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PARTICIPATING PROVIDER AGREEMENT

THIS PARTICIPATING PROVIDER AGREEMENT ("**Agreement**") is made and entered into as of ______________________________ ("**Effective Date**") by and between WellCare Health Insurance of Arizona, Inc. d/b/a 'Ohana Health Plan ("**Health Plan**") and ________________________ ("**Contracted Provider**"). Health Plan and Contracted Provider are sometimes referred to together as the "**Parties**" and individually as a "**Party**".

WHEREAS, Health Plan issues (or is pursuing a license allowing it to issue) health benefit plans and seeks to include health care providers in one or more provider networks for such plans; and

WHEREAS, Contracted Provider provides or arranges for the provision of health care items and services to the general public by health care providers employed by or subcontracted with Contracted Provider; and

WHEREAS, Health Plan and Contracted Provider desire to enter into this Agreement whereby Contracted Provider will provide or arrange for the provision of health care items and services to Health Plan's health benefit plan enrollees in exchange for payments from Health Plan, all subject to and in accordance with the terms and conditions of this Agreement;

NOW THEREFORE, the Parties agree as follows:

1. Construction.

1.1. The base part of this Agreement is designed for use with a variety of providers and Benefit Plans. Provisions specific to particular providers and Benefit Plans are included in Attachments to the Agreement.

1.2. The following rules of construction apply to this Agreement: (a) the word "**include**", "**including**" or a variant thereof shall be deemed to be without limitation; (b) the word "**or**" is not exclusive; (c) the word "**day**" means calendar day unless otherwise specified; (d) the term "**business day**" means Monday through Friday, except Federal holidays; (e) all words used in this Agreement will be construed to be of such gender or number as the circumstances require; (f) references to specific statutes, regulations, rules or forms, such as CMS 1500 and UB-04 forms, include subsequent amendments or successors to them; and (g) references to a government department or agency include any successor departments or agencies to it.

2. Definitions. In addition to terms defined elsewhere in this Agreement, the following capitalized terms when used in this Agreement shall have the meanings set forth below. If an identical term is defined in a Program Attachment, the definition in the Program Attachment shall control with respect to Benefit Plans governed by the Program Attachment.

2.1. "**Affiliate**" means, with respect to a particular entity, another entity that directly, or indirectly through one or more intermediaries, controls, is controlled by or is under common control with, the entity. An entity "**controls**" an entity in which it has the power to vote, directly or indirectly, 50 percent 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.

2.2. "**Benefit Plan**" means a health benefit policy or other health benefit contract or coverage

document (a) issued by Health Plan or (b) administered by Health Plan pursuant to a Government Contract. Benefit Plans and their designs are subject to change periodically.

2.3. “**Carve Out Agreement**” means an agreement between Health Plan and a third party Participating Provider whereby the third party assumes financial responsibility for or may provide certain management services related to particular Covered Services. Examples of possible Carve Out Agreements include agreements for radiology, laboratory, dental, vision, or hearing services.

2.4. “**Clean Claim**” means a claim for Covered Services provided to a Member that (a) is received timely by Health Plan, (b) has no defect, impropriety, or lack of substantiating documentation from the Member’s medical record regarding the Covered Services, (c) is not subject to coordination of benefits or subrogation issues, (d) is on a completed, legible CMS 1500 form or UB-04 form or electronic equivalent that follows then current HIPAA Administrative Simplification ASC X12 837 standards and additional Health Plan specific requirements in the WellCare Companion Guide, including all then current guidelines regarding coding and inclusive code sets, and (e) includes all relevant information necessary for Health Plan to (1) meet requirements of Laws and Program Requirements for reporting of Covered Services provided to Members, and (2) determine payor liability, and ensure timely processing and payment by Health Plan. A Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

2.5. “**Credentialing Criteria**” means Health Plan’s criteria for the credentialing or re-credentialing of Providers.

2.6. “**Covered Services**” means Medically Necessary health care items and services covered under a Benefit Plan.

2.7. “**DHHS**” means the U.S. Department of Health and Human Services, including its agency the Centers for Medicare and Medicaid Services (“**CMS**”) and its Office of Inspector General (“**OIG**”).

2.8. “**Emergency Services**” shall be as defined in the applicable Program Attachment.

2.9. “**Encounter Data**” means encounter information, data and reports for Covered Services provided to a Member that meets the requirements for Clean Claims.

2.10. “**Federal Health Care Program**” means a Federal health care program as defined in section 1128B(f) of the Social Security Act, and includes Medicare, Medicaid and CHIP.

2.11. “**Government Contract**” means a contract between Health Plan and a Governmental Authority or government authorized entity for Health Plan to provide health benefits coverage for Federal Health Care Program beneficiaries.

2.12. “**Governmental Authority**” means the United States of America, the States, or any department or agency thereof having jurisdiction over Health Plan, a Provider or their respective Affiliates, employees, subcontractors or agents.

2.13. “**Ineligible Person**” means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in (i) Federal Health Care Programs, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG, or (ii) Federal procurement or nonprocurement programs, as may be identified in the Excluded Parties List System maintained by the General Services Administration, (b) has been convicted of a criminal offense subject to OIG’s

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mandatory exclusion authority for Federal Health Care Programs described in section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs, or (c) is currently excluded, debarred, suspended or otherwise ineligible to participate in State medical assistance programs, including Medicaid or CHIP, or State procurement or nonprocurement programs as determined by a State Governmental Authority.

2.14. "**Laws**" means any and all applicable laws, rules, regulations, statutes, orders, standards, guidance and instructions of any Governmental Authority, as adopted, amended, or issued from time to time, including (a) the Social Security Act, including Titles XVIII ("**Medicare**"), XIX ("**Medicaid**") and XXI (State Children's Health Insurance Program or "**CHIP**"), (b) the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"), (c) Federal and State privacy laws other than HIPAA, (d) Federal and State laws regarding patients' advance directives, (e) State laws and regulations governing the business of insurance, (f) State laws and regulations governing third party administrators or utilization review agents, and (g) State laws and regulations governing the provision of health care services.

2.15. "**Medically Necessary**" or "**Medical Necessity**" shall be as defined in the applicable Program Attachment.

2.16. "**Member**" means an individual properly enrolled in a Benefit Plan and eligible to receive Covered Services at the time such services are rendered.

2.17. "**Member Expenses**" means copayments, coinsurance, deductibles or other cost share amounts, if any, that a Member is required to pay for Covered Services under a Benefit Plan.

2.18. "**Non-Contracted Services**" means Covered Services that are (a) subject to Carve Out Agreements and not approved by Health Plan in advance as further described in this Agreement, or (b) provided by an Ineligible Person.

2.19. "**Participating Provider**" means an individual or entity that has entered into an agreement with Health Plan or a Health Plan contractor to provide or arrange for the provision of Covered Services to Members.

2.20. "**Principal**" means a person with a direct or indirect ownership interest of five percent or more in Provider.

2.21. "**Program**" means (a) a Federal Health Care Program, or (b) a commercial insurance program, including a program created under Laws regarding commercial health insurance exchanges.

2.22. "**Program Attachment**" means an attachment to this Agreement describing the terms and conditions of a Provider's participation in Benefit Plans under a Program.

2.23. "**Program Requirements**" means the requirements of Governmental Authorities governing a Benefit Plan, including where applicable the requirements of a Government Contract.

2.24. "**Provider**" means (a) Contracted Provider or (b) other individual or entity that is subject to an employment arrangement or direct or indirect subcontract with Contracted Provider to provide or arrange for the provision of Covered Services to Members under this Agreement.

2.25. "**Provider Manual**" means, collectively, Health Plan's provider manuals, quick reference guides and educational materials setting forth Health Plan's requirements, rules, policies and procedures applicable to Participating Providers, as adopted or amended by Health Plan from time to

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time, including requirements, rules, policies and procedures regarding fraud, waste and abuse; health plan accreditation, credentialing/re-credentialing of providers, Member eligibility verification, prior authorization, submission of claims and encounter data (including the WellCare Companion Guide), claims payment, overpayment recoupment, utilization review/management, disease and case management, quality assurance/improvement, model of care, advance directives, collection of Member Expenses, Member rights, including reimbursement of Member Expenses collected in excess of the maximum out of pocket amount under a Benefit Plan; and Member or provider grievances and appeals.

2.26. "**State**" means any of the 50 United States, the District of Columbia or a U.S. territory.

2.27. "**WellCare**" means WellCare Health Plans, Inc., an Affiliate of Health Plan.

2.28. "**WellCare Companion Guide**" means the transaction guide that sets forth data requirements and electronic transaction requirements for Clean Claims and Encounter Data submitted to Health Plan or its Affiliates, as amended from time to time. The WellCare Companion Guide is part of the Provider Manual.

3. Scope.

3.1. Non-Contracted Services are outside the scope of this Agreement.

3.2. Providers may freely communicate with Members about their treatment regardless of benefit coverage limitations. Health Plan does not dictate or control clinical decisions respecting a Member's medical treatment or care. Medical care is the responsibility of the treating Provider regardless of any coverage determination by Health Plan. Nothing in this Agreement shall be interpreted to permit interference by Health Plan with communications between a Provider and a Member regarding the Member's medical condition or available treatment options.

3.3. This is not an exclusive agreement for either Party, and there is no guarantee (a) Health Plan will participate in any particular Program, or (b) any particular Benefit Plan will remain in effect.

3.4. Subject to Laws and Program Requirements, Health Plan reserves the right to create distinct provider networks for a Benefit Plan, and to determine Provider participation in such networks.

3.5. Subject to Laws and Program Requirements, Health Plan reserves the right to approve any Provider's participation under this Agreement, or to terminate or suspend any Provider from participation under this Agreement or one or more particular Benefit Plans. Health Plan is not obligated to refer or assign a minimum number of Members to or maintain a minimum number of Members with a Provider.

4. Provider Responsibilities.

4.1. Principals. Contracted Provider warrants and represents that it has provided Health Plan the information listed on the Attachment titled "Information for Contracted Provider / Principals" for itself and all of its Principals as of the Effective Date. Contracted Provider shall provide notice to Health Plan of any change in the information within 30 days of the change.

4.2. Providers. Contracted Provider warrants and represents that it has provided Health Plan with the information listed on Attachment titled "Information for Providers" for itself and the other Providers as of the Effective Date in a form and format acceptable to Health Plan. Contracted Provider shall provide notice to Health Plan of any change in the information within 30 days of the change.

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4.2.1. <u>Employed Providers</u>. Contracted Provider shall maintain and enforce binding internal policies and procedures or agreements with its employed Providers that are consistent with and require adherence to this Agreement. Contracted Provider shall provide Health Plan with such information requested by Health Plan, or as required by a Governmental Authority or accreditation body, necessary to verify the employment of its employed Providers.

4.2.2. <u>Subcontracted Providers</u>. The following only applies if Contracted Provider, such as an independent practice association, physician hospital organization or physician group, uses subcontracted Providers:

(a) Contracted Provider shall, and shall require its direct or indirect subcontracted Providers to, maintain and enforce written agreements with their respective subcontracted Providers that are consistent with and require adherence to this Agreement. Upon Health Plan's request, Contracted Provider shall provide Health Plan with copies of agreement templates used by itself and other Providers with their subcontracted Providers, and (1) copies of the first page, signature page and other pages necessary to identify the contracting parties and effective date for each such agreement, or (2) copies of entire agreements between itself or other Providers and the subcontracted Providers. Compensation provisions in copies of such agreements may be redacted, except where compensation information is required by Governmental Authorities. In no event shall an agreement between or among Providers supersede this Agreement respecting matters covered by this Agreement. Notwithstanding anything to the contrary in any such agreement, this Agreement shall control over the terms of any such agreement in all respects as to matters covered by this Agreement.

(b) Upon Health Plan's request, Contracted Provider shall provide Health Plan with a duly executed Opt In Agreement in the form set forth on the Attachment titled "Form of Opt-In Agreement" from the subcontracted Provider. Each executed Opt In Agreement shall be made a part of and incorporated into this Agreement, and Contracted Provider accepts the appointment in the Opt In Agreement to act on the subcontracted Provider's behalf. If Health Plan requests and does not receive a duly executed Opt In Agreement for a proposed subcontracted provider, Health Plan shall not approve the proposed subcontracted provider or its employed providers as Providers under this Agreement. Provider waives any non-compete provisions in its agreements with subcontracted Providers to the extent that, if enforced, would prohibit a subcontracted Provider from contracting directly with Health Plan pursuant to the Opt-In Agreement.

(c) Subcontracted Providers shall maintain and enforce binding internal policies and procedures or agreements with their employed Providers that are consistent with and require adherence to this Agreement. Subcontracted Providers shall provide Health Plan with such information requested by Health Plan, or as required by a Governmental Authority or accreditation body, necessary to verify the employment of their employed Providers.

(d) Any obligation of Contracted Provider in this Agreement shall apply to subcontracted Providers to the same extent that it applies to Contracted Provider. Contracted Provider shall require the timely and faithful performance of this Agreement by subcontracted Providers.

4.2.3. <u>Credentialing</u>. All Providers must meet the Credentialing Criteria. Subject to Laws and Program Requirements, (a) Health Plan conducts credentialing of providers before they begin providing Covered Services and re-credentialing from time to time thereafter as required for Health Plan's compliance with Laws, Program Requirements and accreditation standards, and Providers shall consent to

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and cooperate with such credentialing/re-credentialing, which may include site reviews, and (b) until successful completion of credentialing of a provider by Health Plan, (i) the provider shall not be added as a Participating Provider under this Agreement, and (ii) the provision of, and payment for, Health Plan authorized Covered Services to Members by the provider shall be subject to Health Plan's policies and procedures for non-participating providers.

4.3. Covered Services. Providers shall provide Covered Services to Members, subject to and in accordance with the terms and conditions of this Agreement.

4.3.1. Standards. Providers shall provide Covered Services in accordance with Laws and generally accepted standards of medical practice, including nationally recognized clinical protocols and guidelines where available. Providers shall ensure that Covered Services are available to Members on a 24 hour/day, 7 day/week basis, except Providers who do not provide Emergency Services shall ensure that Covered Services are available to Members in accordance with standard operating hours for each Provider location and shall maintain an after-hours phone service for individuals to seek instructions in the event of an emergency.

4.3.2. Eligibility. Except for Emergency Services, Providers shall verify Member eligibility in accordance with the Provider Manual before providing Covered Services to a Member. Health Plan provides member eligibility information through Health Plan's provider website and other means. For Emergency Services, Providers shall verify Member eligibility within 24 hours of the Member being stabilized or the Provider learning the individual may be a Member, whichever is later. Members' eligibility status is subject to retroactive disenrollment, and Health Plan may, unless prohibited by Laws and Program Requirements, recoup payments for items or services provided to such individuals after the effective date of disenrollment even if such items and services were authorized by Health Plan.

4.3.3. Prior Authorization. Except for Emergency Services or where prior authorization is not required by the Provider Manual, Providers shall obtain prior authorization for Covered Services in accordance with the Provider Manual. Except where not permitted by Laws or Program Requirements, Health Plan may deny payment for Covered Services where a Provider fails to meet Health Plan's requirements for prior authorization.

4.3.4. Referrals. Providers shall not refer Members to other health care providers, including other Participating Providers, for Covered Services without the approval of Health Plan, except (a) in case of Emergency Services, (b) when Member self-referral is permitted by the Benefit Plan, or (c) as permitted in Provider Manual provisions regarding utilization management. When making a referral to another health care provider, a Provider shall furnish the other provider complete information on treatment procedures and diagnostic tests performed prior to such referral, which may include providing copies of the medical records.

4.3.5. Non-Covered Services. Every time a Provider provides items or services to a Member that are not Covered Services, before providing the items or services the Provider shall (a) inform the Member of the specific items or services that are not Covered Services and that they will not be paid for by Health Plan, and (b) obtain the Member's written agreement to pay for such specific items or services after being so advised. Provider shall contact Health Plan for a coverage determination in any case where Provider is unsure if an item or service is a Covered Service.

4.3.6. Carve Out Agreements. If at any time during the term of this Agreement Health Plan has a Carve Out Agreement in place, for as long as such Carve Out Agreement is in effect Covered Services subject to the Carve Out Agreement shall not be within the scope of Covered Services contracted for under this Agreement, except for (a) Emergency Services or (b) Covered Services authorized by

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Health Plan in advance in accordance with the Provider Manual, in which cases the terms and conditions of this Agreement, including compensation, shall apply. Health Plan shall notify Contracted Provider of Carve Out Agreements through the Provider Manual or other notice. Providers may enter into separate agreements with the third party Participating Provider designated by Health Plan to provide Covered Services to Members subject to a Carve Out Arrangement ("Carve Out Vendors") and, except as set forth in this paragraph, the compensation in this Agreement shall not apply. Unless otherwise approved by Health Plan in its written notice to Contracted Provider, Providers who do not enter into a separate agreement with Carve Out Vendors will be treated as non-participating with Health Plan and Carve Out Vendor for Covered Services subject to the Carve Out Agreement. If a Carve Out Agreement expires or is terminated, Provider shall thereafter provide the Covered Services that were subject to the Carve Out Agreement to Members, subject to and in accordance with the terms and conditions of this Agreement, including compensation.

4.4. Claims and Encounter Data / EDI.

4.4.1. Clean Claims. Providers shall electronically prepare and submit Clean Claims to Health Plan within 365 days or such other time period required by Laws or Program Requirements, of the date of a Covered Service or the date of discharge from an inpatient facility, as the case may be. Unless prohibited by Laws and Program Requirements, Health Plan may deny payment for any claims that fail to meet Health Plan's submission requirements for Clean Claims or that are received after the time limit in this Agreement for filing Clean Claims.

4.4.2. Encounter Data. If Contracted Provider or other Provider is compensated by capitation, Contracted Provider shall, and shall require the other Providers to, electronically submit Encounter Data to Health Plan within 30 days of the last day of the month in which Covered Services were provided, or such shorter period necessary for Health Plan to comply with Laws or Program Requirements.

4.4.3. Additional Reports. If Health Plan requests additional information, data or reports from a Provider regarding Covered Services to Members for any reason, including for purposes of risk adjustment data validation, even if Health Plan has already paid claims or accepted Encounter Data related to the Covered Services, the Provider shall provide the information, data or reports as requested by Health Plan.

4.4.4. NPI Numbers / Taxonomy Codes. Providers shall give Health Plan their National Provider Identification ("**NPI**") numbers and Provider taxonomy codes prior to becoming Participating Providers under this Agreement. Payment of compensation for Covered Services is conditioned on Providers including their NPI numbers and Provider taxonomy codes on claims or encounter data submitted under this Agreement, and Health Plan may deny payment for Covered Services where a Provider fails to meet these requirements.

4.4.5. Electronic Transaction Requirements. Provider shall submit all claims and encounter data to Health Plan electronically. Providers shall (a) follow the requirements for electronic data interchange in the then current (1) HIPAA Administrative Simplification transaction standards and (2) WellCare Companion Guide, and (b) submit all claims and encounter data either through a clearinghouse used by Health Plan or directly to Health Plan in accordance with the WellCare Companion Guide.

4.4.6. EFT / Remittance Advice. If a Provider is able to accept payments and remittance advice electronically, (a) the Provider shall register and complete the forms for electronic funds transfer and electronic remittance advice as soon as practicable, but no later than 60 days following

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Health Plan's confirmation of Provider's status as participating, and (b) Health Plan shall make all payments and remittance advice to the Provider electronically. If a Provider is not able to accept payments and remittance advice electronically, the Provider shall make good faith efforts to be able to accept electronic funds transfer and electronic remittance within 24 months of the Effective Date.

4.4.7. Coordination of Benefits. Health Plan shall coordinate payment for Covered Services in accordance with the terms of a Member's Benefit Plan and Laws. Providers shall provide Health Plan with electronic versions of explanations of benefits and other documents and information in their possession regarding insurance covering a Member that is primary to the Member's Benefit Plan. Providers shall bill primary insurers for items and services they provide to a Member before they submit claims for the same items or services to Health Plan. If Health Plan is not the primary payor for Covered Services provided to a Member, then when not prohibited by Laws or Program Requirements, Health Plan's payment to Provider for such services shall not exceed the compensation in this Agreement less amounts payable by the primary payor or payors, less Member Expenses. Unless prohibited by Laws and Program Requirements, Health Plan may recoup payments for items or services provided to a Member where other insurers are determined to be responsible for such items and services.

4.4.8. Subrogation. Providers shall follow Health Plan policies and procedures regarding subrogation activity.

4.4.9. No payment made by Health Plan under this Agreement is intended as a financial incentive or inducement to reduce, limit or withhold Covered Services required by Members.

4.5. Member Protections.

4.5.1. Providers shall not discriminate in their treatment of Members based on Members' health status, source of payment, cost of treatment, participation in Benefit Plans, race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, or genetic information.

4.5.2. In no event including nonpayment by Health Plan, Health Plan's insolvency or breach of the this Agreement, shall a 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. This provision (a) shall survive termination or expiration of this Agreement regardless of the cause giving rise to termination or expiration, (b) shall be construed for the benefit of Members, (c) does not prohibit collection of Member Expenses where lawfully permitted or required, and (d) supersedes any oral or written agreement to the contrary now existing or hereafter entered into between a Provider and Members or persons acting on their behalf.

4.5.3. Regardless of any denial of a claim or reduction in payment to a Provider by Health Plan, in no event will a Member be responsible for payment for any Covered Services other than Member Expenses. However, Members shall not be responsible for Member Expenses where collection of Member Expenses is prohibited by Laws, Program Requirements or this Agreement. If payment of an amount sought in a claim is denied or reduced by Health Plan, the Provider shall adjust Member Expenses accordingly.

4.5.4. Except where collection of Member Expenses is prohibited by Laws, Program Requirements or this Agreement, a Provider shall (a) collect Member Expenses directly from the Member, and (b) not waive, discount or rebate any such amounts except as permitted by and in accordance with Laws and Program Requirements regarding prohibited inducements to Federal Health

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Care Program beneficiaries.

4.5.5. Providers shall not bill Members for any items or services, such as missed appointments or administrative fees, where such billing is prohibited by Laws or Program Requirements.

4.6. Provider Manual. The Provider Manual supplements and is made a part of and incorporated into this Agreement, and Providers shall comply with the Provider Manual. Health Plan may amend the Provider Manual from time to time upon notice to Provider by posting to Health Plan's provider website, email or other means of notice permitted by this Agreement, provided that in the case of material revisions to the Provider Manual, Health Plan shall provide notice in accordance with the provisions of this Agreement regarding written notice. Changes to the Provider Manual shall become effective 30 days after such posting or notice, or as of such other time period required for Health Plan to comply with Laws, Program Requirements or accreditation standards. Providers shall have and maintain systems necessary for access to Health Plan's provider website, and check for revisions to the Provider Manual from time to time.

4.7. Quality Improvement. Providers shall comply with Health Plan quality improvement programs, including those designed to improve quality measure outcomes in the then current Healthcare Effectiveness Data and Information Set (HEDIS) or other quality or outcome measures. Health Plan may audit Providers periodically and upon request Providers shall provide Records to Health Plan for HEDIS or other quality reasons and risk management purposes, including Records that will enable Health Plan to perform a thorough assessment of the overall care being provided to Members. Health Plan desires open communication with Providers regarding Health Plan's quality improvement initiatives and activities.

4.8. Bonus Programs. While there is no guarantee under this Agreement, Health Plan may offer certain Providers the opportunity to participate in bonus or incentive programs ("**Bonus Programs**"). If offered, a Bonus Program will be designed to promote preventive care, quality care or ensure the appropriate and cost effective use of Covered Services through appropriate utilization. Bonus Programs may be based in whole or part on Providers achieving certain quality benchmarks using HEDIS or some similar measure, achieving certain Member satisfaction, using electronic funds transfers and remittance or other objective criteria. If offered, Health Plan will set forth the specific terms and conditions of the Bonus Program in a separate policy and the Provider's participation shall be subject to the terms and conditions of this Agreement. Health Plan and Providers agree that no Bonus Program shall limit Medically Necessary services.

4.9. Utilization Management. Providers shall cooperate and participate in Health Plan's utilization review and case management programs. Health Plan's utilization review/case management programs may include provisions for (a) verification of eligibility and prior authorization for Covered Services, (b) concurrent and retrospective reviews, (c) requirements regarding referrals to third party Participating Providers, including those that are party to Carve Out Agreements and (d) corrective action plans.

4.10. Member Grievances / Appeals. Providers shall comply with the Provider Manual, Laws and Program Requirements regarding Member grievances and appeals, including by providing information, records or documents requested by Health Plan and participating in the grievance/appeal process.

4.11. Compliance. In performing this Agreement, Providers shall comply with all Laws and Program Requirements. Providers shall (a) cooperate with Health Plan with respect to Health Plan's compliance with Laws and Program Requirements, including downstream requirements that are inherent to Health Plan's responsibilities under Laws or Program Requirements, and (b) not knowingly take any

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action contrary to Health Plan's obligations under Laws or Program Requirements.

4.11.1. Privacy / HIPAA. Providers shall maintain Member information and medical records in accordance with Laws, including Federal and State Laws related to privacy and confidentiality of Member information and medical records, including HIPAA, and shall use and disclose such information or records only in accordance with Laws and Program Requirements.

4.11.2. Fraud, Waste and Abuse. Providers shall comply with Laws designed to prevent or ameliorate fraud, waste, and abuse, including applicable provisions of Federal criminal law, the False Claims Act (31 USC §§ 3729 et. seq.), and the anti-kickback statute (section 1128B(b) of the Social Security Act).

4.11.3. Accreditation. Providers shall comply with policies and procedures required for Health Plan to obtain or maintain its accreditation from accreditation bodies, including the National Committee for Quality Assurance or Utilization Review Accreditation Commission.

4.11.4. Compliance Program / Reporting. OIG publishes compliance program guidance for health care firms available at http://oig.hhs.gov/fraud/complianceguidance.asp. Contracted Provider shall, and shall require its employees and its subcontractors and their employees to, comply with Health Plan compliance program requirements, including Health Plan's compliance training requirements, and to report to Health Plan any suspected fraud, waste, or abuse or criminal acts by Health Plan, Contracted Provider, other Providers, their respective employees or subcontractors, or by Members. Reports may be made anonymously through the WellCare fraud hotline at (866) 678-8355. Also, if DHHS publishes compliance program requirements that providers must follow as a condition of participation in Federal Health Care Programs, Contracted Provider shall, and shall require its subcontractors to, comply with such requirements.

4.11.5. Acknowledgement of Federal Funding. Claims, data and other information submitted to Health Plan pursuant to this Agreement may be used, directly or indirectly, for purposes of obtaining payments from Federal or State governments under Federal Health Care Programs, and payments that Providers receive under this Agreement may be, in whole or in part, from Federal funds.

(a) Providers shall, upon request of Health Plan, certify, based on its best knowledge, information and belief, that all data and other information directly or indirectly reported or submitted to Health Plan pursuant to this Agreement is accurate, complete and truthful.

(b) Providers shall not claim payment in any form, directly or indirectly, from a Federal Health Care Program for items or services covered under this Agreement, except for wrap around payments made directly by Governmental Authorities to certain qualified providers, such as Federally qualified health centers ("**FQHCs**") or rural health clinics ("**RHCs**") where applicable.

4.11.6. Ineligible Persons. Contracted Provider warrants and represents as of the Effective Date and throughout the term of the Agreement and the duration of post expiration or termination transition activities described in this Agreement, that none of it, its Principals or any individual or entity it employs or has contracted with to carry out its part of this Agreement is an Ineligible Person.

4.11.7. Compliance Audit. Health Plan shall be entitled to audit Providers with respect to compliance issues, including their compliance programs, and require them to address compliance

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issues through education, counseling or corrective action plans. Providers shall cooperate with Health Plan with respect to any such audit, including by providing Health Plan with Records and site access within such time frames as requested by Health Plan.

4.11.8. Fines / Penalties. The following applies if Provider is capitated or Health Plan has delegated activities to Provider pursuant to a separate delegation addendum: Provider shall reimburse Health Plan for any fines, penalties or costs of corrective actions required of Health Plan by Governmental Authorities caused by Provider's failure to comply with Laws or Program Requirements, including failure to submit accurate encounters on a timely basis or to properly perform delegated functions.

4.12. Licensure. Providers shall secure and maintain all necessary licenses, certificates, permits, registrations, consents, approvals and authorizations that must be obtained by them to perform their obligations under this Agreement. As required by Program Requirements, Providers shall meet the conditions of participation and be enrolled in applicable Federal Health Care Programs (including for dual eligible special needs plan Members, both Medicare and Medicaid) and have all accreditations necessary to meet such conditions of participation.

4.13. Insurance. Contracted Provider and its subcontracted Providers shall secure and maintain for themselves and their employees, commercial general liability and professional liability (malpractice) insurance or self insurance coverage for claims arising out of events occurring during the term of this Agreement and any post expiration or termination activities under this Agreement, in amounts required to meet Credentialing Criteria, and worker's compensation insurance as required by State Laws. Contracted Provider and its subcontracted Providers shall, upon request of Health Plan, provide Health Plan with certificates of insurance or other evidence of coverage reflecting satisfaction of the foregoing requirements of this paragraph. Contracted Provider and the subcontracted Providers shall provide at least 30 days prior notice to Health Plan in advance of any material modification, cancellation or termination of their insurance.

4.14. Proprietary Information. In connection with this Agreement, Health Plan or its Affiliates may disclose to Providers, directly or indirectly, certain information that Health Plan or its Affiliate have taken reasonable measures to maintain as confidential and which derives independent economic value from not being generally known or readily ascertainable by the public ("**Proprietary Information**"). Proprietary Information includes Member lists, the compensation provisions of this Agreement, and other information relating to Health Plan's or its Affiliates' business that is not generally available to the public. Contracted Provider shall, and shall require its subcontractors to, hold in confidence and not disclose any Proprietary Information and not use Proprietary Information except (a) as expressly permitted under this Agreement, or (b) as required by Laws or legal or regulatory process. Contracted Provider shall, and shall require its subcontractors to, provide Health Plan with prior notice of any such disclosure required by Laws or legal or regulatory process so that Health Plan can seek an appropriate protective order. Contracted Provider shall, and shall require its subcontractors to, disclose Proprietary Information only in order to perform their obligations under this Agreement, and only to persons who have agreed to maintain the confidentiality of the Proprietary Information. The requirements of this Agreement regarding Proprietary Information shall survive expiration or termination of this Agreement.

4.15. Required Notices. In addition to any other notices required under this Agreement, Contracted Provider shall give notice to Health Plan within two business days of the occurrence of any event that could reasonably be expected to impair the ability of a Provider to comply with the obligations of this Agreement, including any of the following: (a) an occurrence that causes any of the representations and warranties in this Agreement made by or on behalf of a Provider to be inaccurate, (b) a Provider fails to maintain insurance as required by this Agreement, (c) a Provider's license, certification

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or accreditation expires or is suspended, revoked, conditioned or otherwise restricted, (d) a Provider is excluded, suspended or debarred from, or sanctioned under a Federal Health Care Program, (e) a disciplinary action is initiated by a Governmental Authority against a Provider, (f) where applicable, a Provider's hospital privileges are suspended, limited, revoked or terminated, (g) a grievance or legal action is filed by a Member concerning a Provider, (h) a Provider is under investigation for fraud or a felony, or (i) a Provider enters into a settlement related to any of the foregoing.

5. Health Plan Responsibilities.

5.1. ID Cards. Health Plan shall issue identification cards to Members and instruct them to present their cards to providers when seeking health care items and services.

5.2. Claims Processing. Health Plan shall pay or deny Clean Claims within the time period set forth in Attachment C. Health Plan uses claims editing software programs to assist it in determining proper coding for provider claim reimbursement. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative and the National Physician Fee Schedule Database, the AMA and Specialty Society correct coding guidelines, and state specific regulations. These software programs may result in claim edits for specific procedure code combinations.

5.3. Compensation. Compensation shall be as set forth in Attachment C. Providers shall accept such compensation (plus wrap around payments from Governmental Authorities to qualified providers such as FQHCs or RHCs where applicable) as payment in full for Covered Services rendered to Members and all other activities of Providers under this Agreement. Items and services constituting "**never events**" as described in the Provider Manual shall not be paid. Health Plan shall not pay for Non-Contracted Services.

5.4. Medical Record Review. Health Plan shall be entitled to perform concurrent or retrospective reviews of medical records for utilization management purposes or to verify that items and services billed to or paid for by Health Plan were provided and billed correctly in accordance with this Agreement and the Provider Manual, or were Covered Services (including that such items and services were Medically Necessary).

5.5. Recoupment. Unless otherwise prohibited by Laws, Contracted Provider, for itself and the other Providers, authorizes Health Plan to deduct from amounts that may otherwise be due and payable to a Provider any outstanding amounts that the Provider may owe Health Plan for any reason, including Overpayments, in accordance with its recoupment policy and procedure. "**Overpayment**" for purposes of this Agreement means any funds that a Provider receives or retains to which the Provider is not entitled, including overpayments (a) for items and services later determined not to be Covered Services, (b) due to erroneous or excess reimbursement, (c) resulting from errors and omissions relating to changes in enrollment, claims payment errors, data entry errors or incorrectly submitted claims, or (d) for claims paid when Health Plan was the secondary payor and the Provider should have been reimbursed by the primary payor. An Overpayment also includes any payment Health Plan makes which is the obligation of and not paid by a Provider, including for improperly collected Member Expenses due a Member. Prior to deducting Overpayments, Health Plan shall provide the Provider notice in accordance with Health Plan's recoupment policy that an offset will be performed against future payments unless the Provider within such notice period either refunds or repays such amounts or provides Health Plan with a written explanation, with supporting documentation, disputing that such amounts should be refunded or repaid. If there are no future payments to offset, then the Provider shall repay Overpayments to Health Plan within 30 days, or such other timeframe as may be mandated by Laws or Program Requirements, of the Provider's receipt of notice of such Overpayment. Health Plan agrees not to seek repayment of an

SAMPLE

Overpayment from a Provider beyond the time period set forth in Health Plan's recoupment policy, unless a longer time is required by Laws or Program Requirements. Notwithstanding the above, there shall be no deadline within which Health Plan may seek recovery of an Overpayment in a case of fraud. This section shall survive expiration or termination of this Agreement.

5.6. Suspension of Payment. If DHHS suspends payments to a Provider while Governmental Authorities investigate a credible allegation of fraud (as determined by DHHS), then Health Plan may suspend the Provider and payments for Covered Services provided by the Provider during the period of the DHHS suspension of payments.

5.7. Health Plan Designees. Health Plan may delegate administrative functions related to Benefit Plan management to third parties. Provider shall cooperate with any Health Plan designee performing administrative functions for Health Plan to the same extent that it is required to cooperate with Health Plan.

5.8. Insurance. Health Plan shall maintain such policies of general and professional liability insurance in accordance Laws and to insure Health Plan against claims regarding Health Plan operations and performance under this Agreement.

6. Records, Access & Audits.

6.1. Maintenance. Contracted Provider shall, and shall cause its subcontractors to, maintain operational, financial and administrative records, contracts, books, files, data, information, and other documentation related to the Covered Services provided to Members, claims filed, quality and cost outcomes, quality measurements and initiatives, and other services and activities conducted under this Agreement (collectively, "**Records**"). Contracted Provider shall ensure that such Records are kept in accordance with Laws, Program Requirements, generally accepted accounting principles (as applicable) and prudent record keeping practices and are sufficient to enable Health Plan to enforce its rights under this Agreement, including this section, and to determine whether Contracted Provider and its subcontractors and their respective employees are performing or have performed Contracted Provider's obligations in accordance with this Agreement, Laws and Program Requirements. Contracted Provider shall, and shall cause its subcontractors to, maintain such Records for the time period set forth in the applicable Program Attachment governing the Benefit Plan. Records that are under review or audit shall be retained until the completion of such review or audit if that date is later than the time frame indicated above.

6.2. Access & Audit. Health Plan shall have the right to monitor, inspect, evaluate and audit Contracted Provider and its subcontractors. In connection with any monitoring, inspection, evaluation or audit, Contracted Provider shall, and shall cause its subcontractors to, provide Health Plan with access to all Records, personnel, physical facilities, equipment and other information necessary for Health Plan or its auditors to conduct the audit. Within three business days of Health Plan's written request for Records, or such shorter time period required for Health Plan to comply with requests of Governmental Authorities, Contracted Provider shall, and shall cause its subcontractors to, collect, compile, and prepare all such Records and furnish such Records to Health Plan in a format reasonably requested by Health Plan. Copies of such Records shall be at no cost to Health Plan.

6.3. The requirements of this Agreement regarding Records, access and audit shall survive expiration or termination of this Agreement.

7. Term and Termination.

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7.1. Term. The term of this Agreement shall begin on the Effective Date and continue for a period of one year, and thereafter shall renew for successive periods of one year each unless a Party provides notice of nonrenewal to the other at least 90 days before the end of the then current (initial or renewal) term, unless and until the Agreement is terminated in accordance with the terms and conditions of the Agreement, including those in a Program Attachment.

7.2. Termination.

7.2.1. Termination for Convenience. Either Party may terminate this Agreement, in whole or with respect to any particular Program or Benefit Plan, at any time for any reason or no reason upon 90 days prior notice to the other. Health Plan may terminate this Agreement as to any particular Provider at any time for any reason or no reason upon 90 days prior notice to Contracted Provider.

7.2.2. Termination for Cause.

(a) A Party may terminate this Agreement for material breach by the other Party of any of the terms or provisions of this Agreement by providing the other Party at least 90 days prior notice specifying the nature of the material breach. During the first 60 days of the notice period, the breaching Party may cure the breach to the reasonable satisfaction of the non-breaching Party.

(b) Health Plan may terminate this Agreement as to a particular Provider for a material failure by the Provider to comply with any of the terms or provisions of this Agreement by providing Contracted Provider at least 90 days prior notice specifying the nature of the material failure. During the first 60 days of the notice period, the affected Provider may cure the material failure to the reasonable satisfaction of Health Plan.

7.2.3. Immediate Termination. Health Plan may terminate this Agreement in its entirety, or with respect to a particular Provider, upon immediate notice to Contracted Provider upon the occurrence of any of the following: (a) termination is necessary for health and safety of Members, (b) a Provider suffers the loss, suspension or restriction of a license from a Governmental Authority or accreditation from an accreditation body required to carry out its obligations under this Agreement, including meeting the conditions of participation in applicable Programs, (c)(1) Contracted Provider becomes an Ineligible Person or voluntarily withdraws from participation in applicable Programs, or (2) another Provider becomes an Ineligible Person or voluntarily withdraws from participation in applicable Programs, and is not immediately terminated by Contracted Provider, (d) a Governmental Authority orders Health Plan to terminate the Agreement, (e) Health Plan reasonably determines or a Governmental Authority determines or advises that a Provider is engaging or has engaged in fraud or abuse, or has submitted a false claim, (f) a Provider fails to meet Credentialing Criteria, (g) a Provider fails to maintain insurance as required by this Agreement, (h) a Provider undergoes a change of control that is not acceptable to Health Plan, or (i) a Provider becomes insolvent, is adjudicated as bankrupt, has its business come into possession or control of any trustee in bankruptcy, has a receiver appointed for it, or makes a general assignment for the benefit of its creditors.

7.2.4. Transition of Care. To ensure that a transition is undertaken in an orderly manner that maximizes Member safety and continuity of care, upon expiration or termination of this Agreement for any reason except for immediate termination, Providers shall (a) continue providing Covered Services to Members through (1) the lesser of the period of active treatment for a chronic or acute medical condition or up to 90 days, (2) the postpartum period for Members in their second or third trimester of pregnancy, or (3) such longer period required by Laws or Program Requirements, and (b) cooperate with Health Plan for the transition of Members to other Participating Providers. The terms and

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conditions of this Agreement shall apply to any such post expiration or termination activities, provided that if a Provider is capitated, Health Plan shall pay the Provider for such Covered Services at 100 percent of Health Plan's then current rate schedule for the applicable Benefit Plans. The transition of care provisions in this Agreement shall survive expiration or termination of this Agreement.

7.2.5. Notification to Members. Upon expiration or termination of this Agreement, Health Plan will communicate such expiration or termination to Members as required by and in accordance with Laws and Program Requirements. Providers shall obtain Health Plan's prior written approval of Provider communications to Members regarding the expiration or termination of this Agreement. The foregoing sentence shall not prevent a Provider from engaging in communications with his patient regarding the patient's health.

8. Dispute Resolution.

8.1. Provider Administrative Review and Appeals. Where applicable, a Provider shall exhaust all Health Plan's review and appeal rights in accordance with the Provider Manual before seeking any other remedy. Where required by Laws or Program Requirements, administrative reviews and appeals shall be subject to and resolved in accordance with administrative law.

8.2. Except as prohibited by State Laws, all claims and disputes between Health Plan and a Provider related to this Agreement must be submitted to arbitration within one year of the act or omission giving rise to the claim or dispute, except for claims based on fraud, which must be brought within the State statute of limitation governing fraud claims. The failure to initiate arbitration within the foregoing time period will constitute waiver of such claims and disputes.

8.3. Negotiation. Before a Party initiates arbitration regarding a claim or dispute under this Agreement, the Parties shall meet and confer in good faith to seek resolution of the claim or dispute. If a Party desires to initiate the procedures under this section, the Party shall give notice (a "**Dispute Initiation Notice**") to the other providing a brief description of the nature of the dispute, explaining the initiating Party's claim or position in connection with the dispute, including relevant documentation, and naming an individual with authority to settle the dispute on such Party's behalf. Within 20 days after receipt of a Dispute Initiation Notice, the receiving Party shall give a written reply (a "**Dispute Reply**") to the initiating Party providing a brief description of the receiving Party's position in connection with the dispute, including relevant documentation, and naming an individual with the authority to settle the dispute on behalf of the receiving Party. The Parties shall promptly make an investigation of the dispute, and commence discussions concerning resolution of the dispute within 20 days after the date of the Dispute Reply. If a dispute has not been resolved within 30 days after the Parties have commenced discussions regarding the dispute, either Party may submit the dispute to arbitration subject to the terms and conditions herein.

8.4. Arbitration. Except as barred or excepted by this Agreement, all claims and disputes between the Parties shall be resolved by binding arbitration in Honolulu, HI. The arbitration shall be conducted through the American Arbitration Association ("**AAA**") pursuant to the AAA Commercial Arbitration Rules then in effect, subject to the following: Arbitration shall be commenced by completing and filing with AAA a Demand for Arbitration form in accordance with the Commercial Arbitration Rules setting forth a description of the dispute, the amount involved and the remedy sought, and sending notice of the demand to the opposing Party. The arbitration shall be held before a single arbitrator, unless the amount in dispute is more than $10 million, in which case it will be held before a panel of three arbitrators. In a case with a single arbitrator, the Parties shall select the arbitrator by agreement within 30 days of the date the Demand for Arbitration is filed, and if the Parties are unable to agree on the selection of an arbitrator within such time, AAA shall select an independent arbitrator. In the case of a panel,

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within 30 days of the date the Demand for Arbitration is filed each Party shall select an arbitrator, and the two arbitrators shall select the third arbitrator, and if the two arbitrators are unable to agree on the selection of a third arbitrator within such time, AAA shall select an independent third arbitrator. The arbitrator or panel may not certify a class or conduct class based arbitration. The decision of the arbitrator or panel shall be final and binding on the Parties. The award of the arbitrator or panel may be confirmed or enforced in any court having jurisdiction. Each Party shall assume its own costs related to the arbitration, including costs of subpoenas, depositions, transcripts, witness fees, and attorneys' fees. The compensation and expenses of the arbitrator and administrative fees or costs of the arbitration shall be borne equally by the Parties.

9. Miscellaneous.

9.1. Governing Law / Venue. This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of Hawaii, except where Federal law applies, without regard to principles of conflict of laws. Each of the Parties hereby agrees and consents to be subject to the exclusive jurisdiction and venue of the appropriate State or Federal court located in Honolulu, HI, in any suit, action, or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, this Agreement.

9.2. Waiver of Jury Trial. Each Party hereby irrevocably and unconditionally waives, to the fullest extent it may legally and effectively do so, trial by jury in any suit, action or proceeding arising hereunder.

9.3. Equitable Relief. Notwithstanding anything in this Agreement, either Party may bring court proceedings to seek an injunction or other equitable relief to enforce any right, duty or obligation under this Agreement.

9.4. Independent Contractors. The Parties are independent contractors. This Agreement shall not be deemed to create a partnership or joint venture, or an employment or agency relationship between the Parties. Neither Party has the right or authority to assume or create any obligation or responsibility on behalf of the other. Neither Party is liable for the acts of the other.

9.5. No Steering. For the term of this Agreement and for one year thereafter, Providers shall not engage in steering or otherwise directly or indirectly solicit any Member to join a competing health plan or induce any Member to cease doing business with Health Plan.

9.6. No Offshore Contracting. No work related to this Agreement may be performed outside of the United States without Health Plan's prior written consent.

9.7. The following applies to State plans: Contracted Provider shall not, and shall require its subcontractors not to, make any payments for items or services provided under a State plan to financial institutions or entities such as provider bank accounts or business agents located outside of the States. Further Contracted Provider shall not, and shall require its subcontractors not to, make payments to telemedicine providers located outside of the States, or payments to pharmacies located outside of the States. Any such funds paid may be recovered by Health Plan or a State Governmental Authority with applicable jurisdiction over a plan.

9.8. Third Parties. Except as otherwise provided in this Agreement, this Agreement is not a third party beneficiary contract and no provision of this Agreement is intended to create or may be construed to create any third party beneficiary rights in any third party, including any Member.

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9.9. Notices. Except for non-material revisions to the Provider Manual, all notices required or permitted under this Agreement must be in writing and sent by (a) hand delivery, (b) U.S. certified mail, postage prepaid, return receipt requested, (c) overnight delivery service providing proof of receipt, (d) facsimile or (e) email, to the addresses of the Parties as set forth on the signature page. Each Party may designate by notice any future or different addresses to which notices will be sent. Notices will be deemed delivered upon receipt or refusal to accept delivery. Notice to Contracted Provider shall constitute notice to all Providers. Routine day to day operational communications between the Parties are not notices in accordance with this section.

9.10. Incorporation of Laws / Program Requirements / Accreditation Standards. All terms and conditions of this Agreement are subject to Laws, Program Requirements and accreditation standards. Any term, condition or provision now or hereafter required to be included in the Agreement by Laws, Program Requirements or accreditation standards shall be deemed incorporated herein and binding upon and enforceable against the Parties, regardless of whether or not the term, condition or provision is expressly stated in this Agreement. Health Plan may amend this Agreement upon notice to Contracted Provider to comply with Laws, Program Requirements or accreditation standards, and such amendment shall be effective upon receipt.

9.11. Amendment. Except as otherwise set forth in this Agreement, any amendments to this Agreement shall be in writing and signed by both Parties. However, Health Plan may amend this Agreement upon 30 days prior notice to Contracted Provider, and if Contracted Provider objects to the amendment, Contracted Provider shall notify Health Plan of the objection within the 30 day notice period, and Health Plan may terminate this Agreement for convenience in accordance with this Agreement.

9.12. Assignment. Contracted 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 the assets or successor to the operations of Health Plan or its Affiliate. As used in this section, the term "**assign**" or "**assignment**" includes 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.

9.13. Name, Symbol and Service Mark. The Parties shall not use each other's name, symbol, logo, or service mark for any purpose without the prior written approval of the other. However, (a) Providers may include Health Plan's or Benefit Plan names in listings of health plans the providers participate in, and (b) Health Plan may use information about Providers in information or publications identifying Participating Providers or as required by Laws or Program Requirements. Providers shall provide comparable treatment to Health Plan as provided to other managed care organizations with respect to marketing or the display of cards, plaques or other logos provided by Health Plan to identify Participating Providers to Members.

9.14. Other Agreements. If a Provider participates as a Participating Provider under more than one agreement with Health Plan for a particular Program, Health Plan will compensate the Provider for Covered Services it provides to Members of Benefit Plans in that Program under the agreement selected by Health Plan.

9.15. Health Plan Affiliates. If a Provider renders covered services to a member of a benefit plan issued or administered by a Health Plan Affiliate, the Health Plan Affiliate may pay for such covered services, and the Provider shall accept, the applicable out of network rates paid by the Health Plan Affiliate for the member's benefit plan. A list of Health Plan Affiliates is available in the Provider Manual or on Health Plan's provider website. There shall be no joint liability between or among Health Plan and its Affiliates.

SAMPLE

9.16. Force Majeure. The Parties shall have and maintain disaster recovery plans in accordance with high industry standards. However, if either Party's performance under this Agreement is prevented, hindered or delayed by reason of any cause beyond the Party's reasonable control that cannot be overcome by reasonable diligence, including war, acts of terrorism, civil disorders, labor disputes (other than strikes within such Party's own labor force), governmental acts, epidemics, quarantines, embargoes, fires, earthquakes, storms, or acts of God, such Party shall be excused from performance to the extent that it is prevented, hindered or delayed thereby, during the continuances of such cause; and such Party's obligations hereunder shall be excused so long as and to the extent that such cause prevents or delays performance. If a Provider is unable to perform under this Agreement due to an event as described in this paragraph, Health Plan may take whatever action is reasonable and necessary under the circumstances to ensure its compliance with Laws and Program Requirements and equitably adjust payments to the Provider until the Provider resumes its performance under this Agreement.

9.17. Severability. When possible, each provision of this Agreement shall be interpreted in such manner as to be effective, valid and enforceable under Laws. If any provision of this Agreement is held to be prohibited by, or invalid or unenforceable under Laws, such provision shall be ineffective only to the express extent of such prohibition, unenforceability or invalidity, without invalidating the remainder of this Agreement.

9.18. Waiver. No waiver shall be effective unless in writing and signed by the waiving Party. A waiver by a Party of a breach or failure to perform this Agreement shall not constitute a waiver of any subsequent breach or failure.

9.19. Entire Agreement. This Agreement, including the Attachments each of which are made a part of and incorporated into this Agreement, the Provider Manual and any addenda or amendments comprises the complete agreement between the Parties and supersedes all previous agreements and understandings (whether verbal or in writing) related to the subject matter of this Agreement.

9.20. Headings. The various headings of this Agreement are provided for convenience only and shall not affect the meaning or interpretation of this Agreement or any provision of it.

9.21. Interpretation. Both Parties have had the opportunity to review this Agreement with legal counsel, and any ambiguity found in this Agreement shall not be construed in a Party's favor on the basis that the other Party drafted the provision containing the ambiguity.

9.22. Survival. Any provision of this Agreement, including an Attachment, that requires or reasonably contemplates the performance or existence of obligations by a Party after expiration or termination of this Agreement shall survive such expiration or termination regardless of the reason for expiration or termination.

9.23. Rights Cumulative. Except as set forth herein, all rights and remedies of a Party in this Agreement are cumulative, and in addition to all legal rights and remedies available to such Party.

9.24. Counterparts / Electronic Signature. This Agreement may be executed in any number of counterparts. The exchange of copies of this Agreement and of signature pages by facsimile transmission or electronic mail shall constitute effective execution and delivery of this Agreement as to the parties and may be used in lieu of the original Agreement for all purposes.

9.25. Warranties and Representations. Each Party warrants and represents, as of the Effective Date and continuously thereafter throughout the entire term of this Agreement and during the post expiration or termination transition period described herein, as follows:

SAMPLE

9.25.1. The Party is a corporation or other legally recognized entity duly incorporated or organized, validly existing and in good standing under the laws of the State in which it is incorporated, organized or operating and it has the authority to transact business in each State in which it operates.

9.25.2. The Party has the corporate or company power and legal authority to, and has taken all necessary corporate or other action on its part to, authorize the execution and delivery of this Agreement and the performance of its obligations hereunder.

9.25.3. This Agreement has been duly executed and delivered by the Party, and constitutes a legal, valid, and binding agreement that is enforceable against such Party in accordance with its terms, except as limited by applicable bankruptcy, reorganization, moratorium and similar Laws affecting the enforcement of creditors' rights.

9.25.4. The execution and delivery of this Agreement and the performance of the Party's obligations hereunder do not (a) conflict with or violate any provision of the Party's organizational documents or Laws, or (b) conflict with, or constitute a default under, any contractual obligation of the Party.

The following Attachments are incorporated into and made a part of this Agreement:

Attachment A - Provider Specific Requirements/Covered Services/Information
Attachment B - Program Attachments
Attachment C - Compensation

SIGNATURE PAGE FOLLOWS

SAMPLE

SIGNATURE PAGE

IN WITNESS WHEREOF, the undersigned, with the intent to be legally bound, have caused this Agreement to be duly executed and effective as of the Effective Date.

Insert Name of Health Plan

By: ______________________________

Print Name: ______________________________

Title: ______________________________

Date: ______________________________

Notice Address:

Ohana Health Plan
949 Kamokila Boulevard, Ste. 350
Kapolei, HI 96707
ATTN: Network Management

Fax: 1-866-788-9910
Email: HawaiiPR_Request@wellcare.com

Insert Name of Contracted Provider

By: ______________________________

Print Name: ______________________________

Title: ______________________________

Date: ______________________________

Notice Address:

Name of Contracted Provider
Street Address
City, ST Zip
ATTN:

Fax:
Email:

SAMPLE

ATTACHMENT A
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES / INFORMATION

(See following attachments)

SAMPLE

ATTACHMENT A-1
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES
(PHYSICIAN)

1. Additional Definitions.

   a. "**Assigned Member**" means a Member who selects or is assigned by Health Plan to a Primary Care Physician or (if required by Laws or Program Requirements) an allied health care practitioner supervised by a Physician, as the Member's primary care provider.

   b. "**Covering Physician**" means a Physician who provides health care items and services to another Physician's patients when the other Physician is not available.

   c. "**Physician**" means a Provider who is a doctor of medicine or osteopathy.

   d. "**Primary Care Physician**" means a Physician who spends the majority of his clinical time providing Primary Care Services to patients, and may include a Physician in the practice of family medicine, general medicine, internal medicine or pediatrics, or obstetrics and gynecology.

   e. "**Primary Care Services**" means health care items or services available from Primary Care Physicians within the scope of their medical or professional licenses or certifications, and shall include primary care items and services required by the Provider Manual or Program Requirements, which may include (i) assuring the timeliness of urgent, emergent, sick and preventive care to Members; (ii) conducting initial health assessments of new Members when such assessments are Covered Services under the applicable Benefit Plan; (iii) informing Members of specific health care needs that require follow up; (iv) instructing Members on measures they may take to promote their own health; (v) providing the coordination necessary for the referral of Members to specialists; or (vi) monitoring and follow-up of care provided by other providers for diagnosis and treatment.

   f. "**Specialty Physician**" means a Physician who provides Specialty Physician Services.

   g. "**Specialty Physician Services**" means health care items and services within the scope of a particular medical specialty.

2. Subject to and in accordance with the terms of this Agreement, Contracted Provider shall provide or arrange for the provision of all Covered Services available from Providers that are within the scope of their medical or professional licenses or certifications.

3. If Contracted Provider employs or subcontracts with Physicians to provide Covered Services, Contracted Provider shall be responsible to ensure that (a) Primary Care Physicians provide Primary Care Services to Members, including their Assigned Members, and (b) Specialty Physicians provide Specialty Physician Services to Members upon appropriate referral. If a Provider provides Covered Services that are subject to a Carve-Out Agreement, such services shall be Non-Contracted Services.

4. If a Provider provides or arranges for the provision of Primary Care Services to Assigned Members:

   a. The Provider shall have primary responsibility for arranging and coordinating the overall

SAMPLE

health care of Assigned Members, including (i) the provision of Primary Care Services from Primary Care Physicians and appropriate referral to other Participating Providers, or if a Participating Provider is unavailable to any health care provider upon authorization of Health Plan, and (ii) managing and coordinating the performance of administrative functions relating to the delivery of Covered Services to Assigned Members.

b. The Provider shall ensure Primary Care Physicians make all reasonable efforts to (i) establish satisfactory physician-patient relationships with their Assigned Members and (ii) instruct their Assigned Members on measures they may take to promote their own health.

5. If a Provider provides or arranges for the provision of Specialty Physician Services, the Provider shall ensure that Specialty Physicians (i) care for common medical conditions in their medical specialty, (ii) provide consultation summaries or appropriate periodic progress notes to the Member's Primary Care Physician on a timely basis, after a referral or routinely scheduled consultative visit, and (iii) notify the Member's Primary Care Physician when scheduling a hospital admission or other procedure requiring the Primary Care Physician's approval.

6. Except for Emergency Services, when a Member requires a hospital admission by a Physician or another health care provider that the Physician has referred a Member to, the Physician shall, or shall arrange for the other health care provider to, secure authorization for such admission from Health Plan prior to the admission. Physicians shall seek further authorization for any extension of the initial length of stay approved for the Member in accordance with the Provider Manual.

7. Subject to Laws and Program Requirements regarding provider to patient ratios, a Provider shall accept Members as patients as long as the Provider is accepting new patients. Contracted Provider shall give Health Plan 60 days' prior notice in advance of any circumstance where a Provider is not available to accept Members as patients.

8. Primary Care Physicians will accept the minimum number of Members required by Laws and Program Requirements at each Primary Care Physician location prior to giving notice of the closure of the physician's site to Members. This requirement shall not be construed as a guarantee that Health Plan will refer or assign a minimum number of Members to, or maintain a minimum number of Members with, any Physician under this Agreement.

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ATTACHMENT A-1
INFORMATION FOR CONTRACTED PROVIDER / PRINCIPALS

1. Contracted Provider is a:

_____ Sole Proprietor

_____ Corporation

_____ Partnership

_____ Limited Liability Company

_____ Professional Association

2. The Principals of Contracted Provider are:

NAME	ADDRESS	PERCENT OWNERSHIP	TITLE	DATE

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ATTACHMENT A-2
INFORMATION FOR PROVIDERS

Contracted Provider shall provide the following information for (1) Contracted Provider, (2) each other Provider and (3) each of their respective medical facilities:

- Name
- Address
- E-mail address
- Telephone and facsimile numbers
- Professional license numbers
- Medicare/Medicaid ID numbers
- Federal tax ID numbers
- Completed W-9 form
- National Provider Identifier (NPI) numbers
- Provider Taxonomy Codes
- Completed sample CMS 1500 form or UB-04 claim form
- Area of medical specialty
- Age restrictions (if any)
- Area hospitals with admitting privileges (where applicable)
- Whether Providers are employed or subcontracted with Contracted Provider using the designation "E" for employed or "C" for subcontracted.
- For a subcontracted Provider, whether its Providers are employed or contracted with the subcontracted Provider using the designation "E" for employed or "C" for contracted.
- Office contact person
- Office hours
- Billing office
- Billing office address
- Billing office telephone and facsimile numbers
- Billing office email address
- Billing office contact person

ATTACHMENT B

PROGRAM ATTACHMENTS

(See following attachments)

ATTACHMENT B-2

HAWAII QUEST INTEGRATION CONTRACT

PROVIDER PROGRAM ATTACHMENT

1. Participation in Hawaii QUEST Integration Contract. Subject to and in accordance with the terms and conditions of the Agreement, including this Attachment, Contracted Provider shall participate in Benefit Plans offered or administered by Health Plan under the Hawaii QUEST Integration contract.

2. Compensation. Compensation for Covered Services provided to Members of Benefit Plans under the Hawaii QUEST Integration contract is set forth in Attachment C.

   a. Additional Definitions.

      i. "**Covered Services**" means Medically Necessary health care items and services covered under a Benefit Plan. Additional details can be found in the Health Plan Provider Manual.

      ii. "**Emergency Medical Condition**" is a medical condition manifesting itself by a sudden onset of 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.

      iii. "**Emergency Services**" mean any covered inpatient and outpatient 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.

      iv. "**Hawaii QUEST Integration Contract**" means a contract between the State of Hawaii and Health Plan for Health Plan to provide or arrange for the provision of health care items and services to enrollees in the Hawaii QUEST Integration program, as amended from time to time. The Hawaii QUEST Integration Contract is a Government Contract as defined in the Agreement.

      v. "**Medicaid Contract**" means the Hawaii QUEST Integration Contract.

      vi. "**Urgent Care**" means the diagnosis and treatment of medical conditions which are serious or acute but pose no immediate threat to life and health which require medical attention within twenty-four (24) hours.

      vii. **"Member**" means an individual enrolled in a Benefit Plan issued by Health Plan pursuant to the Hawaii QUEST Integration.

      viii. "**State**" means the state of Hawaii.

3. Hawaii QUEST Integration Contract Provider Requirements. All provisions of the Agreement and this Attachment are cumulative. All provisions shall be given effect when possible. If there is

conflicting language between this Attachment and any other part of the Agreement, the provisions of this Attachment shall prevail with respect to the Program described in this Attachment. Any right or responsibility of Provider also applies to the Contracted Provider in this Attachment. All provider contracts and amendments executed by the Health Plan, including the Agreement, shall be in writing, signed and dated by the Health Plan and Provider, and shall meet the following requirements:

a. The covered population is Health Plan's Members covered under the Hawaii QUEST Integration Contract.

b. Provider will render Covered Services identified in the Agreement and otherwise available from Provider within the scope of its professional license to Members.

c. The rate of payment is indicated on the compensation page contained in the Agreement.

d. Provider shall not seek payment from the Member for any Covered Services provided to the Member within the terms of this Agreement, and Provider shall look solely to Health Plan for compensation services rendered, with the exception of cost sharing pursuant to the Hawaii Medicaid State Plan.

e. Provider is prohibited from imposing a no-show fee for Hawaii QUEST Integration Members who were scheduled to receive a Medicaid Covered Service.

f. In the case of newborns, the Provider shall not look to any individual or entity other than QUEST Integration or the mother's commercial health plan for any payment owed to Provider related to the newborn.

g. Provider shall cooperate with the Health Plan's quality improvement activities.

h. Provider shall meet all applicable State and Federal regulations, including but not limited to all applicable Hawaii Administrative Rules (HAR) sections, and Medicaid requirements for licensing, certification and recertification.

i. Provider shall cooperate with the Health Plan's utilization review and management activities.

j. Provider is not prohibited from discussing treatment or non-treatment options with Members that may not reflect the Health Plan's position or may not be covered by the Health Plan.

k. Provider is not prohibited or otherwise restricted from acting within the lawful scope of practice, from advising or advocating on behalf of a Member for the Member's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered.

l. Provider is not prohibited or otherwise restricted from advocating on behalf of a Member to obtain necessary healthcare services in any grievance system or utilization review process, or individual authorization process.

m. Provider shall meet appointment waiting time standards pursuant to the terms of the Hawaii QUEST Integration Contract and described as follows:

i. Emergency medical situations-immediate care (twenty-four (24) hours a day, seven (7) days a week) and without prior authorization;

ii. Urgent Care and Primary Care Physician (PCP) pediatric sick visits-appointments within twenty-four (24) hours;

iii. PCP adult sick visits-appointments within seventy-two (72) hours;

iv. PCP visits (routine visits for adults and children)- appointments within twenty-one (21) days; and

v. Visits with a specialist or non-emergency hospital stays-appointments within four (4) weeks or of sufficient timeliness to meet Medical Necessity.

vi. Visits with Behavioral Health (routine visits for adults and children) – appointments are available within twenty-one (21) days.

n. Provider shall provide continuity of treatment in the event Provider's participation terminates during the course of a Member's treatment by Provider except in the case of adverse reasons on the part of Provider.

o. Provider shall comply and maintain the confidentiality of Member's information and records as required by law, including but not limited to privacy and security regulations adopted under HIPAA.

p. Provider shall keep any records necessary to disclose the extent of services the Provider furnishes to Members.

q. CMS, the State Medicaid Fraud Control Unit and the State of Hawaii, Department of Human Services ("DHS" or "Department") or their respective designee shall have the right to inspect, evaluate, and audit any pertinent books, financial records, medical records, documents, papers, and records of any provider involving financial transactions related to the Hawaii QUEST Integration Contract and for the monitoring of quality of care being rendered without the specific consent of the Member.

r. Provider shall comply with disclosure requirements identified in accordance with 42 CFR Part 455, Subpart B. Disclosures shall include:

i. The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address;

ii. Date of birth and Social Security Number of each person with an ownership or control interest in the disclosing entity; and

iii. Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a five (5) percent or more interest.

iv. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child or sibling; or whether the person with an ownership or control interest in any subcontractor in which the disclosing entity has a five (5) percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child or sibling.

v. The name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.

vi. The name, address, date of birth and Social Security Number of any managing employee of the disclosing entity.

vii. The identity of any individual who has an ownership or control interest in the provider, or is an agent or managing employee of the provider, and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

viii. Provider shall provide disclosure at the following times:' (1) When the Provider submits a provider application; (2) Upon execution of the provider agreement; (3) During re-credentialing; (4) Upon request from Health Plan or DHS; (5) Within thirty-five (35) days after any change in ownership of the disclosing entity information to the Health Plan.

ix. Provider shall submit, within thirty-five (35) days of the date on a request by Health Plan, the DHS or the Secretary full and complete information about: (1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12 month period ending on the date of the request; and (2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5 year period ending on the date of the request.

s. Providers that are compensated by capitation payments must submit complete and accurate encounter data on a monthly basis and any and all medical records to support encounter data upon request from Health Plan without the specific consent of the Member, DHS or its designee for the purpose of validating encounters.

t. Provider shall certify claim/encounter submissions to the Health Plan as accurate and complete.

u. Provider shall provide medical records or access to medical records to Health Plan and the DHS or its designee, within sixty (60) days of a request. Refusal to provide medical records, access to medical records or inability to produce medical records to support the claim/encounter shall result in recovery of payment.

v. "Medically Necessary" or "Medical Necessity" shall mean as defined in Hawaii Revised Statutes (HRS) 432E-1.4, as follows:

i. For contractual purposes, a health intervention shall be covered if it is an otherwise covered category of service, not specifically excluded, recommended by the treating licensed health care provider, and determined by the Health Plan's medical director to be

medically necessary as defined in subsection (b). A health intervention may be medically indicated and not qualify as a covered benefit or meet the definition of medical necessity. A managed care plan may choose to cover health interventions that do not meet the definition of medical necessity.

ii. A health intervention is medically necessary if it is recommended by the treating physician or treating licensed health care provider, is approved by the Health Plan's medical director or physician designee, and is: (1) For the purpose of treating a medical condition; (2) The most appropriate delivery or level of service, considering potential benefits and harms to the patient;
(3) Known to be effective in improving health outcomes; provided that: (A) Effectiveness is determined first by scientific evidence; (B) If no scientific evidence exists, then by professional standards of care; and (C) If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and (4) Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price.

iii. When the treating licensed health care provider and the Health Plan's medical director or physician designee do not agree on whether a health intervention is medically necessary, a reviewing body, whether internal to the plan or external, shall give consideration to, but shall not be bound by, the recommendations of the treating licensed health care provider and the Health Plan's medical director or physician designee.

iv. For the purposes of this section:

(1) "Cost-effective" means a health intervention where the benefits and harms relative to the costs represent an economically efficient use of resources for patients with the medical condition being treated through the health intervention; provided that the characteristics of the individual patient shall be determinative when applying this criterion to an individual case.

(2) "Effective" means a health intervention that may reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

(3) "Health intervention" means an item or service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. A health intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied. New interventions for which clinical trials have not been conducted and effectiveness has not been scientifically established shall be evaluated on the basis of professional standards of care or expert opinion. For existing interventions, scientific evidence shall be considered first and, to the greatest extent possible, shall be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care shall be considered. If professional standards of care do not exist or are outdated or contradictory, decisions about existing interventions shall be based on expert opinion. Giving priority to scientific evidence shall not mean that coverage of existing interventions shall be denied in the absence of conclusive scientific evidence. Existing interventions may meet the definition of

medical necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or in the absence of such standards, convincing expert opinion.

(4) "Health outcomes" mean outcomes that affect health status as measured by the length or quality of a patient's life, primarily as perceived by the patient.

(5) "Medical condition" means a disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

(6) "Physician designee" means a physician or other health care practitioner designated to assist in the decision-making process who has training and credentials at least equal to the treating licensed health care provider.

(7) "Scientific evidence" means controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and the health outcomes may be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases. Scientific evidence may be found in the following and similar sources:

A. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

B. Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database Health Services Technology Assessment Research (HSTAR);

C. Medical journals recognized by the Secretary of Health and Human Services under section 1861(t)(2) of the Social Security Act, as amended;

D. Standard reference compendia including the American Hospital Formulary Service-Drug Information, American Medical Association Drug Evaluation, American Dental Association Accepted Dental Therapeutics, and United States Pharmacopoeia-Drug Information;

E. Findings, studies, or research conducted by or under the auspices of federal agencies and nationally recognized federal research institutes including but not limited to the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office

of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and

F. Peer-reviewed abstracts accepted for presentation at major medical association meetings.

(8) "Treat" means to prevent, diagnose, detect, provide medical care, or palliate.

(9) "Treating licensed health care provider" means a licensed health care provider who has personally evaluated the patient.

w. Provider shall follow the billing and coding requirements as outlined in the Agreement.

x. Provider shall comply with Health Plan's cultural competency plan, which shall include requiring compliance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, 45 CFR Part 80 and 42 CFR 438.6(d)(4), 438.6(f), 438.100(d) and 438.206(c)(2).

y. Provider shall submit to Health Plan any marketing materials developed and distributed by Provider related to the QUEST Integration Program to include the use of either QUEST Integration or Medicaid.

z. Provider shall maintain the confidentiality of Members' information and records as required by the RFP for the QUEST Integration Program and in compliance with Federal and State law, including but not limited to: (i) The Administration Simplification (AS) provisions of HIPAA, Public Law 104-191 and the regulations promulgated thereunder, including but not limited to the Security and Privacy requirements set forth in 45 CFR Parts 160, 162, 164, if the provider is a covered entity under HIPAA; (ii) 42 CFR Part 431, subpart F; (iii) Chapter 17-1702, HAR; (iv) Section 346-10, HRS; (v) 42 CFR Part 2; (vi) Section 334-5, HRS; and; (vii) Chapter 577A, HRS; and (viii) All other applicable federal and State statutes and administrative rules, including but not limited to: (1) Section 325-101, HRS, relating to persons with HIV/AIDS; (2) Section 334-5, HRS relating to persons receiving mental health services; (3) Chapter 577A, HRS relating to emergency and family planning services for minor females;(4) 42 CFR Part 2 relating to persons receiving substance abuse services; (5) Chapter 487J, HRS, relating to social security numbers; and (6) Chapter 487N, HRS, relating to personal information.

4. Additional Requirements. All provider agreements shall contain the following:
   a. Provider shall comply with 42 CFR 434 and 42 CFR 438.6, if applicable.

   b. Provider shall not employ or subcontract with individuals or entities whose owner, those with controlling interest or managing employees are on any State or federal exclusion list.

   c. Provider is prohibited from making referrals for designated health services to healthcare entities with which the provider or a member of the provider's family has a financial relationship. A "financial relationship" is a direct or indirect ownership or investment interest (including an option or nonvested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means and includes an indirect ownership or investment interest no matter how many levels removed from a direct interest, or compensation management with an entity.

d. Providers of transitioning Members shall cooperate in all respects with providers of other health plans to assure maximum health outcomes for Members.

e. Provider shall comply with corrective action plans initiated by the Health Plan.

f. Provider shall cooperate with Health Plan in its efforts to identify and pursue legally liable third parties.

g. Provider shall comply with the Health Plan's compliance plan, including all fraud and abuse requirements and activities.

h. Provider shall accept Members for treatment, unless the provider applies to the Health Plan for a waiver of this requirement.

i. Provider shall provide Covered Services without regard to race, color, creed, ancestry, sex, including gender identity or expression, sexual orientation, religion, health status, income status, or physical or mental disability.

j. Provider shall offer hours of operation that are no less than hours of operation offered to commercial members or, if the provider has no commercial members, that the hours of operation are comparable to hours offered to recipients under Medicaid fee-for-service.

k. Provider shall offer access to interpretation services for Members that have a Limited English Proficiency (LEP) at no cost to the Member, and to document the offer and provision of interpreter services to the same extent as the Health Plan under the Hawaii QUEST Integration Contract.

l. Provider shall offer access to auxiliary aids and services at no cost for Members living with disabilities and to document the offer and provision of auxiliary aids to the same extent as the Health Plan under the Hawaii QUEST Integration Contract.

m. The State of Hawaii and Health Plan Members shall bear no liability for the Health Plan's failure or refusal to pay valid claims of subcontractors or providers for Covered Services.

n. Provider shall accept Health Plan's payment in full and cannot charge the patient for any cost of a Health Plan Covered Service whether or not the service was reimbursed by the Health Plan.

o. The State of Hawaii and Health Plan Members shall bear no liability for Covered Services provided to a Member for which the State of Hawaii does not pay the Health Plan.

p. The State of Hawaii and Health Plan Members shall bear no liability for Covered Services provided to a Member for which the Health Plan or State does not pay the individual or healthcare provider that furnishes the Covered Services under a contractual, referral or other arrangement to the extent that the payments are in excess of the amount that the Member would owe if the Health Plan provided the Covered Services directly.

q. Provider shall secure and maintain all necessary liability insurance and malpractice coverage as is necessary to protect the Health Plan's Members and the Health Plan.

r. Provider shall secure and maintain automobile insurance when transporting Members, if applicable.

s. Provider shall use the definition of "Emergency Medical Condition" included in this Attachment.

t. If Provider provides Early Periodic Screening, Diagnostic and Treatment (EPSDT) services, Provider shall comply with all EPSDT requirements.

u. Provider shall provide copies of medical records to requesting Members and allow them to be amended as specified in 45 CFR Part 164.

v. Provider shall provide record access to any authorized DHS personnel or personnel contracted by the DHS without Member authorization so long as the access to the records is required to perform the duties of the Hawaii QUEST Integration Contract and to administer the Hawaii QUEST Integration Contract.

w. Provider shall comply with Health Plan standards that provide the DHS or its designee(s) prompt access to Members' medical records whether electronic or paper.

x. Provider shall coordinate with the Health Plan in transferring medical records (or copies) when a Member changes PCPs, which includes facilitating the transfer of the Member's medical records (or copies) to the new PCP within seven (7) business days from the receipt of request.

y. Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care , hospices, and HMOs specified in 42 CFR Part 489, subpart I, and 42 CFR 417.436(d).

z. Provider shall retain medical records in accordance with section 622-51 and 622-58, HRS for a minimum of seven (7) years after the last date of entry in the records. For minors, records must be preserved and maintained during the period of minority plus a minimum of seven (7) years after the age of majority. During the retention period, Provider shall allow the State and federal governments' full access to such records, to the extent allowed by law.

5. Additional Requirements. All provider agreements shall contain the following:

a. Provider shall comply with all credentialing and re-credentialing activities.

b. Provider shall refund any payment received from a resident or family member (in excess of share of cost) on behalf of the Member for the prior coverage period.

c. Provider shall submit annual cost reports to the Med-QUEST Division (MQD), if applicable.

d. Provider shall comply with all requirements regarding when they may bill a Member or assess charges as follows: (i) If a Member self-refers to a specialist or other provider within the network without following Health Plan's procedures (i.e. obtaining prior authorization) and the Health Plan denies payment to the Provider, the Provider may bill the Member if the Provider provided the Member with an Advance Beneficiary Notice of non-coverage; (ii) If a Provider fails to follow Health Plan's procedures which results in nonpayment, the Provider may not bill the Member; and (iii) If Provider bills the Member for non-covered services or

for self-referrals, he or she shall inform the Member and obtain prior agreement from the Member regarding the cost of the procedure and the payment terms at time of service.

e. Provider shall be licensed or certified and in good standing in the State of Hawaii.

f. If Provider provides vaccines to children, Provider shall enroll and complete appropriate forms for the Vaccines For Children (VFC) program.

g. If Provider serves as a PCP (including specialists acting as a PCP), Provider agrees to the following: (i) Provider shall be responsible for supervising, coordinating, and providing all primary care to each assigned Member; (ii) Provider shall coordinate and initiate referrals for specialty care; (iii) Provider shall maintain continuity of each Member's healthcare and maintain the Member's health record; (iv) Provider shall have admitting privileges to a minimum of one general acute care hospital which is in the Health Plan's network and on the island of service. For the island of Hawaii this means that the Provider shall have admitting privileges in one general acute care hospital in either East Hawaii or West Hawaii depending on which is closer; and (v) Provider (both PCP and specialist acting as a PCP) shall have a written arrangement with at least one other provider with admitting privileges to an acute care hospital within the Health Plan's network in the event he/she does not have one.

h. Health Plan shall not discriminate with respect to participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely based on that license or certification.

i. Health Plan shall not discriminate against providers serving high risk populations or those that specialize in conditions requiring costly treatments. This is not to be construed as: (a) requiring that the Health Plan contract with providers beyond the number necessary to meet the needs of its Members; (b) precluding the Health Plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or (c) precluding the Health Plan from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Members. The Health Plan is not required to contract with every willing provider.

j. In accordance with 45 CFR Section 162.410, Provider shall obtain a National Provider Identifier (NPI) number.

k. A provider (either PCP or medical specialist) with an ambulatory practice who does not have admission and treatment privileges must have written arrangements with another provider with admitting and treatment privileges with an acute care hospital within Health Plan's network on the island of service. For the island of Hawaii, this requirement means that a provider in East Hawaii who does not have admission and treatment privileges shall have a written arrangement with another provider with admitting and treatment privileges in East Hawaii and that a provider in West Hawaii who does not have admission and treatment privileges shall have a written arrangement with another provider with admitting and treatment privileges in West Hawaii.

l. Providers shall not segregate Members in any way from other persons receiving services, except for health and safety reasons.

m. Health Plan shall not include in its network any provider, when a person with an ownership or controlling interest in the provider (an owner including the provider himself or herself), or an agent or managing employee of the provider have been excluded from participation by the US Department of Health and Human Services (HHS), Office of Inspector General (OIG) under section 1128 of the Social Security Act, or has been excluded by the DHS from participating in the Hawaii Medicaid program. Health Plan shall immediately terminate any provider(s) or affiliated provider(s) whose owners, agents or managing employees are found to be excluded on the State or federal exclusion list(s).

n. Provider shall meet medical record standards for the Hawaii QUEST Integration Contract, which shall include:

i. Requiring that the medical record be maintained by the provider;

ii. Assure that DHS personnel or personnel contracted by the DHS have access to all records, as long as access to the records is needed to perform the duties of the Hawaii QUEST Integration Contract and to administer the Hawaii QUEST Integration Contract for information released or exchanged pursuant to 42 CFR Section 431.400. Health Plan shall be responsible for being in compliance with any and all State and federal laws regarding confidentiality.

iii. Provide DHS or its designee(s) with prompt access to Members' medical records.

iv. Provide Members with the right to request and receive a copy of his or her medical records, and to request they be amended, as specified in 45 CFR Part 164; and

v. Allow for paper or electronic record keeping.

vi. As part of its records standards, Health Plan requires that Provider adhere to the following requirements:

1) All medical records are maintained in a detailed and comprehensive manner that conforms to good professional medical practice;

2) All medical records are maintained in a manner that permits effective professional medical review and medical audit processes;

3) All medical records are maintained in a manner that facilitates an adequate system for follow-up treatment;

4) All medical records shall be legible, signed and dated;

5) Each page of the paper or electronic record includes the patient's name or ID number;

6) All medical records contain patient demographic information, including age, sex, address, home and work telephone numbers, marital status and employment, if applicable;

7) All medical records contain information on any adverse drug reactions and/or food or other allergies, or the absence of known allergies, which are posted in a prominent area on the medical record;

8) All forms or notes have a notation regarding follow-up care, calls or visits, when indicated;

9) All medical records contain the patient's past medical history that is easily identified and includes serious accidents, hospitalizations, operations and illnesses. For children, past medical history includes prenatal care and birth;

10) All pediatric medical records include a completed immunization record or documentation that immunizations are up-to-date;

11) All medical records include the provisional and confirmed diagnosis(es);

12) All medical records contain medication information;

13) All medical records contain information on the identification of current problems (i.e. significant illnesses, medical conditions and health maintenance concerns);

14) All medical records contain information about consultations, referrals, and specialist reports;

15) All medical records contain information about emergency care rendered with a discussion of requirements for physician follow-up;

16) All medical records contain discharge summaries for: (1) all hospital admissions that occur while the member is enrolled; and (2) prior admissions as appropriate;

17) All medical records for members eighteen (18) years of age or older include documentation as to whether or not the member has executed an advance directive, including an advance mental health care directive;

18) All medical records shall contain written documentation of a rendered, ordered or prescribed service, including documentation of medical necessity; and

19) All medical records shall contain documented patient visits, which includes, but is not limited to: (A) A history and physical exam; (B) Treatment plan, progress and changes in treatment plan; (C) Laboratory and other studies ordered, as appropriate; (D) Working diagnosis(es) consistent with findings; (E)Treatment, therapies, and other prescribed regimens; (F) Documentation concerning follow-up care, telephone calls, emails, other electronic communication or visits, when indicated; (G) Documentation reflecting that any unresolved concerns from previous visits are addressed in subsequent visits; (H) Documentation of any referrals and results thereof, including evidence that the ordering physician has reviewed consultation, lab, x-ray, and other diagnostic test results/reports filed in the medical records and evidence that consultations and significantly abnormal lab and imaging study results specifically note physician follow-up plans; (I) Hospitalizations and/or emergency room visits, if applicable; and (J) All other aspects of patient care, including ancillary services.

20) Provider shall facilitate the transfer of Member to a new provider by providing Member's medical records (or copies) to the new PCP within seven (7) business days from receipt of the request.

21) The Provider shall maintain medical records in accordance with HRS 622-58, for a minimum of seven (7) years from the last date of entry in the records. For minors, medical records shall be preserved and maintained during the period of minority plus a minimum of seven (7) years after the age of majority. During the period that records are retained, Provider shall allow the State and federal governments full access to such records, to the extent allowed by law.

o. Health Plan shall pay Provider on a timely basis, consistent with the claims payment procedures described in Section 1902(a)(37)(A) of the Social Security Act.

p. The State and federal standards for audits of the DHS designees, contractors and programs conducted under the Hawaii QUEST Integration Contract are applicable and incorporated by reference. The DHS, the HHS or the Secretary may inspect and audit any records of Provider. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs.

q. Provider, in accordance with generally accepted accounting practices, shall maintain fiscal records and supporting documents and related files, papers and reports that adequately reflect all direct and indirect expenditures and management and fiscal practices related to the Provider's performance of services under the Hawaii QUEST Integration Contract.

r. Provider's accounting procedures and practices shall conform to generally accepted accounting principles and the costs properly applicable to the Hawaii QUEST Integration Contract shall be readily ascertainable from the records.

s. The DHS, the State auditor of Hawaii, the Secretary, the U.S. Department of Health and Human Services (HHS), CMS the General Accounting Office (GAO), the Comptroller General of the United States, the Office of the Inspector General (OIG), Medicaid Fraud control Unit of the Department of the Attorney General, State of Hawaii or their authorized representatives shall have the right to enter the premises of the Provider or such other places where the duties under the Hawaii QUEST Integration Contract are being performed, to inspect, monitor, or otherwise evaluate the work being performed and have access to all records. All inspections and evaluations shall be performed in such a manner to not unduly delay work. This includes timely and reasonable access to the personnel for the purpose of interview and discussion related to the records. All records and files pertaining to the Hawaii QUEST Integration Contract shall be located in the State of Hawaii at the Provider's principal place of business or at a storage facility on Oahu that is accessible to the foregoing identified parties.

t. Pursuant to Section 103-55, HRS, services to be performed by the Provider shall be performed by employees paid at wages or salaries not less than the wages paid to public officers and employees for similar work.

u. The Parties hereby agree as required by section 6032 of the Deficit Reduction Act of 2005 that if it makes or receives annual Medicaid payments of Five Million Dollars or more it (i) will establish and maintain written policies for all of its employees and its contractors and agents that provide information about the False Claims Act, 31 U.S.C. §§ 3729-33, other administrative remedies, State laws pertaining to civil and criminal penalties for false claims or statements, and whistleblower protection under such laws; (ii) will include as part of its written policies detailed provisions outlining the entities' policies and procedures for detecting and preventing fraud, waste and abuse; and (iii) will include in any employee handbook a discussion of the relevant laws and administrative remedies, a discussion of whistleblower protections afforded to employees, and the entities' policies and procedures for detecting fraud. Additional guidance may be found at http://www.cms.hhs.gov/smdl/downloads/SMD121306.pdf.

v. Health Plan's provider incentive plans shall not provide for payment either directly or indirectly, to a provider or provider group as an inducement to reduce or limit Medically Necessary services furnished to an individual.

w. Provider warrants and represents that no Federal appropriated funds have been paid or will be paid, by or on behalf of Provider, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan, or cooperative agreement. Provider shall complete and submit, if required, any applicable certification of compliance. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan or cooperative agreement, the Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

x. Provider shall not knowingly have a director, officer, partner, or person with more than five percent (5%) of the Provider's equity or have an employment, consulting, or other agreement with such a person for the provision of items and services that are significant and material to the Health Plan's contractual obligation with the State of Hawaii, who has been disbarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. The Health Plan shall not, without prior approval of the DHS, lend money or extend credit to any related party. The Provider shall fully disclose such proposed transactions and submit a formal written request for review and approval.

y. Access to Member identifying information shall be limited by the Provider to persons or agencies that require the information in order to perform their duties in accordance with the Hawaii QUEST Integration Contracts, including the DHHS, the Secretary, DHS and other individuals or entities as may be required by the DHS. (See 42 CFR 431.300 et. seq. and 45 CFR Parts 160 and 164).

z. Any other party shall be granted access to confidential information only after complying with the requirements of State and federal laws, including HIPAA, and regulations pertaining to such access. Provider is responsible for knowing and understanding the confidentiality laws listed above as well as any other applicable laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not identify particular individuals, provided that de-identification of protected health information is performed in compliance with the HIPAA Privacy Rule.

aa. Federal and State Medicaid rules, and some other federal and State statutes and rules, including but not limited to those listed above are often more stringent than the HIPAA regulations. Moreover, Provider agrees that the confidentiality provisions contained in Chapter 17-1702 HAR shall apply to the Provider to the same extent they apply to MQD.

bb. The Provider shall implement a secure electronic mail (email) encryption solution to ensure confidentiality, integrity, and authenticity of email communications that contain information relating to Members.

cc. Provider shall notify the Health Plan and the MQD of all breaches of confidential information relating to Medicaid applicants and recipients, as Health Plan Members. The notice to the State will be within two (2) business days of discovery of the breach of confidentiality, including any use or disclosure of confidential information, any breach of unsecured PHI, and any Security Incident (as defined in HIPAA regulations) of which the Provider becomes aware with respect to PHI in the custody of the Provider. In addition, Provider shall provide Health Plan and MQD with a written report of the investigation and mitigation efforts within thirty (30) calendar days of the discovery of the breach. Provider shall work with Health Plan and MQD to ensure that the breach has been mitigated and reporting requirements, if any, are complied with.

6. Subcontractor Provisions. The following provisions apply if Health Plan and Provider have entered into an agreement ("Subcontract") for the provision of administrative services by Provider (referred to as "Subcontractor") on Health Plan's behalf related to the Hawaii QUEST Integration Contract.

7. Delegated Functions. Subcontractor shall adhere to the applicable obligations in this Attachment. To the extent that Health Plan, in its sole discretion, elects to delegate any administrative activities or functions to Subcontractor, Subcontractor must demonstrate to the Health Plan's satisfaction, Subcontractor's ability to perform the activities to be delegated and the parties will set out in a separate written document: (a) the specific activities or functions to be delegated and performed by Subcontractor; (b) any reporting obligations pursuant to the Health Plan's policies and procedures and/or the requirements of the Hawaii QUEST Integration Contract (as applicable); (c) monitoring and oversight activities by the Health Plan; and (d) corrective action measures, up to and including without limitation termination or revocation of the delegated activities or functions. Regardless of any provision in the Agreement to the contrary, Subcontractor shall not further delegate or sub-delegate any administrative services or activities delegated by Health Plan to Subcontractor unless set forth in the Agreement. All subcontracts and amendments executed by the Health Plan, including the Agreement, shall be in writing, signed and dated by the Health Plan and Subcontractor, and shall meet the following requirements.

   a. The Health Plan shall be responsible for all work performed under the Hawaii QUEST Integration Contract, but may with the prior written approval of the State of Hawaii, enter into subcontracts for the performance of work under the Hawaii QUEST Integration Contract.

b. Health Plan shall not be permitted to assign any part of the QUEST Integration Contract until the assignment is approved by the Comptroller of the State of Hawaii, as provided in Section 40-58, HRS, or its successor provision.

c. Subcontractor will require its Downstream Persons to adhere to the requirements of this Attachment to the same extent that Subcontractor is required to adhere to such requirements. "Downstream Person" means an individual or entity, such as an employee or a subcontractor, that enters into an arrangement below the level of the Agreement between Health Plan and Subcontractor, including arrangements down to the level of the ultimate provider of Services.

d. The Subcontractor shall perform the activities, meet the criteria prescribed, provide the services contained in the Agreement, including the Delegation Addendum and the reporting responsibilities in a manner consistent with the minimum standards specified in the Hawaii QUEST Integration Contract (as applicable).

e. The Subcontractor shall fulfill the requirements of 42 CFR 438.6 that are appropriate to the service delegated under the Subcontract.

f. The following information regarding Member rights and processes regarding the Member Grievance System applies:
   i. Health Plan has a formal grievance system that is consistent with the requirements of the State of Hawaii and 42 CFR Part 438, Subpart F. The Member grievance system includes an inquiry process, a grievance process and appeals process. In addition, Health Plan's grievance system provides information to Members on accessing the State's administrative hearing system. Health Plan requires that Members exhaust its internal grievance system prior to accessing the State's administrative hearing system.

   ii. Health Plan shall address, log, track and trend all expressions of dissatisfaction, regardless of the degree of seriousness or regardless of whether the Member or provider expressly requests filing the concern or requests remedial action. The formal grievance system must be utilized for any expression of dissatisfaction and any unresolved issue.

   iii. Health Plan will provide reasonable assistance to Members in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

   iv. Health Plan will acknowledge receipt of each filed grievance and appeal in writing within five (5) business days of receipt of the grievance or appeal. Health Plan will have procedures in place to notify all Members in their primary language of grievance and appeal resolutions as described in Section 50.430 and 50.435 of the QUEST Integrated RFP. These procedures include written translation and oral interpretation activities.

   v. Health Plan will ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested must be made and reviewed by a healthcare professional that has appropriate medical

knowledge and clinical expertise in treating the Member's condition or disease. All denials of medical, behavioral health and long term services and support (LTSS) shall be reviewed and approved by Health Plan's medical director. All administrative denials for children under the age of twenty-one (21) shall be reviewed and approved by the Health Plan medical director.

vi. Health Plan shall ensure that individuals who make decisions on grievances and appeals were not involved in any previous level of review or decision-making and are healthcare professionals who have the appropriate clinical expertise, as determined by the State, in treating the Member's condition or disease. This requirement applies specifically to reviewers of: (1) an appeal of a denial that is based on a lack of medical necessity; (2) a grievance regarding denial of expedited resolution of an appeal; or (3) a grievance or appeal that involves clinical issues.

g. Health Plan shall be permitted: (i) To evaluate the Subcontractor's ability to perform the activities to be delegated; (ii) To monitor the Subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule (the frequency which shall be stated in the Subcontract) established by DHS and consistent with industry standards or State laws and regulations; (iii) To identify deficiencies or areas for improvement; and (iv) To take corrective action or impose other sanctions, including but not limited to revoking the delegation, if the Subcontractor's performance is inadequate.

h. Subcontractor shall submit to the Health Plan a tax clearance certificate from the Director of the DOTAX, State of Hawaii, showing that all delinquent taxes, if any, levied or accrued under State law against the Subcontractor have been paid.

i. The Subcontract shall include a provision that the Health Plan shall designate itself as the sole point of recovery for Subcontractor.

j. Neither the State of Hawaii nor the Health Plan Members shall bear any liability of the Health Plan's failure or refusal to pay valid claims of the Subcontractor.

k. Subcontractor shall track and report complaints against them to the Health Plan.

l. Subcontractor shall fully adhere to the privacy, confidentiality and other related requirements stated in the Quest Integration RFP and in applicable federal and State law.

m. If Health Plan is authorized by the DHS to subcontract any function of the QUEST Integration Contract, Subcontractor is not excused from the indemnification and/or insurance provisions required by the QUEST Integration Contract; and Health Plan shall require Subcontractor to obtain insurance in accordance with said contracts.

n. Subcontractor agrees to cooperate fully with federal and State agencies in investigations and subsequent legal actions to include but not limited to the DHS and the Secretary. Such cooperation shall include providing, upon request, information, access to records, access to claims, and access to interview Subcontractor employees and consultants, including but not limited to those with expertise in the

administration of the program and/or medical or pharmaceutical questions or in any matter related to the investigation.

o. Subcontractor shall disclose required business transactions within 35 days of the date the Health Plan requested the information. Subcontractor shall provide full and complete information about the ownership of any subcontractor with whom Subcontractor has had business transactions totaling more than $25,000 during the 12 month period ending on the date of the request; and any significant business transactions between the Subcontractor and any wholly owned supplier, or between the provider and any subcontractor, during the 5 year period ending on the date of the request.

ATTACHMENT C

COMPENSATION

(See following attachments)

ATTACHMENT C-2
HAWAII MEDICAID/CHIP COMPENSATION
(PHYSICIAN SERVICES)
(FEE FOR SERVICE)

1. The compensation rates set forth in this Attachment apply for Benefit Plans under Medicaid Contracts. Compensation shall be subject to and in accordance with the terms and conditions of the Agreement, including this Attachment.

2. Compensation. Fee for service compensation for Covered Services provided to Members shall be the lesser of the Provider's billed charges, or the following, less Member Expenses:

   a. Primary Care Services:

      One Hundred (100%) percent of Health Plan's Medicaid physician rate schedule, based on the Department's Hawaii Medicaid physician fee schedule published on the Department's website on the date the Covered Services are rendered, as adjusted in this attachment.

   b. Specialty Physician Services:

      One Hundred (100%) percent of Health Plan's Medicaid physician rate schedule, based on the Department's Hawaii Medicaid physician fee schedule published on the Department's website on the date the Covered Services are rendered, as adjusted in this attachment.

3. Payment of compensation is subject to coordination of benefits and subrogation activities and adjustments.

4. Health Plan shall process claims and pay or deny a Clean Claim within 30 days of its receipt of the Clean Claim. The date of receipt of a Clean Claim shall be the date Health Plan receives the Clean Claim electronically, or for paper claims as indicated by Health Plan's date stamp on the Clean Claim. The date of payment shall be the date of the electronic funds transfer, check or other form of payment.

5. Health Plan may automatically update Health Plan's Medicaid rate schedules without notice to Contracted Provider or amendment to the Agreement to include successor code numbers for the same services or delete retired codes, as such are revised or implemented by the Department. Health Plan will include in Health Plan's Medicaid rate schedules those Covered Services and corresponding rates that are not included in the Department's Hawaii Medicaid rate schedule published on the Department's website.

6. Health Plan will implement and prospectively apply changes to Health Plan's Medicaid rate schedules based on the Department's Hawaii Medicaid rate changes (a) on the Department's Hawaii Medicaid effective date, if the Department publishes the rate change at least 45 days prior to the Hawaii Medicaid effective date, or (b) no more than 45 days after the date the Department publishes the rate change, if the publication date is less than 45 days before or after the Hawaii Medicaid effective date. Health Plan will not retrospectively apply increases or decreases to Health Plan's Medicaid rate schedule to any claims that have already been paid.