INDEPENDENT PRACTICE ASSOCIATION (IPA) PARTICIPATION AGREEMENT

This Independent Practice Association Participation Agreement ("**Agreement**") is made and entered into by and between ________________________, an independent practice association organized and operating under the laws of the State of Hawaii, and the Principals of such entity all as listed in Attachment "A"(collectively "**IPA**") 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, IPA is an organization incorporated under the laws of the State of Hawaii to operate a business to manage physician practices, and who wishes to provide and/or arrange for the provision of medical and related health care services to Health Plan Members (as defined below); AND

WHEREAS, IPA represents and warrants that IPA is authorized to negotiate and execute provider agreements, including this Agreement, and to bind IPA and all IPA Providers (as defined below) to the terms and conditions of this Agreement; 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 IPA in selected provider network(s) for the provision of medical and related health care service by IPA Providers to Members.

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

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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.

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 “**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.

1.10 “**IPA Administrator**” means any entity contracted or subcontracted with IPA, including without limitation any third party administrator or licensed Utilization Review Agent (as defined under laws of the state in which services are performed), management services organization, network access entity, fiscal intermediary, or other agent, to perform, on behalf of the IPA, any one or more of IPA’s obligations under this Agreement.

1.11 “**IPA Provider(s)**” means those physicians, health care professionals and/or other health care providers licensed and/or authorized under the laws of the state or states in which services are provided and employed or owned by and/or contracted with IPA and identified in Attachment “B” of this Agreement.

1.12 “**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.

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

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

1.15 “**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.

1.16 “**PMPM**” means per Member per month.

1.17 “**Principal**” means any owner of IPA and/or owners of a majority interest, officer, directors and key management of the IPA (or IPA’s professional association, partnership or corporation).

1.18 “**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’s affiliates, subsidiaries or Health Plan’s

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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.

1.19 "**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 IPA 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 IPA acknowledges and shall require IPA Providers to acknowledge 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 IPA or any IPA Provider; and (b) this is not an exclusive arrangement.

2.1.2 IPA further acknowledges and shall require IPA Providers to further acknowledge 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 IPA Information.

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

2.2.2 IPA: (a) represents and warrants that all employed and/or owned IPA Providers shall comply with the terms and conditions of this Agreement; and (b) that to the extent IPA maintains written agreements with employed and/or owned IPA Providers, such agreements contain similar provisions to this Agreement.

2.2.3 IPA: (a) represents that IPA maintains written agreements with all contracted IPA Providers, which agreements contain similar provisions to this Agreement; (b) shall provide Health Plan with a sample of IPA's form agreements used with contracted IPA 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 IPA Providers who are or will be providing Covered Services to Members under this Agreement prior to execution of this Agreement or contracting with IPA, as applicable; (d) shall obtain signatures from each contracted IPA Provider who is or will be providing Covered Services to Members under this Agreement on a separate Individual Letter Agreement

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& 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 IPA Providers as related to their contracting directly with Health Plan. IPA Providers contracted with IPA 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 To the extent IPA utilizes a process in which IPA Providers may opt-in or opt-out of health plan services agreements negotiated by IPA, IPA agrees: (a) to provide Health Plan with information about such process prior to execution of this Agreement; and (b) that regardless of any provision in this Agreement and/or in any IPA agreements with IPA Providers to the contrary, IPA shall provide Health Plan with a list of those IPA Providers who have opted in to this Agreement and any changes from the list of IPA Providers included in Attachment "B" within no more than thirty (30) days of execution of this Agreement and prior to the Effective Date.

2.2.5 In the event of any conflict between IPA agreements with IPA 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, IPA agrees to provide Health Plan, and/or any authorized government agency, with access to copies of IPA's written agreements with IPA Providers. To the extent not otherwise required by Health Plan for payment purposes and/or an authorized government agency, IPA may redact fees paid by IPA thereunder prior to giving access to such agreements.

2.2.6 IPA understands that IPA and each IPA 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, IPA understands and agrees that should IPA employ, acquire or contract with a new IPA Provider during the term of this Agreement, such new IPA 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, IPA, on behalf of IPA and IPA Providers participating under this Agreement, hereby consents to and will cooperate with any requested in-office or site reviews.

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

2.2.8 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 IPA Provider who is required to be credentialed by Health Plan, or Health Plan's designee, or to terminate or suspend any IPA 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.

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. IPA 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 IPA acknowledges and agrees and shall require IPA Providers to acknowledge and agree that all rights and responsibilities arising in respect to individual Members shall be applicable only to Health Plan or Affiliate, as applicable, which 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 IPA agrees and shall require IPA Providers to agree 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. IPA shall not and shall require IPA Providers to not 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) IPA 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, IPA agrees, on behalf of IPA and each IPA Provider, 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, neither IPA nor any IPA Provider shall: (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 IPA or any Principal of IPA or any IPA 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 IPA and/or any IPA Provider from violating this section. IPA acknowledges, on behalf of IPA and IPA Providers, 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 IPA 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.

2.6.1 Accountability. Prior to execution of this Agreement and at any time thereafter during its term, IPA agrees to notify Heath Plan of any delegation by IPA of IPA's obligations hereunder. Regardless of any delegation of IPA responsibilities or obligations under the Agreement, IPA acknowledges and agrees that IPA is and remains responsible for its responsibilities and obligations hereunder.

2.6.2 Written Agreements. Where an IPA Administrator performs any of IPA's obligations under this Agreement, IPA shall ensure through written agreement with such IPA Administrator that the IPA Administrator performs in accordance with industry standards and abides by and is subject to the terms of this Agreement.

2.6.3 IPA Administrators. As of the date of execution of this Agreement, IPA represents that IPA has not delegated any of IPA's regulatory, administrative or contractual obligations under this Agreement. During the term of this Agreement, should IPA elect to engage an IPA Administrator, IPA agrees to provide written notice to Health Plan, and each such IPA Administrator shall execute a written agreement with IPA prior to such IPA Administrator assuming IPA obligations under this Agreement. IPA understands and agrees that: (a) regardless of anything to the contrary herein, any administrative services delegated by Health Plan to IPA, and for which the parties have entered into a written agreement outlining such delegated services, may not be sub-delegated by IPA without prior written notice to and approval from Health Plan; and (b) upon reasonable request, IPA will provide Health Plan with access to such written agreements with IPA Administrators.

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2.7 Software Use. Through use of or participation in certain processes or activities as a Health Plan contracted provider, IPA and/or IPA Providers 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) their respective 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. IPA and/or IPA Providers 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

Article III
Services

3.1 Eligibility Verification. IPA shall or shall require IPA Providers 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, IPA or IPA Provider, as applicable, 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. IPA shall provide directly or through appropriate arrangements with IPA 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 IPA.); (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 an IPA Provider performs or has available in-office laboratory procedures, tests and/or services: (a) 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; and (b) and such laboratory procedures, tests and/or services are not a Designated Service otherwise provided for in Section 3.2.4 below, IPA shall provide Health Plan with a copy of IPA Providers' CLIA certificates and/or changes thereto 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.

3.2.2 IPA shall and shall require each IPA Provider to 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 If some or all of IPA Providers render primary care services, IPA is responsible for ensuring that such IPA Providers coordinate the overall provision of Covered Services to Members assigned to such physician IPA Provider and to make reasonable efforts to establish a satisfactory physician/patient relationship. The provision of care shall include: (a) assuring the timeliness of urgent, emergent, sick and preventive care to Members in accordance with the Provider Manual and any applicable government program requirements; (b) when a Covered Service under the applicable Benefit Contract, conducting initial health assessments of new Members; (c) informing Members of specific health care needs that require follow up; and (d) instructing Members on measures they may take to promote their own health. Each IPA Provider's coordination of care shall include, but is not limited to, obtaining prior authorization where required and issuing Member referral(s) as Medically Necessary. Such referrals shall be issued only to other Participating Providers except: (i) for Emergency Medical Conditions; (ii) when Member self-referral is permitted under the Benefits Contract; or (iii) as authorized by Health Plan in the event no appropriate Participating Provider is available. To the extent no Participating Provider is available for referral, IPA Provider must obtain a

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prior authorization from Health Plan before referring any Member to a non-participating provider.

3.2.4 IPA, on behalf of IPA and each IPA 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 IPA and/or an IPA Provider has obtained prior authorization from Health Plan, IPA and IPA Providers agree to look solely to the appropriate Designated Provider for the provision of Designated Services to Members. In the event IPA and/or an IPA Provider has a contract with a Designated Provider to provide Designated Services to Members, IPA and/or the IPA Provider shall bill and look only to the Designated Provider for payment for the provision of Designated Services to Members.

3.3 Policies & Procedures. IPA agrees to and shall require IPA Providers 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 IPA, within the later of the ninety (90) day period following execution of this Agreement or approval of applicable state or federal agencies, where necessary. IPA is responsible for disseminating the Provider Manual to IPA 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 IPA and IPA Providers 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 IPA agrees and shall require IPA Providers to cooperate with Health Plan's quality improvement and utilization review/management activities as applicable to IPA, IPA Providers 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 IPA agrees and shall require IPA Providers to cooperate and participate with Health Plan: (a) in Health Plan's 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, IPA shall require IPA Providers to 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 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.

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4.1.1 When submitting Claims and/or Encounter Data to Health Plan, IPA agrees and shall ensure that IPA Providers: (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 an IPA Provider submit claims using retired or replaced codes, IPA understands and agrees and shall require IPA Providers to agree that Health Plan may deny such claims until appropriately coded and resubmitted.

4.1.2 If the payment for Covered Services provided for under this Agreement is on a capitated basis, IPA shall ensure that IPA Providers submit complete Encounter Data to Health Plan for the provision of all Covered Services to Members under this Agreement within thirty (30) days of the end of the month in which services were provided or such lesser period of time otherwise required by applicable law or government contract to which Health Plan is subject. Except to the extent specifically required by applicable state or federal law or regulation, IPA agrees and shall require IPA Providers to agree that submission of Encounter Data to Health Plan as provided for herein, does not require consent from the Member.

4.1.3 Health Plan shall monitor IPA and IPA Providers' 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 IPA and/or any IPA Provider is not meeting such electronic submission requirements, Health Plan, in addition to any other provisions herein, will notify IPA and within five (5) business days of receipt of such notice, IPA shall identify for Health Plan and implement IPA's and IPA 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 IPA Providers 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. IPA agrees and shall require IPA Providers 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, IPA Providers shall collect Member Expenses for Covered Services directly from Members, and shall not waive, discount or rebate any such Member Expenses.

4.2.2 Regardless of any provision to the contrary, IPA, on behalf of IPA and IPA Providers, hereby authorizes Health Plan to deduct from amounts that may otherwise be due and payable to IPA and/or any IPA Provider any such outstanding amounts that IPA and/or any IPA Provider may, for any reason, owe Health Plan, including without limitation any adjustments to payments made to IPA and/or any IPA 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 IPA and/or any IPA Provider is a party to more than one agreement with Health Plan for the provision of medical and related health care services to Members, IPA or IPA Provider, as applicable, 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 IPA or any IPA 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

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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. IPA agrees and shall require IPA Providers to share information obtained or documentation required by Health Plan to facilitate Health Plan's coordination of such other benefits. If IPA and/or any IPA Provider has knowledge of an alternative primary payor, IPA shall require IPA Providers to 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. IPA, on behalf of IPA and each IPA 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 IPA or any IPA 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 IPA and/or any IPA Provider and Members or persons acting on their behalf.

4.5 Non-Covered Services. Health Plan will exclude from payment to IPA Providers the cost of any non-covered service. IPA Providers 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 an IPA Provider is uncertain whether a service is a Covered Service, IPA shall require IPA Providers 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 IPA or any IPA Provider dispute payment or payments made by Health Plan under this Agreement, IPA, on behalf of IPA and IPA Providers, 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. IPA shall require IPA Providers to 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. IPA 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 IPA, any IPA Provider, any IPA Administrator, and/or any related organization or entity as they apply to the obligations of IPA

and/or IPA Providers under this Agreement. The purpose of this requirement is to permit Health Plan to assure compliance by IPA with all obligations, financial, operational, quality assurance, as well as other obligations of IPA and/or IPA Providers under this Agreement and their respective continuing abilities to meet such obligations.

5.2.1 IPA agrees and shall require IPA Administrators and IPA Providers 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, IPA shall and/or shall require IPA Providers 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. IPA agrees and shall require IPA Providers 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

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. IPA, IPA Providers and Health Plan agree to comply with all applicable state and federal laws, rules, and/or 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.

(a) IPA represents that all IPA Administrators performing services for IPA under this Agreement shall maintain applicable licensure, certification or accreditation as may be required under applicable state and/or federal laws, rules and regulations, including without limitation third party administrator licensure/certification and/or designation as a utilization review agent.

6.3 Excluded Individuals/Entities. IPA 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. IPA agrees and shall require IPA Administrators and/or IPA Providers to provide Health Plan with timely access to records, reports, clinical information and/or Encounter Data in the format required for Health Plan to meet obligations under contracts with any government agency sponsoring or overseeing Health Plan products covered under this Agreement.

6.5 Licensure/Certification. During the term of this Agreement, IPA is and will remain properly licensed, certified and/or accredited in good standing and shall require each IPA Provider to remain properly licensed and/or certified in good standing as provided for in this Agreement throughout its term and in accordance with applicable Hawaii and federal laws, rules and regulations. IPA shall and shall require IPA Providers to notify Health Plan immediately in writing upon the occurrence of any event that could reasonably be expected to impair the ability of IPA or any IPA Provider, respectively, 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 IPA or any IPA Provider; (b) the exclusion, suspension or bar from, or imposition of any sanctions against IPA or any IPA Provider relating to any government payor program, or any settlement related thereto; (c) any disciplinary action initiated by any regulatory body against IPA or any IPA Provider; (d) the suspension, limitation, revocation or termination of any IPA Provider's hospital privileges; (e) any action concerning or brought by a Member against IPA

SAMPLE

or any IPA Provider ; (f) the conviction of IPA or any IPA 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 Insurance. IPA shall maintain and shall require each IPA Provider and their respective employed and contracted licensed and/or certified health care providers/practitioners to maintain: (a) such policies of general and professional liability (malpractice) insurance as necessary to insure against claims of personal injury or death alleged or caused by their respective 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: (a) for IPA 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; and (b) for each individual IPA 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, IPA shall and/or shall require IPA Provider to: (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.

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Article VII
Term and Termination

7.1 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 IPA acknowledges, and shall require IPA Providers to acknowledge 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 IPA and IPA Providers who are required to be credentialed; and (b) after successful initial credentialing of IPA and IPA 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 IPA.

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 IPA Provider under this Agreement, immediately upon written notice to IPA, or if applicable only to an individual IPA Provider to that IPA 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