ANCILLARY PROVIDER PARTICIPATION AGREEMENT

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

RECITALS

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

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

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

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

Article I

Definitions

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

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

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

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

1.4 “CLIA” means the Clinical Laboratory Improvement Amendments of 1988, as may be amended.
1.5 “Covered Services” means those Medically Necessary medical, related health care and other services covered under and defined in accordance with the applicable Member Benefit Contract.

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

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

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

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

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

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

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

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

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

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

1.16 “Proprietary Information” means information related to Health Plan: (a) which derives economic value, actual or potential, from not being generally known to or readily ascertainable by other persons who can obtain economic value from its disclosure or use; and (b) which is the subject of efforts that are reasonable under the circumstances to maintain its secrecy or proprietary status, including all tangible reproductions or embodiments of such information. Proprietary Information includes, but is not limited to, technical and non-technical data related to the formulas, patterns, designs, compilations, programs, inventions, methods, techniques, drawings, processes, finances, actual or potential customers and suppliers, existing and future products, manuals, policies and procedures, software, information and operational systems of Health Plan, Health Plan affiliates, subsidiaries or Health Plan’s parent company. Proprietary Information also includes information that has been disclosed to Health Plan or Health Plan’s affiliates by a third party and which Health Plan or any Health Plan affiliate, subsidiary or Health Plan’s parent company is obligated to treat as confidential.
1.17 “Provider Manual” means the Health Plan’s operating policies, standards, and procedures for Participating Providers including, but not limited to, Health Plan’s requirements for claims submission and payment, credentialing/re-credentialing, utilization review/management, disease and case management, quality assurance/improvement, advance directives, Member rights, grievances and appeals.

**Article II**

**Relationship**

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

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

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

2.2 **Provider Information.**

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

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

2.2.3 Provider: (a) represents that Provider maintains written agreements with all contracted Health Care Providers, which agreements contain similar provisions to this Agreement; (b) shall provide Health Plan with a sample of Provider’s form agreements used with Provider’s contracted Health Care Providers; (c) shall provide Health Plan with a copy of the first page (including the names of the contracting parties and the effective date) and the signature page of all contracted Health Care Providers who are or will be providing Covered Services to Members under this Agreement prior to execution of this Agreement or contracting with Provider, as applicable; (d) shall obtain signatures from each contracted Health Care Provider who is or will be providing Covered Services to Members under this Agreement on a separate Individual Letter Agreement & Joinder in the form set forth in Exhibit “B-1” within thirty (30) days of execution of this Agreement; and (e) hereby waives any non-compete provisions contained in arrangements with such contracted Health Care Providers as related to their contracting directly with Health Plan.
Provider and Health Care Providers contracted with Provider who do not execute such Individual Letter Agreement & Joinder shall not be entitled to participate under this Agreement and will not be identified as a Participating Provider.

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

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

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

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

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

2.4 Health Plan Information.

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

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

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

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

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

Article III

Services

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

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

3.2 Provision of Services. Provider shall provide directly or through appropriate arrangements with Health Care Providers those medical and related health care services available within the scope of their respective medical or professional licenses to Members: (a) with coverage on a twenty-four (24) hour a day, seven (7) day per week basis (Any “on-call” or “coverage” pay is the responsibility of Provider.); (b) in accordance with the provisions of this Agreement; (c) on the same basis as those services rendered to other patients; (d) consistent with the prevailing practices and standards within the community; and (e) without discrimination on the basis of type of health benefit plan, source of payment, race, age, sex, national origin, religion, color, health status or handicap.
3.2.1 To the extent Provider performs or has available in-office laboratory procedures, tests and/or services, all such laboratory equipment and supplies shall be maintained and all such laboratory procedures, tests and services shall be rendered in accordance with all applicable state and federal laws, rules and regulations, including without limitation CLIA. Prior to execution of this Agreement and at any time thereafter before any available in-office laboratory procedures, tests and/or services are rendered to Members, Provider shall provide Health Plan with a copy of Provider’s CLIA certificate and/or changes thereto.

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

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

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

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

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

3.4 Grievances and Appeals. Provider agrees to cooperate and participate with Health Plan: (a) in Health Plan grievance and appeals processes to resolve disputes that may arise between Health Plan and Members, including without limitation the timely provision of information and/or records and documents required by Health Plan; and (b) in provider appeals and dispute resolution processes developed and implemented by Health Plan.
industry and as designated by Health Plan, including without limitation use of certain electronic data interface companies or claims clearing houses used by Health Plan and in format(s) and with content otherwise required by a government sponsored health benefits program for which there is a program attachment to this Agreement within ninety (90) days of the date of service or the date of discharge from an inpatient facility, as applicable. Health Plan, in Health Plan’s sole discretion, may deny payment for any claims received following the above referenced time period(s). In the event payment is denied as described herein, any Member Expenses shall be adjusted accordingly.

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

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

4.2 Payment.

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

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

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

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

4.3 Coordination of Benefits/Recovery Rights. Payment for Covered Services provided to each Member are subject to reimbursement, subrogation and/or coordination with other benefits payable or paid to or on behalf of the Member, and to Health Plan’s right of recovery in other third party liability situations. Health Plan will coordinate payment for Covered Services in accordance with the terms of Benefit Contracts and applicable state and federal laws, rules or regulations. If a Member has coverage from more than one payor or source, Health Plan will coordinate benefits with such other payor(s) in accordance with the provisions of Benefits Contracts. Provider agrees to share information obtained or documentation required by Health Plan to facilitate Health Plan’s coordination of such other
benefits. If Provider has knowledge of an alternative primary payor, Provider shall bill such other payor(s) with the primary liability based on such information prior to submitting claims for the same services to Health Plan. To the extent permitted by law, if Health Plan is not Member's primary payor, payment for Covered Services from Health Plan shall be no more than the difference between the amount paid by the primary payor(s) and the applicable rate under this Agreement, less any applicable Member Expenses.

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

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

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

Article V
Records Access & Audits

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

5.2 Access & Audit. Provider agrees that Health Plan, or Health Plan’s designee, shall have the right to audit and reasonable access to examine during normal business hours, on at least forty-eight (48) hours’ advance notice, or such shorter period of time as maybe imposed on Health Plan by a federal or state regulatory agency or accreditation organization, the facilities, billing and financial books, records and operations of Provider, any individual or entity performing services for or on behalf of Provider or any related organization or entity, as they apply to the obligations of Provider under this Agreement. The purpose of this requirement is to permit Health Plan to assure compliance by Provider with all obligations, financial, operational, quality assurance, as well as other obligations of Provider under this Agreement and Provider’s continuing ability to meet such obligations.
5.2.1 Provider agrees to make copies of medical, administrative and/or financial records related to services rendered to Members available to Health Plan for inspection, review and/or audit upon request. Copies of such records shall be at no cost to Health Plan.

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

5.4 Confidentiality. Provider agrees to maintain the confidentiality of, use and/or disclosure any personally identifiable information, any protected health information and/or information contained 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/or federal laws, rules, and regulations. The alleged failure by either party to comply with applicable state and/or federal laws, rules or regulations shall not be construed as allowing either party a private right of action against the other in any legal or administrative proceeding in matters in which such right is not recognized by such law, rule or regulation.

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

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

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

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

6.7 Provider Insurance. Provider shall maintain and shall require Health Care Providers to maintain: (a) such policies of general and professional liability (malpractice) insurance as necessary to insure Provider, respectively, against claims of personal injury or death alleged or caused by Provider and/or Health Care Provider(s) performance under this Agreement; (b) worker’s compensation coverage in accordance with and to the extent required by the laws of the State of Hawaii; and (c) any stop-loss coverage as is or may be required by Health Plan and/or in accordance with applicable state and federal laws, rules and regulations. Such professional liability coverage for Provider and each individual Health Care Provider participating under this Agreement shall be one million dollars ($1,000,000) per
occurrence/three million dollars ($3,000,000) in the aggregate or such amounts as are required by state law, whichever is greater. Prior to execution of this Agreement as part of the credentialing process, and thereafter upon Health Plan request, Provider shall: (a) provide evidence of such insurance coverage; and (b) provide Health Plan with ten (10) days advance notice of any material modification, cancellation or termination of such coverage.

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

**Article VII**

**Term and Termination**

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

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

7.2 **Termination.** This Agreement may be terminated as follows:

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

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

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

7.2.4 **One Time Termination by Provider.** If, within the thirty (30) day period following the initial distribution or provision of electronic access to the Provider Manual as provided for in Section 3.3, Provider should raise issues regarding or dispute a material part of the Provider Manual for which the parties are unable to come to a mutually agreeable resolution, Provider may elect to terminate this Agreement upon sixty (60) days written notice to Health Plan. This provision does not apply to any updates or modifications to or subsequent editions of the Provider Manual made following the initial publication or distribution.
7.3 Obligations Upon Termination. Upon termination of this Agreement under Sections 7.2.1 and 7.2.2, Provider will continue to provide Covered Services to Members as indicated below and to cooperate with Health Plan to transition Members to other Participating Providers in a manner that ensures medically appropriate continuity of care. In accordance with the requirements of applicable government sponsored health benefits programs, Health Plan’s accrediting bodies and applicable law and regulation, Provider will continue to provide Covered Services to Members after the termination of this Agreement, whether by virtue of insolvency or cessation of operations of Health Plan, or otherwise: (a) for those Members who are confined in an inpatient facility on the date of termination until discharge; (b) for all Members through the date of the applicable government sponsored health benefits program contract for which payments have been made by the applicable government agency; and (c) for those Members undergoing active treatment of chronic or acute medical conditions as of the date of expiration or termination through their current course of active treatment not to exceed ninety (90) days unless otherwise required by item (b) above. Unless otherwise provided for herein, the terms and conditions in this Agreement shall apply to such post-termination Covered Services.

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

Article VIII
Dispute Resolution

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

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

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

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

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

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

**Article IX**

**Miscellaneous**

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

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

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

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

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

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

9.6.1 Regardless of any provision to the contrary: (a) In the event of a natural disaster, system failure and/or other event that may adversely impact and/or results and/or may result in Provider's temporary inability to meet any one or more of Provider's obligations under this Agreement (including without limitation the obligation to provide Covered Services to Members), Provider represents that Provider has in place a recovery plan inclusive of a mechanism for notice to contracted entities (including without limitation Health Plan) and the timing of assumption of obligations; and (b) Should Provider be unable to meet Provider’s obligations under this Agreement due to such an...
unanticipated event beyond Provider’s control for a period of more than forty-eight (48) hours, Health Plan, in Health Plan’s discretion, immediately may terminate this Agreement and/or revoke any one or all administrative activities or functions delegated by Health Plan to Provider hereunder, if any, upon written notice to Provider. In such event, payments attributable to such delegated administrative activities or functions, if any, shall be adjusted accordingly.

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

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

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


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

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

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

<Signatures Follow>
The undersigned authorized representatives of the parties have the authority necessary to bind all of the entities identified herein and have executed this Agreement to be effective as of ______________, 20__ (the “Effective Date”).

“Provider”

_______________________________________
Signature

_______________________________________
Print Name/Title

_______________________________________
Print Name of Provider

_______________________________________
Date

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

_______________________________________
Facsimile

“Health Plan”

_______________________________________
Signature

_______________________________________
Print Name/Title

_______________________________________
Print Name of Health Plan

_______________________________________
Date

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

_______________________________________
Facsimile
Name of Legal Entity: ___________________________________________________________ is a:

*(Should Match Entity Identified as “Provider” in the opening paragraph on Page 1)*

Check the appropriate category below:

- [ ] Corporation
- [ ] Partnership
- [ ] Limited Liability Company
- [ ] Professional Association

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

OR

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

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

--TO BE COMPLETED BY PROVIDER PRIOR TO EXECUTION OF THIS AGREEMENT--
Attachment B
Provider Office Location(s) & List of Health Care Providers

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

- Name
- Address
- E-mail address
- Telephone and facsimile numbers
- Professional license number(s)
- Medicare/Medicaid ID number(s)
- Federal tax ID number(s)
- NPI number(s)
- Area of medical specialty
- Age restrictions (if any)
- Area hospitals with admitting privileges (where applicable)
- Identification for each Health Care Provider listed as either employed or owned by or contracted with Provider using the designation “(E)” or “(C)”, respectively
- Office contact person
- Office hours
- Billing office
- Billing office address
- Billing office telephone and facsimile numbers
- Billing office email address
- Billing office contract person

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

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

(4) Provider shall provide Health Plan with no less than sixty (60) days’ prior written notice of any change: (i) in tax identification/NPI/government program identification number or numbers of Provider and/or any Health Care Provider; (ii) closing of an office location; and/or (iii) any Health Care Provider contract termination or cessation of association with or membership in Provider.
This Individual Letter Agreement & Joinder ("Letter Agreement") is entered into by and between WellCare Health Insurance of Arizona, Inc. d/b/a ‘Ohana Health Plan and those Affiliates (as defined in the Agreement) that underwrite or administer health plans and are identified in one or more program attachments appended to the Agreement (as defined below)(severally and collectively, as the context may require, “Health Plan”) and ______________ a Hawaii licensed practitioner (“Practitioner”).

The parties hereto agree as follows:

(1) Health Plan and _____________________ (“Provider”) executed a Provider Participation Agreement (the “Agreement”), and Practitioner is contracted with Provider by virtue of Practitioner’s written agreement with Provider and desires to provide medical services to Health Plan Members under the terms and conditions of the Agreement. Capitalized terms not defined in this Letter Agreement have the same definition as given in the Agreement.

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

(3) Practitioner: (a) agrees that Practitioner has been provided an opportunity to read the Agreement; (b) agrees to abide by the terms and conditions of the Agreement including, without limitation, compliance with Health Plan policies and procedures, Member hold harmless, payment and dispute resolution provisions, all of which are hereby incorporated by reference; (c) assumes those obligations of Provider under the Agreement that are applicable to Practitioner in his/her provision of Covered Services to Health Plan Members; (d) agrees that Health Plan and Provider may amend the Agreement, without notice to or right of approval of Practitioner; (e) agrees that any Health Plan notice to Provider shall be sufficient to notify Practitioner; and (f) that during the term of the Agreement, Health Plan, in Health Plan’s discretion, may terminate Practitioner participation with Health Plan at any time upon written notice, with the Agreement as between Provider and Health Plan remaining in effect.

(4) Practitioner agrees to provide prompt updates to Health Plan, in the event of any change of status in Practitioner’s license or any credentialing/re-credentialing information provided to Health Plan. Practitioner understands and agrees: (a) that prior to rendering any professional services to Health Plan Members, Practitioner must first be approved and credentialed by Health Plan, or Health Plan’s designee, as needed to complete credentialing and/or re-credentialing and (c) to take all actions necessary to advise Health Plan, or Health Plan’s designee, of any change in licensure and/or other information provided pursuant to credentialing and/or re-credentialing. Practitioner authorizes Health Plan and Provider to share information, including without limitation, claims and encounters, credentialing, re-credentialing, quality improvement/management and utilization management/review information as related to the provision of services to Members.

(5) Practitioner further agrees that to the extent payment for Covered Services rendered by Practitioner to Members is made by Health Plan to Provider, this payment to Provider is payment in full to Practitioner for Covered Services rendered by Practitioner to Members and Practitioner shall look solely to Provider for reimbursement. To the extent payment for Covered Services rendered by Practitioner to Members is made by Health Plan directly to Practitioner, Practitioner agrees that this payment is payment in full for such Covered Services.

(6) The parties agree that upon expiration or termination of the Agreement for any reason or Provider is dissolved for whatever reason or Practitioner’s contract with Provider is terminated: (a) Practitioner shall continue to provide medical services to Members under the terms and conditions of the Agreement and Health Plan agrees to pay Practitioner in accordance with the payment terms of the Agreement and fee-for-service rates identified in the applicable program attachment(s) incorporated into the Agreement for a period of ninety (90) days thereafter during which time Health Plan, in Health Plan’s discretion, may elect to negotiate a new separate contract with Practitioner for the provision of medical services to Members, notwithstanding any non-competition provision of any contract between Practitioner and Provider. Health Plan, in Health Plan’s discretion, may terminate Practitioner participation at any time after termination of the Agreement, dissolution of Provider or termination of Practitioner’s contract with Provider, upon written notice.

(7) In the event of any conflict or ambiguity between Practitioner’s contract with Provider and this Letter Agreement, the terms of this Letter Agreement shall control with respect to services rendered to Members.

Practitioner: _______________________________                Health Plan: _______________________________
Signature/Date                                      Signature/Date
Attachment C
Hawaii Medicaid Plans & Payment

I: General Provisions. In addition to the terms and conditions of the Agreement, the following definitions and provisions apply only as to Covered Services rendered to Members covered under those Hawaii State Government Agency sponsored health benefit plans identified below that are offered and/or administered by Health Plan and identified below, and shall control in the event of any conflict between the provisions of the Agreement and this Attachment “C”.

- Hawaii Medicaid Plans offered and/or administered by Health Plan

Health Plan will provide advance written notice of additions or deletions to plans listed above, which written notice shall serve to modify this Attachment “C” of the Agreement without need for signature of Provider, regardless of any provisions to the contrary. Provider understands and agrees that Health Plan, in Health Plan’s sole discretion, may elect to develop and/or implement Hawaii State Government Agency sponsored health benefit plans with limited or alternative provider networks in which Provider does not participate.

A. Definitions. For purposes of this Attachment “C” and its associated exhibits, the following additional terms shall have the meaning set out below:

1. “Advanced Directive” means a written instruction, such as a living will or durable power of attorney for healthcare, recognized under Hawaii law relating to the provision of healthcare when the individual is incapacitated.

2. “Clean Claim” means a Claim that can be processed without obtaining additional information from the provider of service or such provider’s designated representative. It includes a claim with errors originating in the DHS claims systems. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.


4. “Copayment” means a specific dollar amount or percentage of the charge identified which is paid by a Medicaid Member at the time of service to Health Plan for Covered Services provided to the Medicaid Member.

5. “Covered Services” means those Medically Necessary medical, related health care and other services and benefits more fully described in the Provider Manual and to which the Medicaid Member is entitled under Hawaii’s QExA Program.

6. “Cultural Competency” means a set of interpersonal skills that allow individuals to increase their understanding, appreciation, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with Medicaid Members. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better culturally diverse Medicaid Member needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications and other supports.


8. “Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An Emergency Medical Condition shall not be defined on the basis of lists of diagnoses or symptoms.
(9) “Emergency Services” means any inpatient and outpatient Covered Services that are furnished by a provider that is qualified to furnish services and that are needed to evaluate or stabilize an Emergency Medical Condition.

(10) “Encounter Data” means information, data and/or reports about clinical encounters and Covered Services rendered to Medicaid Members as supported with documentation in the Medicaid Member medical record and/or records documenting Covered Services provided and in a format that comports with the HIPAA 837 requirements and any additional DHS, Hawaii QExA Program and/or Medicaid Contract requirements.

(11) “EPSDT” or “Early and Periodic Screening, Diagnosis and Treatment” means a Title XIX mandated program that covers screening and diagnostic services to determine physical and mental conditions in Medicaid Members less than twenty-one (21) years of age, and healthcare treatment and other measures to correct or ameliorate any conditions identified during the screening process.

(12) “Incentive Arrangement” means any payment mechanism under which a provider may receive additional funds from Health Plan for meeting targets specified in the Agreement.

(13) “Medicaid Member(s)” means those individuals determined eligible by the DHS to receive medical services under traditional Medicaid under Title XIX of the Social Security Act and the DHS rules and regulations and enrolled in a Medicaid Plan offered and/or administered by Health Plan and who is designated by Health Plan.

(14) “Medicaid Plan” means one or more Medicaid/QExA plans in the Medicaid Program offered or administered by Health Plan. For purposes of this Agreement, “Medicaid Plan” means those identified in this Section I above and in Health Plan’s Medicaid Contract.

(15) “Medicaid Program” means the Hawaii Medicaid managed care program run and administered by the DHS, or DHS’ successor.

(16) “Medicaid Contract” means Health Plan’s contract(s) with the DHS, to arrange for the provision of health care services to certain persons enrolled in a Medicaid Plan and eligible for Medicaid under Title XIX of the Social Security Act.

(17) “Medical Necessity” is defined in Hawaii Revised Statutes (HRS) 432E-1.4 or those Health Interventions that Health Plan is required to cover within the specified categories that meet the criteria identified below, whichever is the least restrictive:

   (a) The Health Intervention must be used for a Medical Condition;

   (b) There is Sufficient Evidence to draw conclusions about the Health Intervention’s effects on Health Outcomes;

   (c) The Sufficient Evidence demonstrates that the Intervention can be expected to produce the intended effects on Health Outcomes;

   (d) The Health Intervention’s beneficial effects on Health Outcomes outweigh its expected harmful effects; and

   (e) The Health Intervention is the most Cost-Effective method available to address the Medical Condition.

For purposes of this definition, the following terms are defined as:

(i) “Medical Condition” means a disease, an illness or an injury. A biological or psychological condition that lies within the range of normal human variation is not considered a disease, illness or injury.

(ii) “Health Outcomes” means outcomes of Medical Conditions that directly affect the length or quality of a person’s life.

(iii) “Sufficient Evidence” means evidence considered to be sufficient to draw conclusion, if it is peer-reviewed, is well-controlled, directly or indirectly relates to the Intervention to Health Outcomes, and is reproducible both within and outside of research settings.
(iv) “Health Intervention” means an activity undertaken for the primary purpose of preventing, improving or stabilizing a Medical Condition. Activities that are primarily custodial, or part of normal existence, or undertaken primarily for the convenience of the patient, family, or practitioner, are not considered Health Interventions.

(v) “Cost-Effective” means there is no other available Health Intervention that offers a clinically appropriate benefit at a lower cost.

(18) “Post-Stabilization Services” means Covered Services related to an Emergency Medical Condition that are provided after a Medicaid Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Medicaid Member’s condition.

(19) “QExA” or “QUEST Expanded Access” means the capitated managed care program that provides all acute and long term care services to individuals eligible as aged, blind or disabled (ABD) under the Medicaid Program.

(20) “Urgent Care” means the diagnosis and treatment of Medical Conditions which are serious or acute but pose no immediate threat to life and health but which require medical attention within twenty-four (24) hours.

II: Additional Medicaid Program Obligations and Requirements: In addition to the other provisions set forth in the Agreement, the following additional provisions are provider obligations and/or provider contract requirements under Health Plan’s Medicaid Contract and Hawaii laws, rules and/or regulations.

A. Relationship

(1) Health Plan does not:

(a) Prohibit providers from (i) discussing the health status, medical care and treatment or non-treatment options with Medicaid Members that may or may not reflect the Health Plan’s position or may or may not be Covered Services, (ii) acting within the lawful scope of their respective medical practices, (iii) advising or advocating on behalf of a Medicaid Member for treatment or non-treatment options, (including any alternative treatments that might be self-administered), or (iv) providing information the Medicaid Member needs in order to decide among all relevant options; (v) discussing the risks, benefits and consequences of treatment or non-treatment; (vi) advocating on behalf of a Medicaid Member in a grievance system, utilization management process or individual authorization process to obtain coverage for Medically Necessary Covered Services; or (vii) discussing the Medicaid Member's right to participate in decisions regarding the Medicaid Member's healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions; nor

(b) Discriminate with respect to participation, reimbursement, or indemnification of providers acting within the scope of their respective professional license or certification, solely on the basis of such license or certification nor does Health Plan discriminate against providers serving high-risk populations or those that specialize in conditions requiring costly treatments; and

(c) Regardless of anything to the contrary above, Provider agrees that: (i) Health Plan is not required to provide, reimburse for, or provide coverage for counseling or referral services for specific services if Health Plan objects to the service on moral or religious grounds; and (ii) that this Paragraph II(A)(1) is not and shall not be construed as an “any willing provider” contract obligation and does not prohibit measures used by Health Plan to limit participation to meet the needs of its Medicaid Members and/or to maintain quality and cost controls.

(2) As indicated in Section 2.1.2 of the Agreement, Health Plan has a compliance program entitled ‘The Trust Program’. Acknowledging that Provider is a business partner (as that term is used in Health Plan’s compliance program, The Trust Program) of Health Plan, Provider agrees to comply with the standards of The Trust Program as they apply to Provider and services rendered by Provider to Medicaid Members and the Health Plan’s policies and procedures applicable to Participating Providers and the provisions of the Provider Manual regarding fraud, waste and abuse programs and activities.
B. Services

(1) During the term of the Agreement, up to and including the last day the Agreement is in effect, and during any continuation of care period following expiration or termination of this Agreement identified herein, Provider agrees to: (a) accept Medicaid Members for treatment unless Provider has applies for and receives from Health Plan a waiver for this requirement; and (b) provide Covered Services to Medicaid Members in accordance with the terms and conditions of the Agreement and the Medicaid Contract and shall not refuse to provide Medically Necessary or preventive Covered Services to Medicaid Members.

(2) Provider shall:
   (a) maintain hours of operation no less than the hours of operation offered to other patients, and provides timely access to physician appointments to comply with the availability schedule: Emergency Services – immediately (24 hours a day/7 days a week) and without prior authorization, Urgent Care & pediatric sick visits - within twenty-four (24) hours, Primary Care adult sick care - within seventy-two (72) hours, Routine Primary Care visits for adult & children – within twenty-one (21) days, and specialists or non-emergency hospital stays – within four (4) weeks;
   (b) comply with the Health Plan's Cultural Competency plan as made available to Participating Providers by Health Plan and/or as set out in the Provider Manual and under which Provider shall render services to Medicaid Members of all cultures, races, ethnic backgrounds and religions in a manner that recognizes, values, affirms and respects the worth of Medicaid Members and protects and preserves their dignity;
   (c) not make referrals for designated health services to healthcare entities with which Provider or a member of Provider’s family has a direct or indirect (regardless of how many levels removed from a direct interest) ownership or investment interest in the form of equity, debt, compensation management, or other means (including without limitation an option or non-vested interest) in any such entity;
   (d) comply with corrective action plans initiated and/or required by Health Plan; and
   (e) enroll and complete appropriate forms for the VFC program, if Provider provides vaccines to children.

C. Claims/Encounter Data Submission & Payment

(1) Regardless of any provision to the contrary, Provider:
   (a) Subject to the terms and conditions of the Medicaid Contract and the Medicaid Member’s Benefit Contract, shall look solely to Health Plan for payment of Covered Services rendered to newborns of Medicaid Members until such newborn is enrolled in a different QExA health plan or in a QUEST health plan or other health plan;
   (b) Acknowledges and agrees and shall require Health Care Providers to agree: (i) that Medicaid Member Expenses are included in the payment from Health Plan; and (ii) not to seek payment from or to collect Medicaid Member Expenses from Members;
   (c) Will refund any payment or amounts received from Medicaid Members and/or their family members and/or Health Plan that exceed the Medicaid Member Expenses for the prior coverage period;
   (d) Acknowledges and agrees to bill or assess charges for services to Medicaid Members as provided for in the Agreement and the Provider Manual, and consistent with the Medicaid Contract;
   (e) Agrees to submit annual cost reports to the Med-QUEST Division (MQD) of DHS;
   (f) Agrees to certify that information included in Claims and/or Encounter Data submitted by Provider for Covered Services rendered to Medicaid Members under this Agreement is accurate, complete and truthful to the best of Provider's knowledge, belief and information available at the time;
   (g) Agrees to submit Encounter Data to Health Plan, or Health Plan’s designee, on a monthly basis as provided for in the Medicaid Contract and that except to the extent specifically required by applicable state or federal law or regulation, submission of Encounter Data to Health Plan as provided for in the Agreement does not require consent from the Member; and
   (h) Agrees that neither the DHS nor any Medicaid Member will be held liable for: (a) the Health Plan's failure or refusal to pay valid Clean Claims submitted by Provider to Health Plan; (b) services provided to a Medicaid Member for which DHS does not pay Health Plan under the Medicaid Contract; and/or (c) services provided to a Medicaid Member for which the Health Plan or DHS does not pay the individual or the healthcare
provider that furnishes the services under a contractual, referral, or other arrangement to the extent that the payments are in excess of the amount that the Medicaid Member would owe if the Health Plan provided the services directly. This subsection shall survive any termination or expiration of this Agreement, regardless of the cause including without limitation insolvency.

(2) Any Incentive Plans between Health Plan and Provider and/or between Provider and Health Care Providers shall be in compliance with applicable state and federal laws, rules and regulations and in accordance with the Medicaid Contract. Upon request, Provider agrees to disclose to Health Plan the terms and conditions of any Incentive Plan and/or any “physician incentive plan” as defined by the CMS, the DHS and/or any state or federal law, rule or regulation.

D. Records, Access & Audit

(1) Provider agrees, and shall require any individual or entity performing administrative services or obligations on behalf of Provider, to:

(a) Maintain up-to-date and detailed medical records for Medicaid Members at the site where medical services are rendered and in accordance with the requirements of the Medicaid Contract;

(b) Allow for amendment to Medicaid Member medical records as provided for in 45 C.F.R. Part 164;

(c) Provide Health Plan and/or the DHS with timely access to records, Encounter Data, medical records, information and data necessary for: (i) Health Plan to meet Health Plan’s obligations under the Medicaid Contract; and/or (ii) DHS to administer and evaluate the Medicaid Program;

(d) Provide copies of medical records to Medicaid Members upon request;

(e) Coordinate the transfer of medical records with Health Plan when a Medicaid Member changes primary care physicians and/or providers and/or transfers from one provider or facility to another;

(f) Retain such records in accordance with HRS §622-51 and HRS §622-58 for the greater of the seven (7) year period following the last date of entry, or completion or any government agency required or conducted review or audit (For minors, medical records must be preserved and retained during the period of minority plus a minimum of seven (7) years after the age of minority); and

(g) Submit all reports and clinical information required by the Health Plan under the Medicaid Contract.

(2) Provider shall and shall require those individuals or entities performing administrative services for or on behalf of Provider to make space available for review and inspection and provide access to, whether announced or unannounced and without restriction or waiting for Medicaid Member authorization, any pertinent contracts, books, financial records, medical records, documents, papers and other records and information (whether electronic or paper), including without limitation financial or otherwise, and Provider’s facilities, as they apply to Provider’s obligations under the Agreement and/or as related to services rendered to Medicaid Members and/or the Medicaid Contract and further to fully cooperate in investigations conducted by and any subsequent legal actions resulting from such investigations conducted by the Department of Health and Human Services, the Office of Inspector General (OIG), the CMS, the DHS, the Hawaii State Medicaid Fraud Control Unit and/or other applicable regulatory agencies, Health Plan’s accrediting bodies, or their respective designees.

(3) Regardless of any provision to the contrary, Provider understands and agrees that Health Plan may automatically recover any prior payments made to Provider for Covered Services rendered where Provider and/or those individuals or entities performing administrative services for or on behalf of Provider fails or is unable to provide access to medical records to support Claims/Encounter Data to Health Plan and/or DHS, or their respective designees, within sixty (60) days of a request.

(4) Provider agrees to maintain the confidentiality of, use and/or disclose personally identifiable information, protected health information and/or information contained in the medical records of Medicaid Members in accordance and consistent with applicable state and federal laws, rules and/or regulations, including without limitation: (a) HIPAA; (b) 42 C.F.R. Part 431 Subpart F; (c) HAR §17-1702; (d) HRS §346-10; (e) 42 C.F.R. Part 2; (e) HRS §334-5; and (f) HRS Chapter 577A.
E. Laws, Regulatory Requirements, Licensure & Insurance

(1) Provider agrees to comply with all applicable state and federal laws, rules and regulations governing the Medicaid Program, DHSS instructions, and applicable requirements of the Medicaid Contract, including without limitation: (a) the applicable provisions of the Hawaii Medicaid Program set forth in the Hawaii Administrative Rules, Title 17, Subtitle 12, and applicable provisions set forth in the Code of Federal Regulations related to the Medical Assistance Program; (b) Title VI of the Civil Rights Act of 1964, 42 U.S.C. §2000d, 45 C.F.R. Part 80, 42 C.F.R. §438(c)(2), 42 C.F.R. §438.100(d) and 42 C.F.R. §§438.6(d)(4) and (f); (c) laws and regulations designed to prevent or ameliorate fraud, waste, and abuse; (d) applicable state laws regarding patients’ Advance Directives as defined in the Patient Self Determination Act (P.L. 101-58), as may be amended from time to time; (e) 42 C.F.R. §422.434 and 42 C.F.R. §422.5, where applicable; and (f) laws, regulations and DHS instructions and guidelines regarding marketing.

(2) Provider further agrees to maintain: (a) licensure and/or certification in accordance with the terms and conditions of the Agreement, and as may be required under Hawaii and federal laws, rules and/or regulations and/or the Medicaid Program; and (b) full participation status in the Hawaii Medicaid Program. (This includes Provider, all of Health Care Providers, and those other employees, contracted individuals and entities who will provide services to Medicaid Members under the Agreement.)

(3) Provider shall submit to Health Plan for review and approval any marketing materials developed and/or distributed or to be distributed by Provider relating to the Medicaid Program and/or Medicaid Plans covered under the Agreement prior to use and/or distribution.

(4) Provider understands that Health Plan form provider participation agreements, including without limitation Ancillary Provider Participation Agreements, and any proposed changes to a previously approved form, along with any subcontracting arrangement forms of Provider, require review and approval of the DHS. Should changes be necessary as a result of such reviews, Provider, on behalf of Provider and Health Care Providers, agrees that such changes shall be incorporated herein upon notice from Health Plan.

F. Term & Termination

(1) Health Plan may terminate the Agreement and/or any Health Care Provider immediately upon written notice should the State of Hawaii and/or the DHS determine that Provider and/or any Health Care Provider: (a) fails to meet or violates any state and/or federal laws, rules and/or regulations; or (b) performance under this Agreement is deemed inadequate based upon accepted community or professional standards.

(2) In the event of expiration or termination of the Agreement, Provider agrees: (a) to continue to provide covered services to Medicaid Members in active treatment in accordance with the terms and conditions in the Agreement as applicable to Medicaid Members until care can be arranged by Health Plan consistent with sound medical judgment and as provided for in Section 7.3 of the Agreement; and (b) to cooperate in all respects with other providers and/or other Medicaid Program managed care plans to assure maximum outcomes for Medicaid Members.

(3) Notwithstanding the termination of participation with Health Plan for any particular Health Care Provider, the Agreement shall remain in full force and effect with respect to all other Health Care Providers covered under the Agreement.

G. Miscellaneous

(1) Provider agrees to submit all reports and clinical information required by the Health Plan under the Medicaid Contract in the form and/or formats and with information as may be required under the Medicaid Contract and/or the DHS, including without limitation Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) where applicable.

III: Payment

(1) Payment rates for Covered Services rendered to Medicaid Members are set out in Exhibit “C-2”, which is attached hereto and incorporated herein.
(1) Provider agrees to provide Covered Services (as defined in Section I(A)(5) of Attachment “C”) available from Provider within the scope of Provider's license and/or certification.

(2) Notwithstanding anything to the contrary above, Provider understands and agrees that regardless of whether available at Provider or not, unless otherwise agreed to in writing by the parties, this Agreement is not intended to cover Designated Services, or the professional services of any facility-based physicians or their respective physician extenders contracted with Provider.
I: Payment for Covered Services

A. Fee-For-Service Rates

(1) Provider agrees to accept and shall require Health Care Providers to accept the amount set out in Paragraph (2) below as payment in full for Covered Services rendered to Medicaid Members.

(2) Health Plan will process and pay or deny Clean Claims submitted for Covered Services rendered to Medicaid Members under this Agreement and shall make payments to Provider or Health Care Provider, as applicable, within thirty (30) calendar days of receipt of such Clean Claims at the lesser of the rates set out below, or Provider or Health Care Provider billed charges, as applicable, and subject to any coordination of benefits or subrogation activities or adjustments.

One hundred percent (100%) of Health Plan’s Medicaid fee schedule(s) based on the DHS published Hawaii Medicaid fee schedule(s) as adjusted per Paragraph (4) below

(3) The parties agree that: (a) date of receipt of a Clean Claim is the date Health Plan, or Health Plan’s designee, receives the claim, as indicated by its date stamp on the Clean Claim; and (b) the date of payment is the date of the check or other form of payment.

(4) Health Plan will: (a) supplement the above referenced Hawaii Medicaid fee schedule(s) for such Covered Services and corresponding rates not otherwise included and/or for which there is not a corresponding rate in the Hawaii Medicaid fee schedule(s); and (b) apply changes made by the DHS, or its successor, to the Hawaii Medicaid fee schedule loaded into the Health Plan systems on the effective date, if such DHS changes are published at least forty-five (45) days prior to such effective date, or if such DHS changes are published less than forty-five (45) days prior to such effective date, the DHS changes will be applied prospectively to Clean Claims with dates of service no later than forty-five (45) days following DHS publication.
I. In connection with the performance of Provider’s obligations under the Agreement and any amendments hereto, Provider, as a “business associate” (as that term is defined under HIPAA) of Health Plan, and/or Health Plan agrees to the following provisions, restrictions and requirements contained in federal and state privacy and security laws, as currently promulgated and as hereafter amended.

(A) **Privacy Rule.** Provider covenants and agrees:

1. Not to use or disclose Protected Health Information (“PHI”) in a manner that would violate the requirements of 45 C.F.R. 164 Subpart E (the “Privacy Rule”) if done by Health Plan;

2. Not to use or disclose PHI except as permitted or required by this Business Associate Agreement (“BAA”) or by law;

3. To use appropriate safeguards to prevent the use or disclosure of any PHI in any manner other than as provided for by this Attachment “D” and/or the Agreement;

4. To report to Health Plan any use or disclosure of any PHI not otherwise provided by this Attachment “D” and/or the Agreement, of which Provider becomes aware;

5. To ensure that any agents, including subcontractors and independent contractors, to whom Provider provides PHI received from or created or received by Provider on behalf of Health Plan, agree in writing to substantially the same restrictions and conditions that apply to Provider with respect to such PHI;

6. To make available PHI in accordance with §164.524 of the Privacy Rule;

7. To make available PHI for amendment and to incorporate any amendments to protect such information in accordance with §164.526 of the Privacy Rule;

8. To make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Rule;

9. To make its internal practices, books and records relating to the use and disclosure of PHI received from or created or received by Provider on behalf of Health Plan available to government agencies with regulatory authority over Health Plan or Provider, including without limitation, the U.S. Department of Health and Human Services; and

10. To return or destroy all PHI received from, or created or received by Provider on behalf of Health Plan that Provider still maintains in any form upon the expiration or termination of this Attachment “D” and/or the Agreement, and to retain no copies of such information; or, if such return or destruction is not feasible, to extend the protections of this Agreement to such retained PHI and limit further uses and disclosures to those purposes that make return or destruction infeasible.

(B) **Security Rule.** Provider covenants and agrees:

1. To implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that Provider creates, receives, maintains or transmits on behalf of Health Plan as required by 45 C.F.R. 164 Subpart C (the “Security Rule”);

2. To ensure that any agent, including an independent contractor and/or subcontractor, to whom Provider provides such information agrees to implement reasonable and appropriate safeguards to protect it; and
(3) To report to Health Plan any Security Incident (as defined in the Security Rule) of which it becomes aware.

(C) Standard Transactions. If Provider conducts any Standard Transactions on behalf of Health Plan, Provider shall comply with the applicable requirements of 45 C.F.R. Parts 160-162.

(D) Other Laws and Regulations. Provider shall comply with Title V of the Gramm-Leach-Bliley Act (15 U.S.C. § 6801 et. Seq.) (the “GLBA”) and any applicable state privacy or security laws.

(E) Termination. Regardless of any provision in the Agreement to the contrary, Health Plan may terminate this BA Agreement upon written notice to Provider if Health Plan reasonably determines that Provider has breached a material term contained herein.

(F) Miscellaneous.

(1) Definitions. “Protected Health Information” shall have the meaning as defined in 45 C.F.R. §160.103, but shall also include “Non-Public Personal Financial Information” as defined in the GLBA. Other capitalized terms in this Agreement not defined herein shall have the meaning ascribed to them by 45 C.F.R. Parts 160-164, the GLBA, or any applicable state laws.

(2) Survival. The respective rights and obligations of Health Plan and Provider under this BAA shall survive the termination of this Attachment “D” and/or the Agreement.

(3) Indemnity. Provider will indemnify and hold harmless Health Plan and any affiliates, officers, directors, employees or agents of Health Plan from and against any claim, cause of action, liability, damage, cost or expense, including attorney’s fees and court or proceeding costs, arising out of or in connection with any non-permitted or prohibited use or disclosure of PHI or other breach of this Attachment “D” and/or the Agreement by Provider or any independent contractor or subcontractor of Provider, agent, person or entity under Provider’s control.

(4) Controlling Document. In the event of any conflict between the provisions of the Agreement and this BAA, this BAA shall control.

The authorized representatives of the parties have executed this BAA to be effective as of the Effective Date of the Agreement.

Health Plan: ____________________________ Provider: ____________________________

Signature/Date ____________________________ Signature/Date ____________________________

Print Name/Title ____________________________ Print Name/Title ____________________________