation of any one or more of such administrative functions or activities by Health Plan shall be: (a) consistent with Health Plan policies and procedures and pursuant to a written arrangement; and (b) in accordance with applicable state and/or federal laws, rules and regulations and government program requirements.

2.7 Software Use. Through use of or participation in certain processes or activities as a Health Plan contracted provider, Provider may use certain software that is licensed to Health Plan and/or Health Plan's parent and/or affiliates. Use of such software is conditioned upon: (a) Provider's strict compliance with any Health Plan information security guidelines; (b) compliance with HIPAA; (c) treatment of such software as Proprietary Information of Health Plan or Health Plan's licensor, as applicable; and (d) non-disclosure of such software to any third party without the prior written consent of Health Plan. Provider shall return any copies of such software and purge all machine-readable mediate relating to such software upon request by Health Plan. These obligations of confidentiality, non-disclosure, and return of material survive any expiration or termination of this Agreement.

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Article III
Services

3.1 Eligibility Verification. Provider agrees to verify the eligibility of Members prior to rendering non-emergency services using processes made available by Health Plan to Participating Providers. In the event of emergency services, Provider will verify Member eligibility as soon as reasonably practicable after rendering such services.

3.1.1 Health Plan, or Health Plan's designee, will provide Members with identification cards indicating enrollment with Health Plan. Members' Benefit Contracts will require them to present their identification cards when seeking Covered Services. Health Plan will provide access to Member eligibility information through electronic or other means.

3.2 Provision of Services. Provider shall provide directly or through appropriate arrangements with Health Care Providers those medical and related health care services available within the scope of their respective medical or professional licenses to Members: (a) with coverage on a twenty-four (24) hour a day, seven (7) day per week basis (Any "on-call" or "coverage" pay is the responsibility of Provider.); (b) in accordance with the provisions of this Agreement; (c) on the same basis as those services rendered to other patients; (d) consistent with the prevailing practices and standards within the community; and (e) without discrimination on the basis of type of health benefit plan, source of payment, race, age, sex, national origin, religion, color, health status or handicap.

3.2.1 To the extent Provider performs or has available in-office laboratory procedures, tests and/or services, all such laboratory equipment and supplies shall be maintained and all such laboratory procedures, tests and services shall be rendered in accordance with all applicable state and federal laws, rules and regulations, including without limitation CLIA. Prior to execution of this Agreement and at any time thereafter before any available in-office laboratory procedures, tests and/or services are rendered to Members, Provider shall provide Health Plan with a copy of Provider's CLIA certificate and/or changes thereto.

3.2.2 Provider shall obtain a National Provider Identification number (NPI) timely as required under §1173(b) of the Social Security Act, as enacted by §4707(a) of the Balanced Budget Act of 1997, and shall submit such NPI(s) to Health Plan prior to execution of this Agreement.

3.2.3 Provider acknowledges that Health Plan may have certain subcontracted agreements with Designated Providers for Designated Services (e.g., mental and behavioral health services, outpatient laboratory services, non-medical vision or dental services). Health Plan will identify Designated Providers via the Provider Manual or otherwise. Unless Provider has obtained prior authorization from Health Plan, Provider agrees to look solely to the appropriate Designated Provider for the provision of Designated Services to Members. In the event Provider has a contract with a Designated Provider to provide Designated Services to Members, Provider agrees to look to and bill only the Designated Provider for payment for the provision of Designated Services to Members.

3.3 Policies & Procedures. Provider agrees to comply with: (a) all applicable government program requirements, policies, procedures and guidance applicable to those Health Plan products covered under this Agreement; and (b) Health Plan policies and procedures, including without limitation those addressing quality assurance/improvement, utilization management/review, fraud, waste and abuse, health plan accreditation, credentialing/re-credentialing, disease/case management, Member/provider grievances and appeals and such other administrative policies and procedures as are identified in the Provider Manual, as may be amended by Health Plan from time to time and which is incorporated herein by reference. Health Plan either will make copies of the Provider Manual and/or access to the electronic version of the Provider Manual available to Participating Providers, including without limitation Provider, within the later of the ninety (90) day period following execution of this Agreement or approval of applicable state or federal agencies, where necessary. Provider is responsible for disseminating the Provider Manual to Health Care Providers.

3.3.1 Health Plan will provide updates of material revisions or additions to the Provider Manual via posting to Health Plan's website or other means, which shall become binding upon Provider thirty (30) days after such notice, or such lesser period of time as necessary for Health Plan to comply with any statutory, regulatory or accreditation requirements.

3.3.2 Provider agrees to cooperate with Health Plan's quality improvement and utilization review activities as applicable to Provider and/or Participating Providers, including without limitation: (a) prior authorization and verification of eligibility processes; (b) concurrent and retrospective reviews; and (c) implementation of corrective action and/or quality improvement plans initiated and/or required by Health Plan.

3.4 Grievances and Appeals Provider agrees to cooperate and participate with Health Plan: (a) in Health Plan grievance and appeals processes to resolve disputes that may arise between Health Plan and Members, including without limitation the timely provision of information and/or records and documents required by Health Plan; and (b) in provider appeals and dispute resolution processes developed and implemented by Health Plan.

Article IV
Claims/Encounter Data Submission & Payment

4.1 Claim/Encounter Data Submission. During the term of this Agreement, Provider shall prepare and submit electronically to Health Plan, or Health Plan's designee where applicable, Claims and Encounter Data for Covered Services rendered to Members along with all information necessary for Health Plan to process such claims and/or to verify Covered Services rendered to Members in accordance with published standards applicable to the health care

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industry and as designated by Health Plan, including without limitation use of certain electronic data interface companies or claims clearing houses used by Health Plan and in format(s) and with content otherwise required by a government sponsored health benefits program for which there is a program attachment to this Agreement within ninety (90) days' of the date of service or the date of discharge from an inpatient facility, as applicable. Health Plan, in Health Plan's sole discretion, may deny payment for any claims received following the above referenced time period(s). In the event payment is denied as described herein, any Member Expenses shall be adjusted accordingly.

4.1.1 When submitting Claims and/or Encounter Data to Health Plan, Provider shall: (a) use the most current coding methodologies on all forms; (b) abide by all applicable coding rules and associated guidelines, including without limitation inclusive code sets; and (c) agree that regardless of any provision or term in this Agreement, in the event a code is formally retired or replaced, discontinue use of such code and begin use of the new or replacement code following the effective date published by the appropriate coding entity or government agency. Should Provider submit claims using retired or replaced codes, Provider understands and agrees that Health Plan may deny such claims until appropriately coded and resubmitted.

4.1.2 Health Plan shall monitor Provider's compliance with Health Plan's electronic Claims and/or Encounter Data submission, reporting, and/or other administrative requirements. Following the initial thirty (30) days after the Effective Date, in the event Health Plan determines that Provider is not meeting such electronic submission requirements, Health Plan, in addition to any other provisions herein, will notify Provider and within five (5) business days of receipt of such notice, Provider shall identify for Health Plan and implement Provider's actions for correction of such non-compliance.

4.2 Payment.

4.2.1 Health Plan, or Health Plan's designee: (a) determines what services are Covered Services under the applicable Member Benefit Contract; and (b) will process and pay or deny Claims submitted by Provider in accordance with the terms and conditions of this Agreement and applicable state and/or federal laws, rules and regulations regarding the timeliness of claims payments using Health Plan's routine claims and payment processing policies, procedures and guidelines, which may include claim and code audit and edit determinations and other claims logic implemented by Health Plan. Provider agrees to accept as payment in full for Covered Services rendered to Members during the term of this Agreement the rates set out in the applicable program attachment(s) hereto. Unless otherwise provided for in a program attachment appended hereto, Provider shall collect Member Expenses for Covered Services directly from Members, and shall not waive, discount or rebate any such Member Expenses.

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4.2.2 Regardless of any provision to the contrary, Provider hereby authorizes Health Plan to deduct from amounts that may otherwise be due and payable to Provider any such outstanding amounts that Provider may, for any reason, owe Health Plan, including without limitation any adjustments to payments made to Provider for errors and omissions relating to changes in enrollment, claims payment errors, data entry errors and/or incorrectly submitted claims.

4.2.3 In the event Provider and/or any acquired or contracted physician, practitioner, or provider of Provider is a party to more than one agreement with Health Plan for the provision of medical and related health care services to Members, Provider will be paid by Health Plan for Covered Services under the agreement selected by Health Plan.

4.2.4 The parties agree that nothing contained in this Agreement nor any payment made by Health Plan to Provider is a financial incentive or inducement to reduce, limit or withhold Medically Necessary services to Members.

4.3 Coordination of Benefits/Recovery Rights. Payment for Covered Services provided to each Member are subject to reimbursement, subrogation and/or coordination with other benefits payable or paid to or on behalf of the Member, and to Health Plan's right of recovery in other third party liability situations. Health Plan will coordinate payment for Covered Services in accordance with the terms of Benefit Contracts and applicable state and federal laws, rules or regulations. If a Member has coverage from more than one payor or source, Health Plan will coordinate benefits with such other payor(s) in accordance with the provisions of Benefits Contracts. Provider agrees to share information obtained or documentation required by Health Plan to facilitate Health Plan's coordination of such other

benefits. If Provider has knowledge of an alternative primary payor, Provider shall bill such other payor(s) with the primary liability based on such information prior to submitting claims for the same services to Health Plan. To the extent permitted by law, if Health Plan is not Member's primary payor, payment for Covered Services from Health Plan shall be no more than the difference between the amount paid by the primary payor(s) and the applicable rate under this Agreement, less any applicable Member Expenses.

4.4 Member Hold Harmless. Provider hereby agrees that in no event including, but not limited to, nonpayment by Health Plan, Health Plan's determination that services were not Medically Necessary, Health Plan's insolvency, or Health Plan's breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member, or persons other than Health Plan acting on any Member's behalf, for amounts that are the legal obligation of Health Plan. The parties agree that this provision: (a) shall be construed for the benefit of Members; (b) does not prohibit collection of Member Expenses for Covered Services from Members, unless otherwise provided for in a program attachment appended hereto; and (c) supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and Members or persons acting on their behalf.

4.5 Non-Covered Services. Health Plan will exclude from payment to Provider the cost of any non-covered service. Provider may charge and collect from Members for non-covered services if in each instance prior to their provision: (a) Member is advised in writing that the specific services are non-covered services; and (b) the Member affirmatively agrees in writing to assume financial responsibility for payment of such specific services after being so advised. If Provider is uncertain whether a service is a Covered Service, Provider agrees to obtain a coverage determination from Health Plan before advising the Member as to coverage and liability for payment and rendering services.

4.6 Claims/Payment Disputes. Should Provider dispute payment or payments made by Health Plan under this Agreement, Provider must notify Health Plan in writing of the dispute within ninety (90) days of the payment date or notice of denial or recoupment from Health Plan, or Health Plan's designee. Failure to submit such disputes within the above referenced time period constitutes a waiver of any such dispute and Health Plan's payment shall be considered final, with no further appeal provided.

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Article V
Records Access & Audits

5.1 Maintenance. Provider shall prepare, maintain and retain complete and accurate medical, fiscal and administrative records regarding Covered Services rendered to Members: (a) in accordance with generally accepted medical practice and Health Plan policies; (b) in a form required by applicable state and federal laws and regulations; and (c) for a time period of not less than ten (10) years, or such longer period of time as may be required by law, from the end of the calendar year in which expiration or termination of this Agreement occurs or from completion of any audit or investigation, whichever is greater, unless an authorized federal agency, or such agency's designee, determines there is a special need to retain records for a longer period of time, which may include but not be limited to: (i) up to an additional six (6) years from the date of final resolution of a dispute, allegation of fraud or similar fault; or (ii) such greater period of time as provided for by law. Records that are under review or audit shall be retained until the completion of such review or audit should that date be later than the time frame(s) indicated above.

5.2 Access & Audit. Provider agrees that Health Plan, or Health Plan's designee, shall have the right to audit and reasonable access and an opportunity to examine during normal business hours, on at least forty-eight (48) hours' advance notice, or such shorter period of time as maybe imposed on Health Plan by a federal or state regulatory agency or accreditation organization, the facilities, billing and financial books, records and operations of Provider, any individual or entity performing services for or on behalf of Provider or any related organization or entity, as they apply to the obligations of Provider under this Agreement. The purpose of this requirement is to permit Health Plan to assure compliance by Provider with all obligations, financial, operational, quality assurance, as well as other obligations of Provider under this Agreement and Provider's continuing ability to meet such obligations.

5.2.1 Provider agrees to make copies of medical, administrative and/or financial records related to services rendered to Members available to Health Plan for inspection, review and/or audit upon request. Copies of such records shall be at no cost to Health Plan.

5.3 Transfer. Upon request from Health Plan, another treating provider or a Member, Provider agrees to transfer a copy of the medical records and to provide relevant clinical information for Members referred and/or transferred to another provider or medical facility for any reason, including without limitation expiration or termination of this Agreement. The copy and transfer of medical records shall be at no cost to Health Plan or the Member.

5.4 Confidentiality. Provider agrees to maintain the confidentiality of, use and/or disclosure any personally identifiable information, any protected health information and/or information contain in the medical records of Members in accordance and consistent with applicable state and federal laws, rules and/or regulations, including without limitation HIPAA.

Article VI
Laws, Regulatory Requirements, Licensure & Insurance

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6.1 Governing Law. This Agreement has been executed and delivered and shall be interpreted, construed and enforced in accordance with the laws of the State of Hawaii, without regard to its conflicts of laws provisions.

6.2 Compliance. The parties agree to comply with all applicable state and/or federal laws, rules, and regulations. The alleged failure by either party to comply with applicable state and/or federal laws, rules or regulations shall not be construed as allowing either party a private right of action against the other in any legal or administrative proceeding in matters in which such right is not recognized by such law, rule or regulation.

6.3 Excluded Individuals/Entities. Provider and Health Plan respectively represent that neither is nor knowingly employs or contracts with individuals or entities excluded from or ineligible for participation in any government sponsored health care program.

6.4 Reporting. Provider agrees to provide Health Plan with timely access to records, reports, clinical information and/or Encounter Data in the format required by Health Plan to meet obligations under contracts with any government agency sponsoring or overseeing Health Plan products covered under this Agreement.

6.5 Provider Licensure/Certification. Provider is and will remain properly licensed, certified and/or accredited in good standing in accordance with applicable state and federal laws, rules and regulations and as provided for in this Agreement throughout its term. Provider shall notify Health Plan immediately in writing upon the occurrence of any event that could reasonably be expected to impair the ability of Provider to comply with the obligations of this Section 6.5 including, but not limited to: (a) any suspension, revocation, condition, expiration or other restriction of any licensure, certification or accreditation of Provider; (b) the exclusion, suspension or bar from, or imposition of any sanctions against Provider relating to any government payor program, or any settlement related thereto; (c) any disciplinary action initiated by any regulatory body against Provider; (d) the suspension, limitation, revocation or termination of Provider's hospital privileges; (e) any action concerning or brought by a Member against Provider; (f) the conviction of Provider of fraud or any felony; and/or (g) settlement related to any of the foregoing.

6.6 Health Plan Licensure. Health Plan is and will remain properly licensed and/or accredited in accordance with the laws of the State of Hawaii.

6.7 Provider Insurance. Provider shall maintain and shall require Health Care Providers to maintain: (a) such policies of general and professional liability (malpractice) insurance as necessary to insure Provider, respectively, against claims of personal injury or death alleged or caused by Provider and/or Health Care Provider(s) performance under this Agreement; (b) worker's compensation coverage in accordance with and to the extent required by the laws of the State of Hawaii; and (c) any stop-loss coverage as is or may be required by Health Plan and/or in accordance with applicable state and federal laws, rules and regulations. Such professional liability coverage for Provider and each individual Health Care Provider participating under this Agreement shall be one million dollars ($1,000,000) per

occurrence/three million dollars ($3,000,000) in the aggregate or such amounts as are required by state law, whichever is greater. Prior to execution of this Agreement as part of the credentialing process, and thereafter upon Health Plan request, Provider shall: (a) provide evidence of such insurance coverage; and (b) provide Health Plan with ten (10) days advance notice of any material modification, cancellation or termination of such coverage.

6.8 Health Plan Insurance. Health Plan shall maintain such policies of general and professional liability insurance as necessary to insure Health Plan against claims regarding Health Plan operations and performance under this Agreement.

Article VII
Term and Termination

7.1 Term. Term. The term of this Agreement shall be for one (1) year commencing on the Effective Date. Thereafter, the Agreement shall automatically renew for periods of one (1) year unless either party provides written notice of non-renewal at least ninety (90) days prior to the end of the initial term or any renewal terms thereafter, or the Agreement terminated in accordance with Section 7.2 below.

7.1.1 Provider acknowledges that, regardless of any provision to the contrary: (a) the Effective Date of this Agreement is dependent upon successful completion by Health Plan or Health Plan's designee of credentialing of Provider and Health Care Providers who are required to be credentialed; and (b) after successful initial credentialing of Provider and Health Care Providers identified in Attachment "B" on the date of execution, Health Plan will countersign this Agreement and complete the blank portions on the signature page indicating the Effective Date, and return a countersigned original to Provider.

7.2 Termination. This Agreement may be terminated as follows:

7.2.1 Without Cause. Notwithstanding anything to the contrary herein, either party may terminate this Agreement at any time, without cause, upon ninety (90) days written notice to the other party.

7.2.2 With Cause. Either party may terminate this Agreement for material breach of any of the terms or provisions of this Agreement by providing the other party with at least ninety (90) days prior written notice specifying the nature of the alleged material breach. During the first sixty (60) days of the above referenced notice period, the breaching party may cure the breach to the reasonable satisfaction of the non-breaching party.

7.2.3 Immediate Termination. Health Plan, at Health Plan's sole election, may terminate this Agreement, and/or the participation of any Health Care Provider under this Agreement, immediately upon written notice to Provider in the event of any of the following: (a) suspension, revocation, condition, expiration or other restriction of their respective licensure, certification and/or accreditation; (b) failure to meet or maintain Health Plan credentialing/re-credentialing standards, as determined by Health Plan; (c) suspension or bar of Provider and/or any Health Care Provider from participation in any government health care program; (d) determination by a government agency or any judicial or administrative review body that Provider and/or any Health Care Provider has engaged or is engaging in fraud; (e) failure by Provider or any Health Care Provider to maintain the general and/or professional liability insurance coverage requirements of this Agreement; or (f) Health Plan's reasonable determination that Provider or any Health Care Provider immediate termination is necessary for the health and safety of Member. Further, Health Plan may terminate this Agreement immediately upon written notice to Provider in the event that: (i) there is a change in control in Provider or any new owner or ownership is not acceptable to Health Plan; (ii) Provider engages in or acquiesces to any act of bankruptcy, receivership or reorganization; or (iii) Health Plan permanently loses Health Plan's authority to do business in total or as to any segment of business, but then only as to that segment.

7.2.4 One Time Termination by Provider. If, within the thirty (30) day period following the initial distribution or provision of electronic access to the Provider Manual as provided for in Section 3.3, Provider should raise issues regarding or dispute a material part of the Provider Manual for which the parties are unable to come to a mutually agreeable resolution, Provider may elect to terminate this Agreement upon sixty (60) days written notice to Health Plan. This provision does not apply to any updates or modifications to or subsequent editions of the Provider Manual made following the initial publication or distribution.

SAMPLE

7.3 Obligations Upon Termination. Upon termination of this Agreement under Sections 7.2.1 and 7.2.2, Provider will continue to provide Covered Services to Members as indicated below and to cooperate with Health Plan to transition Members to other Participating Providers in a manner that ensures medically appropriate continuity of care. In accordance with the requirements of applicable government sponsored health benefits programs, Health Plan's accrediting bodies and applicable law and regulation, Provider will continue to provide Covered Services to Members after the termination of this Agreement, whether by virtue of insolvency or cessation of operations of Health Plan, or otherwise: (a) for those Members who are confined in an inpatient facility on the date of termination until discharge; (b) for all Members through the date of the applicable government sponsored health benefits program contract for which payments have been made by the applicable government agency; and (c) for those Members undergoing active treatment of chronic or acute medical conditions as of the date of expiration or termination through their current course of active treatment not to exceed ninety (90) days unless otherwise required by item (b) above. Unless otherwise provided for herein, the terms and conditions in this Agreement shall apply to such post-termination Covered Services.

7.4 Notice to Members. Regardless of any provision to the contrary, Provider agrees: (a) that in the event of expiration or termination of this Agreement, Health Plan will communicate such expiration or termination of this Agreement to Members, as required and pursuant to applicable state and federal laws, rules and regulations and/or applicable government program requirements; and (b) to obtain the prior written consent of Health Plan for any Provider communications designed for notice to Members and not other patients regarding the expiration or termination of this Agreement.

Article VIII
Dispute Resolution

SAMPLE

8.1 Dispute Resolution. Health Plan and Provider agree to attempt to resolve any disputes arising with respect to the performance or interpretation of this Agreement promptly by negotiation between the parties. Prior to submission of any unresolved disputes to binding arbitration pursuant to the provisions herein, Provider agrees comply with Health Plan's administrative review and/or appeal procedures, where applicable.

8.1.1 Other than disputes arising from or related to Section 2.4.2 and/or disputes alleging inappropriate or fraudulent billing practices for which the parties may pursue any available legal or equitable remedy including without limitation litigation, the exclusive remedy for unresolved disputes between the parties under this Agreement, including without limitation a dispute involving interpretation of any provision of this Agreement, questions regarding application and/or interpretation of applicable state and/or federal laws, rules or regulations, the parties' respective obligations under this Agreement, or otherwise arising out of the parties' business relationship, shall be resolved by binding arbitration.

8.1.2 The party initiating binding arbitration shall provide prior written notice to the other party identifying the nature of the dispute, the resolution sought, the amount, if any, involved in the dispute, and the names and background of at least two (2) potential arbitrators. The submission of any dispute to arbitration shall not adversely affect any party's right to seek available preliminary injunctive relief.

8.1.3 Any arbitration proceedings shall be held in a mutually agreeable location in Hawaii in accordance with and subject to the Arbitration Rules, Procedures and Protocols of Dispute Prevention and Resolution, Inc. ("DPR") then in effect, or under such other mutually agreed upon guidelines and before a single arbitrator selected by the parties. Discovery shall be permitted in the same manner, types and times periods provided for by the Federal Rules of Civil Procedure. To the extent the parties are unable to agree upon an arbitrator, the parties agree to use an arbitrator selected by the DPR from a list of arbitrators chosen by the parties as individuals with knowledge and expertise in the area or issue in dispute.

8.1.4 The arbitrator: (a) may construe or interpret but shall not vary or ignore the terms of this Agreement; (b) shall be bound by applicable state and/or federal controlling laws, rules and/or regulations; and (c) shall not be empowered to certify any class or conduct any class based arbitration. The decision of the arbitrator shall be final, conclusive and binding. Judgment upon the award rendered in any such arbitration may be entered in any court of

competent jurisdiction, or application may be made to such court for judicial application and enforcement of the award, as applicable law may require or allow.

8.1.5 Each party shall assume its own costs (including without limitation its own attorneys' fees and such other costs and expenses incurred related to the proceedings), but the compensation and expenses of the arbitrator and any administrative fees or costs of any arbitration proceeding(s) hereunder shall be borne equally by Health Plan and Provider.

Article IX
Miscellaneous

9.1 Notices. Any notice required or permitted to be given under this Agreement, except notices of Provider Manual updates pursuant to Section 3.3.1, shall be in writing and shall be delivered (a) in person; (b) by certified mail, postage pre-paid, return receipt requested; (c) by facsimile; or (d) by commercial courier that guarantees delivery and provides a receipt. Any notice shall be effective only upon delivery, which for any notice given by facsimile, shall mean notice that has been received by the party to whom it is sent as evidenced by confirmation of transmission by the sender. Such notices shall be sent to the locations identified below the parties' respective signature to this Agreement. Either party may from time to time specify in writing to the other party a change in address for purposes of notice hereunder. Unless a notice specifically limits its scope, notice to any one party included in the term "Provider" or "Health Plan" shall constitute notice to all parties included in the respective terms.

9.2 Amendment. Any amendment to this Agreement must be made in writing and executed by both parties. Notwithstanding the above, this Agreement shall be automatically amended to comply with applicable state and/or federal laws, rules or regulations, and/or accreditation requirements to which Health Plan is or may be subject and/or applicable government sponsored health benefits program requirements for which there is a program attachment included in this Agreement. Additionally, Health Plan may amend this Agreement upon thirty (30) days written notice to Provider. Unless Provider objects in writing to such amendment during the thirty (30) day notice period, Provider shall be deemed to have accepted the amendment.

9.3 Assignment. This Agreement is intended to secure the provision of services by Provider, as such Provider may not assign, delegate or transfer this Agreement, in whole or in part, without the prior written consent of Health Plan. Health Plan may assign this Agreement, in whole or in part, to any purchaser of or successor to the assets or operations of Health Plan or to any affiliate of Health Plan, provided that the assignee agrees to assume those Health Plan obligations hereunder so assigned. As used in this Section 9.3, the term "assign" or "assignment" shall also include a change of control of a party by merger, consolidation, transfer, or the sale of the majority or controlling stock or other ownership interest in such party.

SAMPLE

9.4 Severability. If any part of this Agreement should be determined invalid, unenforceable, or contrary to law, that part shall be reformed, if possible, to conform to law, and if reformation is not possible, that part shall be deleted, and the other parts of this Agreement shall remain fully effective.

9.5 Waiver. Waiver of any breach of any provision of this Agreement or of any of the remedies available to either party in the event of a default or breach of this Agreement shall not be deemed a waiver of any other provision or a waiver of any subsequent or continuing breach of the same provision or a party's right to elect a remedy at any subsequent time if a condition of default or breach continues or recurs.

9.6 Force Majeure. Neither party shall be deemed to be in default for a delay or failure to perform an act under this Agreement resulting from civil or military authority, acts of public enemy, war, fires, earthquake, flood or other natural disaster.

9.6.1 Regardless of any provision to the contrary: (a) In the event of a natural disaster, system failure and/or other event that may adversely impact and/or results and/or may result in Provider's temporary inability to meet any one or more of Provider's obligations under this Agreement (including without limitation the obligation to provide Covered Services to Members), Provider represents that Provider has in place a recovery plan inclusive of a mechanism for notice to contracted entities (including without limitation Health Plan) and the timing of assumption of obligations; and (b) Should Provider be unable to meet Provider's obligations under this Agreement due to such an

unanticipated event beyond Provider's control for a period of more than forty-eight (48) hours, Health Plan, in Health Plan's discretion, immediately may terminate this Agreement and/or revoke any one or all administrative activities or functions delegated by Health Plan to Provider hereunder, if any, upon written notice to Provider. In such event, payments attributable to such delegated administrative activities or functions, if any, shall be adjusted accordingly.

9.7 Use of Name. Neither party will advertise or utilize any marketing materials, logos, trade names, service marks, or other materials created or owned by the other without their prior written consent. Neither party shall acquire any right or title in or to the marketing materials, logos, trade names, service marks or other materials of the other. Notwithstanding the above: (a) Provider may include the name of Health Plan in listings of health plans in which Provider participates; and (b) Health Plan may use certain demographic and descriptive information regarding Provider in information and/or publications identifying Participating Providers, and as may be required under any government sponsored health benefits program contract.

9.8 Confidentiality. The parties agree to treat as confidential and not to disclose the terms of this Agreement and/or information regarding any dispute arising out of this Agreement to any third party without the express written consent of the other party, except pursuant to a valid court order or when disclosure is required by a government agency. Notwithstanding any provision to the contrary, the parties agree that each may discuss the payment methodology contained herein with Members requesting such information, and further that Health Plan may disclose the payment rates and terms to: (a) capitated and/or risk-bearing Participating Providers; (b) designated Health Plan vendors performing services for Members and whose compensation from Health Plan is in whole or in part related to amounts paid to Participating Providers; and/or (c) current and/or prospective plan or program clients of Health Plan.

9.9 Duplicate Originals & Captions. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which constitute one and the same Agreement. The captions in this Agreement are for reference purposes only and shall not affect the meaning of terms and provisions herein.

9.10 Incorporation of Attachments, Exhibits and Addenda. Attachments "A", "B", "C", "D", and their associated exhibits are incorporated herein by reference and made a part of this Agreement.

9.11 Entire Agreement. This Agreement, inclusive of all attachments, exhibits, amendments, addenda and documents incorporated herein, is the entire agreement between the parties with regard to the subject matter hereof. Unless otherwise provided for in the Agreement, there are no other agreements or understandings, either oral or written, between the parties affecting this Agreement and this Agreement supersedes all prior or contemporaneous agreements, negotiations and understandings between the parties with regard to the subject matter hereof.

9.12 Survival. The following provisions survive the expiration or termination of this Agreement regardless of cause: Sections 2.1, 2.2.4, 2.4, 2.4.1, 2.4.2, 2.7, 3.1, 3.2, 3.2.1, 3.2.3, 3.3, 3.3.2, 3.4, 7.3, 7.4, 9.1, 9.7 and 9.8, Articles IV, V, VI and VIII, and Attachments "C" and "D" and all of their respective subparts.

9.13 Document Construction. The parties have participated jointly in the negotiation and drafting of this Agreement. In the event an ambiguity or question of intent or interpretation arises, this Agreement shall be construed as if drafted jointly by the parties and no presumption or burden of proof shall arise favoring or disfavoring any party by virtue of the authorship of any provision(s) of this Agreement.

<Signatures Follow>

SAMPLE

The undersigned authorized representatives of the parties have the authority necessary to bind all of the entities identified herein and have executed this Agreement to be effective as of _______________, 20___ (the "Effective Date").

"Provider"	**"Health Plan"**
______________________	______________________
Signature	Signature
______________________	______________________
Print Name/Title	Print Name/Title
______________________	______________________
Print Name of Provider	Print Name of Health Plan
______________________	______________________
Date	Date

Address for Notice:	**Address for Notice:**
______________________	**WellCare Health Insurance of Arizona, Inc.**
______________________	**d/b/a 'Ohana Health Plan**
______________________	**94-450 Mokuola Street**
______________________	**Suite 106**
______________________	**Waipahu, HI 96797**
____________	____________
Facsimile	Facsimile

SAMPLE

Attachment A
Ownership Disclosure

Name of Legal Entity: ____ is a:
(Should Match Entity Identified as "Provider" in the opening paragraph on Page 1)

Check the appropriate category below:

_____ Corporation
_____ Partnership
_____ Limited Liability Company
_____ Professional Association

__________ Check here if Provider is 100% owned, operated and managed by the signatory to this Agreement and there are no other Principals

OR

__________ Check here and complete the table below if Provider is owned, operated and/or managed by any one other than or in addition to the signatory to this Agreement listing the names, addresses and percentage of ownership of all Principals of Provider

SAMPLE

NAME	ADDRESS	PERCENT OWNERSHIP	TITLE	DATE

***Provider has a continuing obligation to notify the Health Plan of any changes to the information listed herein and of any change of ownership in Provider.**

--TO BE COMPLETED BY PROVIDER PRIOR TO EXECUTION OF THIS AGREEMENT--

Attachment B
Provider Office Location(s) & List of Health Care Providers

(1) Prior to execution of the Agreement and at any time thereafter during the term of the Agreement, Provider agrees to provide Health Plan with demographic information for Provider and for each of the Health Care Provider office locations and the Health Care Providers seeking participation under this Agreement, including:

- Name
- Address
- E-mail address
- Telephone and facsimile numbers
- Professional license number(s)
- Medicare/Medicaid ID number(s)
- Federal tax ID number(s)
- NPI number(s)
- Area of medical specialty
- Age restrictions (if any)
- Area hospitals with admitting privileges (where applicable)
- Identification for each Health Care Provider listed as either employed or owned by or contracted with Provider using the designation "(E)" or "(C)", respectively
- Identification for each Health Care Provider listed that is a group or multi-provider practice, and whether the individual licensed health care practitioners or providers are employed or owned by or contracted with such group or multi-provider practice of that Health Care Provider group or multi-provider practice using the designation "(E)" or "(C)" respectively
- Office contact person
- Office hours
- Billing office
- Billing office address
- Billing office telephone and facsimile numbers
- Billing office email address
- Billing office contract person

(2) All information identified above should be provided for each office location and/or Health Care Provider; attach the information or submit separate written document or electronic data containing said information, indicating if a specific piece of information regarding Health Care Providers is otherwise provided in credentialing applications submitted to Health Plan.

(3) Provider agrees, on behalf of Provider and Health Care Providers, that Health Plan may use such demographic and descriptive information relating to Provider and Health Care Providers in Participating Provider information distributed by Health Plan or Health Plan designee.

(4) Provider shall provide Health Plan with no less than sixty (60) days' prior written notice of any change: (i) in tax identification/NPI/government program identification number or numbers of Provider and/or any Health Care Provider; (ii) closing of an office location; and/or (iii) any Health Care Provider contract termination or cessation of association with or membership in Provider.

SAMPLE