

PHYSICIAN PARTICIPATION AGREEMENT

This Physician Participation Agreement (“**Agreement**”) is made and entered into by and between _____, a professional physician practice in the specialty of _____ 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 “**Physician**”) 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, Physician is an individual licensed under the laws of the State of Hawaii to practice medicine or osteopathy, or a physician group practice licensed and organized as a professional association, professional services corporation, professional limited liability corporation, partnership or similar organization, as applicable, duly licensed and/or authorized to operate a practice of medicine or osteopathy and providing services in accordance with state and federal laws, rules and regulations, and who wishes to provide medical and related health care services to Health Plan Members (as defined below); AND

WHEREAS, Physician represents and warrants that Physician is authorized to negotiate and execute provider agreements, including this Agreement, and to bind itself and all Health Care Practitioners to the terms and conditions of this Agreement. Whenever in this Agreement the term “Physician” is used to describe an obligation or duty, such duty or obligation shall also be the responsibility of each individual Health Care Practitioner, 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 Physician in selected provider network(s) for the provision of medical and related health care service by Physician 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:

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 “**Health Care Practitioner(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 who are: (a) employed by or contracted with Physician; (b) rendering services to Members under this Agreement and identified in Attachment “B”; and (c) will be submitting claims to Health Plan under 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 “**PMPM**” means per Member per month.
- 1.16 “**Principal**” means any owner of Physician and/or owners of a majority interest, officer, directors and key management of the Physician (or Physician’s professional association, partnership or corporation).
- 1.17 “**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 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.

1.18 “**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 Physician 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 Physician 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 Physician; and (b) this is not an exclusive arrangement.

2.1.2 Physician 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 Physician Information.

2.2.1 Physician: (a) shall provide Health Plan with a complete list of all Health Care Practitioners prior to execution of this Agreement and shall provide notice to Health Plan prior to the addition of any new Health Care Practitioners under this Agreement consistent with the provisions of Attachment “B”; (b) represents and warrants that all Health Care Practitioners: (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 Physician negotiated contracts; and (c) agrees that it is Physician's responsibility to assure the compliance of Health Care Practitioners with the terms and conditions of this Agreement.

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

2.2.3 Physician: (a) represents that Physician maintains written agreements with all contracted Health Care Practitioners, which agreements contain similar provisions to this Agreement; (b) shall provide Health Plan with a sample of Physician's form agreements used with contracted Health Care Practitioners; (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 Practitioners who are or will be providing Covered Services to Members under this

Agreement prior to execution of this Agreement or contracting with Physician, as applicable; (d) shall obtain signatures from each contracted Health Care Practitioner 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 Practitioners as related to their contracting directly with Health Plan. Health Care Practitioners contracted with Physician 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 Physician agreements with Health Care Practitioners 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 obligation, Physician agrees to provide Health Plan, and/or an authorized government agency, with access to copies of Physician's written agreements with Health Care Practitioners. To the extent not otherwise required by Health Plan for payment purposes and/or an authorized government agency, Physician may redact fees paid by Physician thereunder prior to giving access to such agreements.

2.2.5 Physician understands that Physician and each Health Care Practitioner is required to be credentialed and/or re-credentialed under Health Plan's policies and 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, Physician understands and agrees that should Physician employ or contract with a new Health Care Practitioner during the term of this Agreement, such new Health Care Practitioner 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, Physician 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, Physician agrees that Physician will accept new Members for as long as Physician is accepting any new patients. If Physician is no longer available to prospective Members under the above requirements, Physician 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 Practitioner who is required to be credentialed by Health Plan, or Health Plan's designee, or to terminate or suspend any Health Care Practitioner 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. Physician 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 Physician 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 Physician 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. Physician 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) Physician 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, Physician 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, Physician 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 Physician or any Principal of Physician. Regardless of any provision to the contrary, in the event of a violation or threatened violation of this section, Health Plan is entitled to seek all available remedies at law or equity including an injunction enjoining and restraining Physician from violating this section. Physician 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 Physician 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 Physician Administrators. As of the date of execution of this Agreement, Physician represents that Physician has not delegated any of Physician's regulatory, administrative or contractual obligations under this Agreement. During the term of this Agreement, should Physician elect to engage a third party administrator and/or other individual or entity, Physician agrees to provide written notice to Health Plan, and each such individual or entity shall execute a written agreement with Physician prior to assuming any Physician obligations under this Agreement. Physician understands and agrees that: (a) regardless of anything to the contrary herein, any administrative services delegated by Health Plan to Physician, and for which the parties have entered into a written agreement outlining such delegated services, may not be sub-delegated by Physician without prior written notice to and approval from Health Plan; and (b) upon reasonable request, Physician will provide Health Plan with access to such written agreements with individuals or entities.

2.7 Software Use. Through use of or participation in certain processes or activities as a Health Plan contracted provider, Physician 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) Physician'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. Physician 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.** Physician 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, Physician 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.** Physician shall provide directly or through appropriate arrangements with Health Care Practitioners 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 Physician.); (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 Physician 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 under Section 3.2.4 below, Physician shall provide Health Plan with a copy of Physician's CLIA certificate(s) 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 Physician 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 If Physician and/or some or all Health Care Practitioners render primary care services, Physician is responsible for coordinating the overall provision of Covered Services to Members assigned to Physician, and shall 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. Physician'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 Benefit 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 Physician's referral, Physician must obtain a prior authorization from Health Plan before referring any Member to a non-participating provider.

3.2.4 Physician 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 Physician has obtained prior authorization from Health Plan, Physician agrees to look solely to the appropriate Designated Provider for the provision of Designated Services to Members. In the event Physician has a contract with a Designated Provider to provide Designated Services to Members, Physician agrees to look to and bill only the Designated Provider for payment for the provision of Designated Services to Members.

3.3 Policies & Procedures. Physician 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 Physician, within the later of the ninety (90) day period following execution of this Agreement or approval of applicable state or federal agencies, where necessary. Physician is responsible for disseminating the Provider Manual to Health Care Practitioners.

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 Physician 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 Physician agrees to cooperate with Health Plan's quality improvement and utilization review/management activities as applicable to Physician 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 Physician agrees 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, Physician 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 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, Physician 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 Physician submit claims using retired or replaced codes, Physician understands and agrees 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, Physician shall 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, Physician agrees 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 Physician's compliance with Health Plan's electronic Claims and/or Encounter Data submission, reporting, and/or other administrative requirements. In the event Health Plan determines that Physician is not meeting such electronic submission requirements, Health Plan will notify Physician and Physician shall identify Physician'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 Physician 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. Physician 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, Physician 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, Physician hereby authorizes Health Plan to deduct from amounts that may otherwise be due and payable to Physician any such outstanding amounts that Physician may, for any reason, owe Health Plan, including without limitation any adjustments to payments made to Physician 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 Physician and/or any acquired or contracted physician or physician practice of Physician is a party to more than one agreement with Health Plan for the provision of medical and related health care services to Members, Physician will be paid 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 Physician 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. Physician agrees to share information obtained or documentation required by Health Plan to facilitate Health Plan's coordination of such other benefits. If Physician has knowledge of an alternative primary payor, Physician 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. Physician 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 Physician 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 Physician and Members or persons acting on their behalf.

4.5 Non-Covered Services. Health Plan will exclude from payment to Physician the cost of any non-covered service. Physician 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 Physician is uncertain whether a service is a Covered Service, Physician 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 Physician dispute payment or payments made by Health Plan under this Agreement, Physician 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.

Article V

Records Access & Audits

5.1 Maintenance. Physician 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. Physician 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 Physician, any individual or entity performing services for or on behalf of Physician, or any related organization or entity, as they apply to the obligations of Physician under this Agreement. The purpose of this requirement is to permit Health Plan to assure compliance by Physician with all obligations, financial, operational, quality assurance, as well as other obligations of Physician under this Agreement and Physician's continuing ability to meet such obligations.

5.2.1 Physician 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, Physician 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. Physician 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

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 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.

6.3 Excluded Individuals/Entities. Physician 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. Physician 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 Physician Licensure/Certification. During the term of this Agreement, Physician will and will require all employees, subcontractors, independent contractors and Health Care Practitioners to procure and maintain in good standing such licensure, certification and/or registration as provided for in this Agreement and in accordance with applicable Hawaii and federal laws, rules and regulations. Physician shall notify Health Plan immediately in writing upon the occurrence of any event that could reasonably be expected to impair the ability of Physician 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 Physician; (b) the exclusion, suspension or bar from, or imposition of any sanctions against Physician relating to any government payor program, or any settlement related thereto; (c) any disciplinary action initiated by any regulatory body against Physician; (d) the suspension, limitation, revocation or termination of Physician's hospital privileges; (e) any action concerning or brought by a Member against Physician; (f) the conviction of Physician 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 Physician Insurance. Physician shall maintain and shall require Health Care Practitioners to maintain: (a) such policies of general and professional liability (malpractice) insurance as necessary to insure Physician, respectively, against claims of personal injury or death alleged or caused by Physician and/or Health Care Practitioner 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 Physician and each individual Health Care Practitioner 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, Physician 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. 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 Physician 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 Physician and Health Care Practitioners who are required to be credentialed; and (b) after successful initial

credentialing of Physician and Health Care Practitioners 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 Physician.

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 Practitioner under this Agreement, immediately upon written notice to Physician 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) exclusion, suspension or bar of Physician and/or any Health Care Practitioner from participation in any government health care program; (d) determination by a government agency or any judicial or administrative review body that Physician and/or any Health Care Practitioner has engaged or is engaging in fraud; (e) failure by Physician or any Health Care Practitioner to maintain the general and/or professional liability insurance coverage requirements of this Agreement; or (f) Health Plan’s reasonable determination that Physician or any Health Care Practitioner immediate termination is necessary for the health and safety of Member. Further, Health Plan may terminate this Agreement immediately upon written notice to Physician in the event that: (i) there is a change in control in Physician or any new owner or ownership is not acceptable to Health Plan; (ii) Physician 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 Physician. 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, Physician 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, Physician 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 initial publication or distribution.

7.3 Obligations Upon Termination. Upon termination of this Agreement under Sections 7.2.1 and 7.2.2, Physician 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, Physician 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, Physician 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

Physician communications designed for notice to Members and not other patients regarding the expiration or termination of this Agreement.

Article VIII Dispute Resolution

8.1 Dispute Resolution. Health Plan and Physician 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, Physician agrees to 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 agreed upon location in the State of Hawaii in accordance with and subject to the Arbitration Rules, Procedure 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 Physician.

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 “Physician” 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: (a) 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; and/or (b) Health Plan may amend this Agreement upon thirty (30) days written notice to Physician. Unless Physician objects in writing to such amendment during the thirty (30) day notice period, Physician shall be deemed to have accepted the amendment.

9.3 Assignment. This Agreement is intended to secure the provision of services by Physician; as such Physician 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.

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 Physician’s temporary inability to meet any one or more of Physician’s obligations under this Agreement (including without limitation the obligation to provide Covered Services to Members), Physician represents that Physician 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 Physician be unable to meet Physician’s obligations under this Agreement due to such an unanticipated event beyond Physician’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 Physician hereunder, if any, upon written notice to Physician. 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) Physician may include the name of Health Plan in listings of health plans in which Physician participates; and (b) Health Plan may use certain demographic and descriptive information regarding Physician 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

