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Ccpa
Effective Date: ~~10/01/2003~~ 11-1-03

L.S.

INDEPENDENT PRACTICE ASSOCIATION AGREEMENT

Dear Independent Practice Association:

Welcome to the Aetna U.S. Healthcare provider network! We are delighted that your independent practice association ("You" or "IPA") has decided to join our provider network.

We mutually desire to enter into an agreement under which the licensed physicians and other IPA providers in your IPA ("Participating IPA Providers") will furnish Covered Services to Members to achieve our shared objective of providing our Members and Participating IPA Providers' patients with access to quality health care services. IPA and Participating IPA Providers agree to abide by the quality improvement, utilization management and other applicable rules, policies and procedures of the health maintenance organization ("HMO"), preferred provider organization ("PPO"), and other health benefit plans or products issued, administered or serviced by Company (collectively, "Policies"). This Agreement (consisting collectively of this Letter and the attached Agreement, schedules and exhibits) constitutes the complete and sole contract between us regarding the subject matter of the Agreement and supersedes any and all prior or contemporaneous oral or written communications not expressly included in the Agreement.

Nothing in this Agreement or the Policies should be construed to prohibit, limit or restrict Participating IPA Providers from advocating on behalf of their patients or providing information, letters of support to, or assistance consistent with the health care needs of their patients and their professional responsibility, conscience, medical knowledge, license and applicable law. In fact, we encourage Participating IPA Providers to discuss with their patients all pertinent details regarding their condition and all care alternatives, including potential risks and benefits, even if a care option is not covered. We also encourage them to discuss the compensation arrangements hereunder with their patients. Nothing in this Agreement or the Policies should be construed to create any right of Company or any Payor to intervene in the manner, methods or means by which Participating IPA Providers render health care services to their patients.

Subject to any necessary regulatory approvals, the effective date of this Agreement is ~~October~~ November 1, 2003 ("Effective Date"). In consideration of the mutual covenants and promises stated herein and other good and valuable consideration, and intending to be legally bound hereby, Aetna Health of Illinois Inc., an Illinois corporation, on behalf of itself and its Affiliates (collectively, "We" or "Company"), and Ccpa enter into this Agreement.

Sincerely,

Company
By: _____
(Signature)
Printed Name:

Title:
Date: 10/16/03

IPA
By: Teresa Chan
(Signature)
Printed Name: Children's Community Physicians Association
Title: Executive Director
Date: Septemebr 8, 2003
Address: 2300 Children's Plaza, Mail Box # 113
City: Chicago
State: IL. Zip: 60614
Federal Tax I.D. #:36-4071049

RECEIVED
OCT 03 2003
CONTRACT MANAGEMENT

INDEPENDENT PRACTICE ASSOCIATION AGREEMENT

This Agreement is entered by and between Company and the IPA who has signed the Independent Practice Association Letter attached hereto.

1.0 SERVICES

1.1 Provision of Covered Services. Participating IPA Providers shall provide to Members those Covered Services which are within the scope of the respective Participating IPA Provider's license and certification to practice. A **Services Schedule** shall be attached hereto and made a part hereof to the extent IPA contains any Participating IPA Providers who are not physicians. Company and IPA may mutually agree in writing at any time, and from time to time, either to increase or decrease the services described in the **Services Schedule**. It is understood and agreed that Company, or, when applicable, the Payor shall have final authority to determine whether any services provided by Participating IPA Providers were Covered Services and to adjust or deny payment for services rendered by Participating IPA Providers to Members in accordance with such determinations.

1.2 Non-Discrimination. Participating IPA Providers shall accept and treat as patients all Members without regard to the health status or health care needs of such Members, and shall protect the rights of such Members as patients. Participating IPA Providers shall not differentiate or discriminate in the treatment, or in the access to treatment, of Members on the basis of race, gender, creed, ancestry, lawful occupation, age, religion, marital status, sex, sexual orientation, mental or physical disability, color, ethnicity, national origin, place of residence, health status, genetic information, source of payment for services, cost or extent of Covered Services required, status as Members, or any other grounds prohibited by law or this Agreement. Each Participating IPA Provider shall provide or arrange for the provision of Covered Services to Members: (i) in no less than the same manner and in accordance with at least the same standards as offered to said Participating IPA Provider's other patients; and (ii) in accordance with at least the same standard of practice, care, skill, and diligence customarily used by similarly situated providers at the time at which such services are rendered.

1.3 IPA Providers. Notwithstanding any contrary interpretation of this Agreement or of any contracts between IPA and Participating IPA Providers, IPA acknowledges and agrees that all provisions of this Agreement applicable to IPA shall apply with equal force to Participating IPA Providers, unless clearly applicable only to IPA. IPA agrees that it is IPA's responsibility to assure that the obligations of Participating IPA Providers under this Agreement are fully satisfied, that IPA will take all steps necessary to cause Participating IPA Providers to comply with and perform the terms and conditions of this Agreement, and that IPA's failure to do so shall constitute a material breach of this Agreement by IPA. IPA agrees, and shall require Participating IPA Providers to agree, that in the event of any inconsistency between this Agreement and the contracts entered into between IPA and Participating IPA Providers, the terms of this Agreement shall control. Upon request by Company, IPA shall provide copies of its contracts with Participating IPA Providers to Company. IPA agrees that each Participating IPA Provider shall execute an individual participation agreement with Company.

1.4 IPA Capacity. IPA shall provide, at the earliest possible time, notice to Company of any significant changes in the capacity of IPA to provide or arrange for the provision of Covered Services to Members as contemplated by this Agreement, including, but not limited to, any reduction in the number of Participating IPA Providers. If Company determines at any time that Members' access to Participating IPA Providers is unacceptable due to any reduction in the number of Participating IPA Providers, or any change in the types or geographic mix of Participating IPA Providers, Company may request that IPA take corrective action acceptable to Company within thirty (30) days. If IPA fails to take such corrective action within such thirty (30) day period, Company may terminate this Agreement as provided in Section 7.3.

1.5 IPA Providers' Information. IPA shall provide to Company a complete list of IPA Providers, including names, office addresses, office hours, telephone and facsimile numbers, and area of practice or specialty. IPA shall notify Company in writing within ten (10) business days of its acquiring knowledge of any change in this information. IPA shall provide to Company at least ninety (90) days prior notice (or, if IPA does not

receive at least ninety (90) days notice, then such notice as IPA actually receives) of the termination of IPA's relationship with a Participating IPA Provider. IPA shall obtain a completed credentialing application to become a Participating Provider from each IPA Provider, and shall, at Company's request, make available to Company any credentialing material held by or accessible to IPA. IPA shall obtain all necessary releases from IPA Providers to permit IPA to release said credentialing files to Company, and Company shall be entitled to presume that such releases have been obtained.

1.6 Primary Care Physicians. Each Participating IPA Provider who is a Primary Care Physician shall comply with the following:

1.6.1 Coordination of Care. A Primary Care Physician shall arrange and coordinate the overall provision of Covered Services to each Member who may obtain care from said Primary Care Physician, in accordance with the terms and conditions of the Member's Plan. A Primary Care Physician shall provide or arrange for the provision of Covered Services, including, without limitation, urgently needed services or Emergency Services, regardless of whether the Primary Care Physician has previously seen or treated the Member.

1.6.2 Referrals. Unless the requirement does not apply to a Member's Plan, a Primary Care Physician shall refer or admit Members only to Participating Providers, to the fullest extent possible consistent with sound medical judgment, for Covered Services as is Medically Necessary. For the purpose of providing quality care to Members, a Primary Care Physician shall furnish to other physicians and providers treating Member all relevant medical information, including treatments and diagnostic tests, related to Member.

1.6.3 New Members. IPA and Company agree that a broad selection of physicians is important to Members and that Members expect physicians listed in Company's provider directories to be available to them. Accordingly, only upon at least ninety (90) days' prior written notice with good cause acceptable to Company, may a Primary Care Physician prospectively decline to accept new Members as patients. To prevent discrimination against Company or its Members, for such time as such Primary Care Physician's office declines to accept new Members as patients, such office shall not accept as patients additional members from any other health maintenance organization.

1.7 IPA Providers Other than Primary Care Physicians. A Participating IPA Provider who is not a Primary Care Physician shall: (a) except for Emergency Services, provide Covered Services to Members only upon prior referral of such patients by a Primary Care Physician to said Participating IPA Provider on prescribed forms or by electronic means as instructed by Company, if such a referral is required by the applicable Plan; (b) render services to Members only at those inpatient, extended care, and ancillary service facilities which have been approved in advance by Company; and (c) promptly submit a report on the treatment of each Member to the referring Primary Care Physician, if applicable. Except for Emergency Services, payment for retroactive referrals shall be subject to adjustment or denial by Company.

2.0 REPRESENTATIONS

2.1 IPA Representation. IPA represents and warrants that: (a) it and Participating IPA Providers have and shall maintain all appropriate licenses and certifications mandated by governmental agencies, which for Participating IPA Providers shall include, without limitation, DEA certification (unless such certification is not a criterion for participation for a given Participating IPA Provider under the applicable **Participation Criteria Schedule**), and an unencumbered license to practice medicine (or, for any Participating IPA Provider who is not a physician, an unencumbered license, certification or other authorization to practice his or her other professional discipline) in the states in which the respective Participating IPA Provider provides services to Members; (b) it and Participating IPA Providers shall comply with all applicable laws related to this Agreement and the services to be provided hereunder, including, but not limited to, laws related to fraud, abuse, discrimination, disabilities, confidentiality, self-referral, false claims and prohibition of kickbacks; (c) each Participating IPA Provider has and shall maintain unencumbered hospital privileges at a Participating Hospital (unless the maintenance of such privileges is not a criterion for participation for a given Participating IPA Provider under the applicable **Participation Criteria Schedule**); (d) it has not discriminated and will not

discriminate in the selection or retention of IPA Providers on the basis of gender, race, age, sex, religion, national origin or any other grounds prohibited by law; (e) it is legally authorized to negotiate on behalf of IPA Providers and to bind those IPA Providers who are Participating IPA Providers to abide by the terms of this Agreement, as amended from time to time; (f) it has executed this Agreement through its duly authorized representative; and (g) executing and performing its obligations under this Agreement shall not cause IPA or any IPA Provider to violate any term or covenant of any other arrangement now existing or hereafter entered into.

2.2 Quality Assessment. IPA and Participating IPA Providers shall ensure that all personnel employed by, associated or contracted with IPA or Participating IPA Providers who treat Members: (a) are and shall remain appropriately licensed, certified and supervised (as required by law), and qualified by education, training and experience to perform their professional duties; and (b) shall act within the scope of their licensure or certification, as the case may be. As part of its quality improvement processes, Company may audit compliance with this section upon prior notice and, upon Company's request, IPA and Participating IPA Providers shall supply to Company all relevant documentation, including, but not limited to, licenses, certifications, and registrations. IPA must obtain the approval of Company prior to utilizing any subcontractors to provide Covered Services to Members. IPA acknowledges and agrees that all Medicare-required provisions of this Agreement shall apply to any subcontractors, and IPA agrees to take all steps necessary to cause subcontractors to comply with and perform such Medicare requirements. Upon request of Company, IPA shall provide copies of its contracts with subcontractors to Company.

3.0 COMPENSATION

3.1 Payment. Company shall, or when it is not the applicable Payor shall notify each Payor to, pay Participating IPA Providers for Covered Services rendered to Members in accordance with the **Compensation Schedule** attached hereto and made a part hereof, or, if such Compensation Schedule is not applicable to the individual Participating IPA Provider, in accordance with the compensation arrangement then in effect as applicable to such Members' Plans. Company will provide ninety (90) days notice by letter, newsletter, or other media, of material changes in compensation. Participating IPA Provider's compensation for non-capitated Covered Services rendered to Members shall be: (A) the lower of (i) the rates in the **Compensation Schedule**, or (ii) the Participating IPA Provider's customary billed charge, (B) minus any applicable Copayments, Coinsurance or Deductibles. Payments for non-capitated Covered Services are subject to any and all valid and applicable laws related to claims payment. Participating IPA Provider shall notify Company of any overpayments or payments made in error as soon as becoming aware thereof, and shall return or arrange for the return of any such overpayment or payment made in error to Company, or to Payor or Member, as applicable. Company reserves the right to rebundle to the primary procedure those services determined by Company to be part of, incidental to, or inclusive of the primary procedure. When Company is not the Payor, Company shall have no obligation to pay IPA and Participating IPA Providers in the event that the Payor or Member fails to pay IPA or Participating IPA Providers.

3.2 Billing of Members. Under certain Plans, Members may be required to pay Copayments, Coinsurance or Deductibles for certain Covered Services. Participating IPA Providers shall collect any applicable Copayments, Coinsurance and Deductibles from Members. Copayments shall be collected at the time that Covered Services are rendered. Except for applicable Copayments, Coinsurance and Deductibles, Participating IPA Providers may bill Members only in the circumstances described below:

3.2.1 If the applicable Payor is not a health maintenance organization ("HMO"), Participating IPA Providers may bill a Member for Covered Services provided to the Member in the event that the Payor becomes insolvent or otherwise breaches the terms and conditions of its agreement to pay, provided that: (a) Participating IPA Provider shall have first exhausted all reasonable efforts to obtain payment from the Payor; and (b) Participating IPA Provider shall not institute or maintain any collection activities against a Member to collect any sums that are owed by a Payor to Participating IPA Provider unless Participating IPA Provider provides at least thirty (30) days prior notice to Company of Participating IPA Provider's intent to institute such activities.

3.2.2 Services that are not Covered Services may be billed to Members by Participating IPA Providers only if: (a) the Member's Plan provides and/or Company confirms that the services are not covered; (b) the Member was advised in writing prior to the services being rendered that the specific services are not Covered Services; or (c) the Member agreed in writing to pay for such services.

Nothing in this section is intended to prohibit or restrict Participating IPA Providers from billing individuals who were not Members at the time that services were rendered.

3.3 Coordination of Benefits. When a Payor is the primary payor under applicable coordination of benefit principles, the Payor shall pay in accordance with this Agreement, and when a Payor is secondary under said principles, Payor's payment shall be limited as specified in the applicable Plan. If the Plan fails to specify coordination of benefits requirements, and unless prohibited by applicable law, Payor's payment shall be limited to the amount which, together with the amount paid by the primary payor following all reasonable efforts by Participating IPA Provider to collect same, equals the compensation due to Participating IPA Provider under this Agreement, or if the primary payor fails to pay, Payor's payment shall be in accordance with this Agreement. In no event shall amounts billed and retained under coordination of benefits for Covered Services exceed the Participating IPA Provider's usual and customary billed charges for such services.

3.4 Claims Submission. Participating IPA Provider shall submit claims to Company or the applicable Payor for non-capitated Covered Services rendered to Members by Participating IPA Providers. Claims shall be submitted within one hundred and twenty (120) days of the date of service or Participating IPA Provider's receipt of an explanation of benefits from a primary payor. Billings shall include detailed and descriptive medical and Member data and identifying information on HCFA 1500 forms or any subsequent form adopted for that purpose. Participating IPA Provider shall submit bills electronically as required by Company or the applicable Payor. Company primarily utilizes CPT-4 for the coding and description of services. If a Participating IPA Provider has not billed Company or the applicable Payor within the stated time frame, said Participating IPA Provider's claim shall be deemed waived, and Participating IPA Provider shall not bill any other person or entity, including, but not limited to, Company, the applicable Payor, Sponsor, or Member, for such services. Company may return to Participating IPA Provider any claims which are incomplete, inaccurate, or not in the proper format as required by Company. Statements made in any claim or related documentation submitted by or on behalf of a Participating IPA Provider shall be considered statements made by said Participating IPA Provider, regardless of whether such statements are prepared by Participating IPA Provider's employees, agents, or representatives. Any adjustments to claims submitted by Participating IPA Providers must be filed with Company or the applicable Payor within thirty (30) days of the submission of the original claim, or the original claim will be deemed final.

3.5 Hold Harmless.

3.5.1 Holding Members Harmless. If the applicable Payor is an HMO, IPA and Participating IPA Providers agree that in no event, including, but not limited to, non-payment by the HMO, insolvency of the HMO or breach of this Agreement, shall IPA or any Participating IPA Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member or persons (other than the HMO) acting on a Member's behalf for Covered Services. This provision shall not prohibit collection of Deductibles, Coinsurance, or Copayments from Members in accordance with the terms of the Member's Plan.

IPA and Participating IPA Providers further agree that: (a) this provision shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Members; and (b) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between IPA or any Participating IPA Provider and a Member or persons acting on a Member's behalf.

3.5.2 Hold Harmless and Indemnify. IPA and Participating IPA Provider shall hold Company, its Affiliates, Sponsors, Members and Payors harmless and indemnify them against any and all claims related to or arising out of payment for Covered Services rendered to Members for which IPA or Participating IPA

Provider is financially responsible, when a Payor has remitted payment to Participating IPA Provider as set forth in this Agreement and said claim alleges that IPA or Participating IPA Provider has failed to remit payment to providers as required by this Agreement.

4.0 COMPLIANCE WITH COMPANY POLICIES

4.1 Compliance and Participation. Company's Participation Criteria and Policies are necessary to the mutual objectives of IPA and Company of providing Members with access to and promotion of quality health care services. Participating IPA Providers shall comply with any of Company's then-current Participation Criteria described in the **Participation Criteria Schedule** (attached hereto and made a part hereof) and Company's then-current Policies regarding, among other things: (a) quality improvement/management/assessment; (b) disease and utilization management, including, but not limited to, precertification of elective admissions and procedures, referral process or protocols, case management, and reporting of clinical encounter data; (c) claims payment review; (d) appeals, grievances and reviews; (e) provider credentialing; (f) electronic submission of referrals, encounter data, claims and other data required by Company; (g) confidentiality of medical records; (h) Health Plan Employer Data Information Set ("HEDIS") and similar data collection and reporting; and (i) information collection and reporting required or requested by National Committee for Quality Assurance ("NCQA"), Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), American Accreditation HealthCare Commission/Utilization Review Accreditation Commission ("URAC"), Professional Review Organizations ("PROs"), state and federal regulatory and oversight agencies, and other accreditation or evaluation organizations. Company will provide ninety (90) days notice by letter, newsletter, electronic mail or other media, of material changes in such Policies.

4.2 Utilization Review. Company's Policies are designed promote adherence to accepted medical treatment standards and encourage Participating Providers to minimize unnecessary medical costs consistent with sound medical judgment. To further this end, Participating IPA Providers agree, consistent with sound medical judgment:

a. To participate, as requested, and abide by Company's then-current utilization review, patient management, quality improvement programs, any programs mandated by applicable state law, and all other related programs and decisions.

b. To comply with Company's precertification (when applicable) and utilization management requirements for Covered Services.

c. To interact and cooperate with Company's Nurse Case Managers and other utilization management personnel.

d. To utilize Participating Providers (who have been credentialed by Company and have met its Participation Criteria) to the fullest extent possible.

e. To abide by Company's credentialing criteria and procedures, including site visits and medical chart reviews.

f. To obtain advance authorization from Company prior to any non-emergency admission, and notify Company in cases where a Member requires an emergency hospital admission.

g. To cooperate with the Member's Primary Care Physician, if applicable, including timely scheduling of appointments and appropriate communication after patient evaluation and treatment.

4.3 Member Grievances. IPA and Participating IPA Providers shall cooperate with and participate in Company's applicable appeal, grievance and external review procedures (including, but not limited to, Medicare appeals and expedited appeals procedures), shall provide Company with the information necessary to resolve same, and shall abide by decisions of the applicable appeals, grievance and review committees. Company shall not terminate or otherwise penalize IPA or Participating IPA Providers because IPA or Participating IPA

Providers advocate on behalf of Members or provide information consistent with the health care needs of Members in connection with any appeal, grievance or external review proceeding.

4.4 Notices and Reporting. IPA and Participating IPA Providers shall notify Company promptly of: (a) any litigation brought against IPA or any Participating IPA Provider related to patient care; (b) any actions taken or investigations initiated by any government agency involving IPA or any Participating IPA Provider, or any health care entity in which IPA or any Participating IPA Provider holds more than a five percent (5%) interest; (c) IPA's or a Participating IPA Provider's five percent (5%) ownership interest or significant position with another health maintenance organization or other managed care organization or health plan; and (d) any legal actions or investigations initiated against IPA or Participating IPA Providers by governmental agencies or individuals regarding fraud, abuse, self-referral, false claims, or kickbacks. Upon Company's request, IPA and Participating IPA Providers shall provide all known details of the nature, circumstances and disposition of any suits, claims, actions or investigations to Company.

4.5 Assignments of Benefits and Consents to Release of Medical Information. Participating IPA Providers shall obtain from all non-HMO Members to whom Covered Services are provided: (a) signed assignments of benefits authorizing payment for Covered Services to be made directly to Participating IPA Provider or the Participating IPA Provider's designee; and (b) consents to release medical information to Company and Payors or their authorized representatives.

4.6 Proprietary Information. IPA agrees, on its behalf and on behalf of Participating IPA Providers, that Proprietary Information is the exclusive property of Company and that IPA and Participating IPA Providers have no right, title or interest in same. IPA and Participating IPA Providers shall keep Proprietary Information strictly confidential and shall not disclose any Proprietary Information to any third party, except to governmental authorities having jurisdiction. IPA and Participating IPA Providers shall not use any Proprietary Information, and shall, at the request of Company, return all Proprietary Information upon termination of this Agreement. In the event of a breach or a threatened breach of this section by IPA or a Participating IPA Provider, Company shall have the right of specific performance and injunctive relief in addition to any and all other remedies and rights at law or in equity, and such rights and remedies shall be cumulative. Nothing herein prohibits, limits or restricts Participating IPA Providers from discussing Company's provider reimbursement methodologies with Members; Company affirmatively encourages Participating IPA Providers to discuss such reimbursement methodologies with Members.

4.7 Encounter Data. IPA shall provide Company with complete and accurate encounter data by type of Covered Service rendered to Members in the form and manner as specified by Company. IPA certifies that such encounter data is truthful and complete.

5.0 INSURANCE

5.1 IPA's Insurance. During the entire term of this Agreement, IPA shall maintain, with respect to the activities in which IPA, Participating IPA Providers, and its or their employees or agents engage pursuant to this Agreement, insurance at minimum levels required from time to time by Company, but in no event less than: (a) professional liability insurance in the minimum amounts of $5,000,000 per occurrence/$10,000,000 annual aggregate, except in cases where this level of insurance exceeds that required by applicable state law, in which instance IPA shall maintain the maximum level of professional liability insurance required by law; (b) comprehensive general liability insurance in the minimum amounts of $1,000,000 per occurrence/$3,000,000 annual aggregate; and (c) director and officer liability insurance for IPA's directors, officers and managers in the minimum amount of $1,000,000. Memorandum copies of such policies shall be delivered to Company upon request. IPA shall notify Company at least thirty (30) days in advance of any cancellation, limitation, or non-renewal of, or any material change to, said policies.

5.2 IPA Providers' Insurance. Each Participating IPA Provider shall maintain throughout the term of this Agreement professional liability insurance and comprehensive general liability insurance in at least the minimum amounts specified in the applicable **Participation Criteria Schedule**. Participating IPA Provider shall notify Company at least thirty (30) days in advance of any cancellation, limitation or non-renewal of, or any material change to, said insurance.

6.0 MEMBER INFORMATION.

6.1 Confidentiality of Medical Records. IPA, Participating IPA Providers and Company agree that confidentiality of Member medical records must be safeguarded and that Member medical records shall be treated as confidential in accordance with all applicable laws. According to the terms of Company's HMO enrollment forms, agreements with Members and applicable law, Company is authorized to obtain Member Information (as defined below) from IPA and Participating IPA Providers without additional written release by the Member.

6.2 Access to Information. (a) To Company. Company requires access to Member information for a variety of necessary and appropriate purposes, including claims payment and fraud prevention, fulfilling state and federal requirements, grievance resolution, preventive health and disease management programs, HEDIS and similar data collection and reporting, and accreditation by NCQA, URAC, and other accreditation organizations. IPA and Participating IPA Providers therefore agree that Company, on behalf of itself and its Affiliates, shall have access to data and information obtained, created or collected by IPA and Participating IPA Providers related to Members or the ability to deliver care to Members ("Member Information"). Neither IPA nor Participating IPA Providers shall enter into any contract or arrangement whereby Company or its Affiliates do not have unlimited free and equal access to Member Information in electronic or other form at no cost to Company. IPA and Participating IPA Providers agree to implement all activities reasonably necessary to assist Company to obtain accreditation by NCQA, URAC, or any other similar organization as determined by Company, including cooperating in the auditing of Members' medical records. Similarly, IPA and Participating IPA Providers shall cooperate with any review of Company or a Plan conducted by a state or federal agency with authority over Company or a Plan, as applicable. (b) To Governmental Authorities. IPA and Participating IPA Providers further agree to provide federal, state and local governmental authorities having jurisdiction, access to all Member Information.

6.3 Maintenance of Records. IPA and Participating IPA Providers agree to maintain Member Information as well as all other books, records and other papers in a current, detailed, organized and comprehensive manner and in accordance with good medical practice, applicable laws, and accreditation standards and shall maintain such for the longer of six (6) years after the term of this Agreement or the period required by applicable law.

7.0 TERM AND TERMINATION

7.1 Term and Renewal. This Agreement shall commence on the Effective Date and, subject to the termination provisions contained herein, shall continue for an initial term of one (1) year and shall thereafter automatically renew for successive one (1) year periods unless written notice of non-renewal is given to the other party at least ninety (90) days prior to the end of the then-current term.

7.2 Termination without Cause. This Agreement may be terminated by either party at any time without cause upon at least ninety (90) days prior written notice to the other party.

7.3 Termination for Breach. This Agreement may be terminated at any time by either party upon at least sixty (60) days prior written notice of such termination to the other party upon default or breach by such party of one or more of its obligations hereunder, unless such default or breach is cured within thirty (30) days of the notice of termination.

7.4 Termination or Suspension.

7.4.1 Termination or Suspension of IPA. This Agreement may be immediately terminated, or IPA's participation in any or all Plans may be immediately suspended, by Company at any time due to: (a) the suspension, withdrawal, expiration, non-renewal or revocation of any state or local license, certificate, approval or authorization of IPA; (b) IPA's indictment, arrest, charge or conviction of any felony or criminal charge related to moral turpitude or the practice of medicine or other professional discipline; (c) the cancellation, reduction, limitation or termination of any insurance required by Section 5.1; (d) the suspension or debarment of IPA from participation in any governmental sponsored

program, including, without limitation, the Medicare or Medicaid programs; (e) a filing in bankruptcy, the appointment of a receiver, the marshaling of debts or assets, or the proposed settlement of outstanding debts under applicable reorganization or insolvency laws filed by or against IPA; (f) change of control of IPA to an entity not acceptable to Company; or (g) Company's determination that continuation of this Agreement could place the health or safety of Members in serious jeopardy. IPA shall provide immediate notice to Company of any of the aforesaid events.

7.4.2 Termination or Suspension of Participating IPA Providers. Company may terminate the status of any Participating IPA Provider as a Participating Provider for default or breach of said Participating IPA Provider's obligations hereunder upon at least thirty (30) days notice to said Participating IPA Provider, unless such default or breach is cured within the notice period. In addition, Company may immediately terminate or suspend the status of any Participating IPA Provider as a Participating Provider, at any time, due to: (a) a suspension, withdrawal, expiration, non-renewal or revocation of any state or local license, certificate or other legal credential authorizing said Participating IPA Provider to practice medicine (or his or her other professional discipline); (b) a suspension or revocation of said Participating IPA Provider's DEA certification (unless such certification is not a criterion for participation for said Participating IPA Provider under the applicable **Participation Criteria Schedule**) or any other right to prescribe controlled substances; (c) said Participating IPA Provider's indictment, arrest, charge or conviction of any felony or criminal charge related to moral turpitude or the practice of medicine (or Participating IPA Provider's other professional discipline); (d) the cancellation, reduction, limitation or termination of said Participating IPA Provider's insurance required by this Agreement; (e) said Participating IPA Provider's suspension or debarment from participation in any governmental sponsored program, including, without limitation, the Medicare or Medicaid programs; (f) a filing in bankruptcy, the appointment of a receiver, the marshaling of debts or assets, or the proposed settlement of outstanding debts under applicable reorganization or insolvency laws filed by or against said Participating IPA Provider; (g) any false statement or material omission in said Participating IPA Provider's participation application and/or confidential information forms and all other requested information, as determined by Company; (h) any adverse action with respect to said Participating IPA Provider's hospital staff privileges, if said Participating IPA Provider is required to maintain such privileges under the applicable **Participation Criteria Schedule**; or (i) Company's determination that continuation of this Agreement could place the health or safety of Members in serious jeopardy. IPA and Participating IPA Providers shall provide immediate notice to Company of any of the aforesaid events.

7.5 Obligations Following Termination. Following the effective date of any termination or non-renewal of this Agreement, or termination of any Plan, IPA and Participating IPA Providers shall comply with the following obligations.

7.5.1 Upon Termination. Company, Participating IPA Providers and IPA desire to promote continuity of care. Accordingly, upon termination or non-renewal of this Agreement for any reason, other than termination by Company in accordance with Section 7.4 above, each Participating IPA Provider shall remain obligated at Company's request to provide Covered Services to: (a) any Member under said Participating IPA Provider's care who, at the time of the termination or non-renewal, is a registered bed patient at a Participating Facility until such Member's discharge therefrom or Company's orderly transition of such Member's care to another provider, whichever is less; and (b) any Member, upon request of such Member or the applicable Payor, until the anniversary date of such Member's respective Plan or for one (1) calendar year, whichever is less. The terms of this Agreement shall apply to such services.

7.5.2 Upon Insolvency or Cessation of Operations. If this Agreement terminates as a result of insolvency or cessation of operations of a Company Affiliate that is an HMO, and as to Members of HMOs that become insolvent or cease operations, then, in addition to the other obligations set forth in this section, Participating IPA Providers shall continue to provide Covered Services to: (a) all Members for the period for which premium has been paid; and (b) Members confined in an inpatient facility on the date of insolvency or other cessation of operations until medically appropriate discharge. This section shall

be construed to be for the benefit of Members. No modification to this section shall be effective without the prior written approval of the applicable regulatory agencies.

7.5.3 Obligation to Cooperate. Upon notice of termination or non-renewal of this Agreement or termination of a Plan, IPA and Participating IPA Providers shall cooperate fully with Company and comply with Company procedures, if any, in the transfer of Members to other providers. In addition, upon notice of termination or non-renewal, at Company's option, Members shall not be permitted to select Participating IPA Providers as their Primary Care Physicians.

8.0 MODIFICATIONS

8.1 Amendments. No changes, amendments, or alterations to this Agreement shall be effective unless signed by duly authorized representatives of both parties, except as expressly provided herein. Notwithstanding the foregoing, at Company's discretion, Company may amend this Agreement upon written notice to IPA to comply with any applicable law or regulation, or any order or directive of any governmental agency.

8.2 Plan Participation. (a) IPA and Participating IPA Providers agrees to participate in those Plans listed on the Plan Participation Schedule attached hereto and made a part hereof. Company reserves the right to introduce new Plans during the course of this Agreement and shall provide IPA and Participating IPA Providers with ninety (90) days prior written notice of such new Plans and associated compensation schedules. IPA and Participating IPA Providers shall, within thirty (30) days of receipt of such notice, notify Company in writing if IPA and Participating IPA Providers elects not to participate in such Plans(s). (b) To the extent applicable to IPA and Participating IPA Provider's service area, Medicare and Medicaid beneficiaries shall be considered Members, and IPA and Participating IPA Providers shall be bound by all requirements applicable to such Members and all rules and regulations of the Medicare and Medicaid programs. With respect to Medicare HMO Members, IPA and Participating IPA Providers acknowledges that compensation under this Agreement for such Members constitutes receipt of federal funds.

9.0 RELATIONSHIP OF THE PARTIES

9.1 Independent Contractor Status. IPA and Participating IPA Providers are independent contractors of Company. IPA, Participating IPA Providers, and their respective employees and agents shall in no way be considered agents or representatives of Company for any purpose, nor shall IPA, Participating IPA Providers, or their respective employees and agents hold themselves out to be agents or representatives of Company for any purpose. Company and its employees and agents shall in no way be considered agents or representatives of IPA or Participating IPA Providers for any purpose, nor shall Company or its agents and employees hold themselves out to be agents or representatives of IPA or Participating IPA Providers for any purpose. Company shall in no event be liable for the activities of IPA, Participating IPA Providers, or their respective agents and employees, including, without limitation, any liabilities, losses, damages, injunctions, suits, actions, fines, penalties, claims or demands of any kind or nature by or on behalf of any person, party or governmental authority arising out of or in connection with: (a) any failure to perform any of the agreements, terms, covenants or conditions of this Agreement; (b) any negligent act or omission or other misconduct; (c) the failure to comply with any applicable laws, rules or regulations; or (d) any accident, injury or damage. IPA and Participating IPA Providers shall in no event be liable for the activities of [illegible] its agents and employees, including, without limitation, any liabilities, losses, damages, injunctions, suits, actions, fines, penalties, claims or demands of any kind or nature by or on behalf of any person, party or governmental authority arising out of or in connection with: (i) any failure to perform any of the agreements, terms, covenants or conditions of this Agreement; (ii) any negligent act or omission or other misconduct; (iii) the failure to comply with any applicable laws, rules or regulations; or (iv) any accident, injury or damage. IPA and Participating IPA Providers acknowledge that all Member care and related decisions are the sole responsibility of Participating IPA Providers, and that nothing herein dictates or controls Participating IPA Providers' clinical decisions with respect to the care of Members or shall be construed to require Participating IPA Providers to recommend any procedure or course of treatment which Participating IPA Providers deem professionally unacceptable. IPA and Participating IPA Providers further acknowledges and agrees that an actual or prospective coverage decision with respect to a particular course of medical treatment shall not relieve Participating IPA Providers from providing or recommending care to Member as Participating IPA

Providers deem clinically appropriate. IPA agrees to indemnify, defend and hold harmless Company from any and all claims, liabilities and causes of action (including costs and counsel fees) arising out of Participating IPA Providers' care of Members. This provision does not require IPA to indemnify, defend or hold harmless Company (including costs and counsel fees) for any acts or conduct of Company giving rise to liability, and nothing in this section shall be construed to transfer to IPA or Participating IPA Providers any liability for any acts or conduct of Company as opposed to IPA or Participating IPA Providers.

9.2 Use of Name. To assist in making known to Members the availability of IPA and Participating IPA Providers, IPA consents, on its behalf and on behalf of Participating IPA Providers, to the use of its and Participating IPA Providers' names and other identifying and descriptive material in provider directories and other materials and marketing and advertising in all media. IPA and Participating IPA Provider may use Company's names, logos, trademarks and service marks in marketing materials or otherwise, with Company's prior written consent.

9.3 Interference with Contractual Relations. IPA and Participating IPA Providers shall not: (a) counsel or advise, directly or indirectly, Payors, Sponsors or other entities who are currently under contract with Company or any Affiliate to cancel, modify, or not renew said contracts; (b) impede or otherwise interfere with negotiations which Company or an Affiliate is conducting for the provision of Plans; or (c) use or disclose to any third party membership lists acquired during the term of this Agreement for the purpose of directly or indirectly soliciting individuals who were or are Members or otherwise to compete with Company or any Affiliate. Nothing in this section is intended to restrict any communication between a Participating IPA Provider and a Member determined by the Participating IPA Provider to be necessary or appropriate for the care of the Member. In the event of a breach or a threatened breach of this section by IPA or a Participating IPA Provider, Company shall have the right of specific performance and injunctive relief in addition to any and all other remedies and rights at law or in equity, and such rights and remedies shall be cumulative.

9.4 Liaison. IPA shall appoint and retain at all times an administrator and a medical director to serve as liaisons to Company in connection with this Agreement. The medical director (or the administrator, if a physician) shall have authority to bind IPA with respect to clinical matters and the administrator shall have authority to bind IPA with respect to all other matters.

10.0 COMPANY OBLIGATIONS AND DISPUTE RESOLUTION

10.1 Company Obligations. Company or Payors shall provide a means to identify Members (e.g., identification cards). Company shall further provide Participating IPA Providers with an explanation of benefits available to Members, a description of utilization standards, administrative requirements, a listing of physicians, hospitals and ancillary providers in Company's network, and timely notification of significant changes in this information. Company will enable IPA or Participating IPA Providers to check eligibility. Company will include Participating IPA Providers in the applicable Participating Provider directory or directories and will make such directories available to Members.

10.2 Dispute Resolution/Arbitration

10.2.1 Dispute Resolution. Company shall provide an internal mechanism whereby IPA or any Participating IPA Provider may raise issues, concerns, controversies or claims regarding the obligations of the parties under this Agreement. IPA or any Participating IPA Provider shall utilize this internal mechanism prior to submitting a complaint to any regulatory agency or instituting any arbitration or other permitted legal proceeding. Discussions and negotiations held specifically pursuant to this Section 10.2.1 shall be treated as compromise and settlement negotiations for purposes of applicable rules of evidence.

10.2.2 Submission of Claim or Controversy to Arbitration. Any controversy or claim arising out of or relating to this Agreement or the breach, termination, or validity thereof, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration administered by the American Arbitration Association ("AAA") and conducted by a sole Arbitrator ("Arbitrator") in accordance with the AAA's Commercial Arbitration Rules

("Rules"). A stenographic record shall be made of all testimony in any arbitration in which any disclosed claim or counterclaim exceeds $250,000. The arbitration shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16, to the exclusion of state laws inconsistent therewith or that would produce a different result, and judgment on the award rendered by the Arbitrator (the "Award") may be entered by any court having jurisdiction thereof. An Award for $250,000 or more shall be accompanied by a short statement of the reasoning on which the Award rests.

10.2.3 Appeal of Arbitration Award. Within thirty (30) days of receipt of an Award of $250,000 or more (which shall not be binding if an appeal is taken), a party may notify the AAA of its intention to appeal the Award to a second Arbitrator (the "Appeal Arbitrator"), designated in the same manner as the Arbitrator except that the Appeal Arbitrator must have at least twenty (20) years' experience in the active practice of law or as a judge. The Appeal Arbitrator shall not take new testimony or other evidence and shall not modify or replace the Award except for clear error of law. The Award, as confirmed, modified or replaced by the Appeal Arbitrator, shall be final and binding, and judgment thereon may be entered by any court having jurisdiction thereof.

10.2.4 Confidentiality. Except as may be required by law or to the extent necessary in connection with a judicial challenge, permitted appeal, or enforcement of an Award, neither a party nor an arbitrator may disclose the existence, content, record, status or results of a negotiation or arbitration. Any information, document, or record (in whatever form preserved) referring to, discussing, or otherwise related to a negotiation or arbitration, or reflecting the existence, content, record, status, or results of a negotiation ("Negotiation Record") or arbitration ("Arbitration Record"), is confidential and each party to this Agreement shall (i) protect Negotiation and Arbitration Records from unauthorized use or disclosure with at least the same degree of care it uses to protect its own confidential information of a similar nature; (ii) use Negotiation and Arbitration Records only for the purpose(s) expressly set forth in, and in accordance with, the terms of this Agreement; (iii) not disclose or otherwise permit any third person or entity access to Negotiation or Arbitration Records except with the other party's prior written consent; and (iv) take any and all other steps necessary to safeguard Negotiation and Arbitration Records against disclosure to third parties. The arbitration hearing shall be closed to any person or entity other than the arbitrator, the parties, witnesses during their testimony, and attorneys of record. Upon the request of a party, an arbitrator may take such actions as are necessary to enforce this Section 10.2.4, including the imposition of sanctions.

10.2.5 Pre-hearing Procedure for Arbitration. The parties will cooperate in good faith in the voluntary, prompt and informal exchange of all documents and information (that are neither privileged nor proprietary) relevant to the dispute or claim, all documents in their possession or control on which they rely in support of their positions or which they intend to introduce as exhibits at the hearing, the identities of all individuals with knowledge about the dispute or claim and a brief description of such knowledge, and the identities, qualifications and anticipated testimony of all experts who may be called upon to testify or whose report may be introduced at the hearing. The parties and Arbitrator will make every effort to conclude the document and information exchange process within sixty (60) calendar days after all pleadings or notices of claims have been received. At the request of a party in any arbitration in which any disclosed claim or counterclaim exceeds $250,000, the Arbitrator may also order pre-hearing discovery by deposition upon good cause shown. Such depositions shall be limited to a maximum of three (3) per party and shall be limited to a maximum of six (6) hours' duration each. As they become aware of new documents or information (including experts who may be called upon to testify), all parties remain under a continuing obligation to provide relevant, non-privileged documents, to supplement their identification of witnesses and experts, and to honor any understandings between the parties regarding documents or information to be exchanged. Documents that have not been previously exchanged, or witnesses and experts not previously identified, will not be considered by the Arbitrator at the hearing. Fourteen (14) calendar days before the hearing, the parties will exchange and provide to the Arbitrator (a) a list of witnesses they intend to call (including any experts) with a short description of the anticipated direct testimony of each witness and an estimate of the length thereof, and (b) premarked copies of all exhibits they intend to use at the hearing.

10.2.6 Arbitration Award. The arbitrator may award only monetary relief and is not empowered to award damages other than compensatory damages and, in the arbitrator's discretion, pre-award interest. The Award shall be in satisfaction of all claims by all parties. Arbitrator fees and expenses shall be borne equally by the parties. Postponement and cancellation fees and expenses shall be borne by the party causing the postponement or cancellation. Fees and expenses incurred by a party in successfully enforcing an Award shall be borne by the other party. Except as otherwise provided in this Agreement, each party shall bear all other fees and expenses it incurs, including all filing, witness, expert witness, transcript, and attorneys' fees.

11.0 MISCELLANEOUS

11.1 Waiver. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, a waiver must be in writing and signed by the duly authorized representative of the party to be charged.

11.2 Governing Law. This Agreement shall be governed in all respects by the laws of the State of Illinois, without regard to conflict of law principles.

11.3 Liability. Company's liability, if any, for damages to IPA or any Participating IPA Provider for any cause whatsoever arising out of or related to this Agreement, and regardless of the form of the action, shall be limited to IPA's or the Participating IPA Provider's actual damages. In no event shall the amount of such damages exceed, as to IPA and Participating IPA Providers in total, all amounts paid for services rendered by all Participating IPA Providers under this Agreement during the twelve (12) month period immediately prior to the date the cause of action arose or $100,000.00, whichever is greater. Company shall not be liable to IPA or Participating IPA Providers for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind whatsoever sustained as a result of a breach of this Agreement or any action, inaction, alleged tortious conduct, or delay by Company related thereto.

11.4 Survival. The provisions of Section 3.5, 4.6, 6.1, 6.2, 6.3, 7.5, 9.1, 9.3, 10.2 and 11.1 - .13 shall survive expiration or termination of this Agreement, regardless of the cause giving rise to termination.

11.5 Severability. Any determination that any provision of this Agreement or any application thereof is invalid, illegal or unenforceable in any respect in any instance shall not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality, or enforceability of any other provision of this Agreement.

11.6 Inconsistencies. If any term or provision of this Agreement is inconsistent with a term or provision of a non-insured Plan, then as to individuals entitled to receive Covered Services through said Plan, the term or provision of the Plan shall prevail.

11.7 Assignment. This Agreement, being intended to secure the services of IPA and Participating IPA Providers, shall not be assigned, subcontracted, delegated or transferred by IPA in any manner. Company may assign, delegate or transfer this Agreement in whole or in part to any Affiliate, existing now or in the future, or to any entity which succeeds to the applicable portion of its business through a sale, merger or other transaction, provided that such other entity assumes the obligations of Company hereunder.

11.8 Affirmative Action. Company is an Equal Opportunity Employer which maintains an Affirmative Action Program. To the extent applicable to IPA or Participating IPA Providers, IPA and Participating IPA Providers shall comply with the following, as amended from time to time: Executive Order 11246, the Vietnam Era Veterans Readjustment Act of 1974, the Drug Free Workplace Act of 1988, Section 503 of the Rehabilitation Act of 1973, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, any similar legislation regarding transactions relating to any government contract of Company or an Affiliate, and any rules and regulations promulgated under such laws.

11.9 Headings. The headings contained in this Agreement are included for purposes of convenience only, and shall not affect in any way the meaning or interpretation of any of the terms or provisions of this Agreement.

11.10 Notices. Any notice required hereunder shall be effective only if given in writing and sent by overnight delivery service with proof of receipt, or by certified mail return receipt requested. Notices shall be sent to the following addresses (which may be changed by giving notice in conformity with this section):

To IPA at:

Children's Memorial Hospital
2300 Children's Plaza, Mailbox 113
Chicago, IL 60614

and to Company at:

Aetna Health Inc.
Regional Network Contracting and Operations
100 North Riverside Plaza, Suite 1800
Chicago, IL 60606

11.11 Non-Exclusivity. This Agreement is not exclusive. Company makes no representation or guarantee as to the number of Members who may obtain care from IPA or any Participating IPA Provider, or as to any volume of business. Company retains the right to discontinue any particular product or to terminate operations entirely, and shall have no liability to IPA or Participating IPA Providers stemming from such discontinuance or termination.

11.12 Entire Agreement. This Agreement (including any attached schedules) constitutes the complete and sole contract between the parties regarding the subject hereof and supersedes any and all prior or contemporaneous oral or written communications or proposals not expressly included herein.

11.13 Restrictive Covenant. IPA agrees that during the term of this Agreement, IPA and its owned and contracted entities, including but not limited to any owned, non-profit, for profit, taxable or tax exempt entities, shall not directly or indirectly, enter into or engage in the ownership, management, operation or control of, or act as a consultant or advisor to any existing or proposed entity operating or planning to operate an HMO, risk based preferred provider organization, managed care organization, point-of-service plan, or third party administration company for self-insured employers.

12.0 DEFINITIONS

When used in this Agreement, all capitalized terms shall have the following meanings:

12.1 Affiliate. An Affiliate, with respect to Company, means any corporation, partnership or other legal entity (including any Plan) directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with, Company.

12.2 Coinsurance. The percentage of the lesser of: (a) the rates established under this Agreement; or (b) the Participating IPA Provider's reasonable and customary billed charges, which a Member is required to pay for Covered Services under a Plan.

12.3 Copayment. A charge required under a Plan that must be paid by a Member at the time of the provision of Covered Services.

12.4 Covered Services. Those Medically Necessary Services (including Emergency Services) which a Member is entitled to receive under the terms and conditions of a Plan.

12.5 Deductible. An amount that a Member must pay for Covered Services per specified period in accordance with the Member's Plan before benefits will be paid.

12.6 Emergency Services. Those services necessary to treat a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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: (a) placing the health of individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part; or such broader definition required by applicable law.

12.7 IPA Provider. A duly licensed and qualified health care provider who is under contract, or on whose behalf a contract has been entered, with IPA.

12.8 Medically Necessary Services. Unless otherwise defined in an applicable Plan or by applicable law, health care services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards and which are likely to result in demonstrable medical benefit, and which are the least costly of alternative supplies or levels of service which can be safely and effectively provided to the patient. Medically Necessary Services do not include custodial or supportive care or rest cures, or services or supplies provided for the convenience of the patient, the patient's family, or the provider. When used in relation to hospital inpatient care, Medically Necessary Services include only those services and supplies that cannot be safely and satisfactorily provided at home, in a physician's office, as an outpatient service, or in any lesser facility. Medically Necessary Services must be related to diagnosis or treatment of an existing illness or injury, except for preventive and well baby care. Health services are not Medically Necessary Services if they are experimental services. Medical necessity, when used in relation to services, shall have the same meaning as Medically Necessary Services.

12.9 Member. An individual covered by or enrolled in a Plan.

12.10 Participating IPA Provider. An IPA Provider who has been accepted as a Participating Provider by Company.

12.11 Participating Provider. Any physician, hospital, skilled nursing facility, or other individual or entity involved in the delivery of health care or ancillary services who or which has a current valid contract to provide Covered Services to Members. Certain categories of Participating Providers may be referred to herein more specifically as, e.g., "Participating Physicians" or "Participating Hospitals."

12.12 Payor. An employer, insurer, HMO, PPO, labor union, organization or other person or entity which has agreed to be responsible for funding benefit payments for Covered Services provided to Members under the terms of a Plan.

12.13 Plan. Any health benefit product, plan or program issued, administered, or serviced by Company or one of its Affiliates, including, but not limited to, HMO-based and Non-HMO based Plans, as described in the Plan Participation Schedule.

12.14 Primary Care Physician. A Participating Physician whose area of practice and training is family practice, general medicine, internal medicine or pediatrics, or who is otherwise designated as a Primary Care Physician by Company, and who has agreed to provide primary care services and to coordinate and manage all Covered Services for Members who have selected or been assigned to such Participating Physician, if the applicable Plan provides for a Primary Care Physician.

12.15 Proprietary Information. Company's confidential information and all information developed by or belonging to Company or any third party Payor including, but not limited to, Schedules to this Agreement, mailing lists, patient lists, employer lists, encounter data, Company payment rates, product-related information and structure, utilization review procedures, formats and structure and related information and documents concerning Company's systems and operations of Plans.

12.16 Specialist Physician. A Participating Physician who is not a Primary Care Physician.

12.17 Sponsor. An entity that has contracted with Company to issue, administer, or service a Plan. Sponsors shall include, without limitation, employer groups sponsoring or offering a self-insured Plan to their employees.

PLAN PARTICIPATION SCHEDULE

IPA agrees to participate in the following Plans:

PLAN	MARK "X" IF PARTICIPATING
HMO-based Plans Including, but not limited to, the following Plans: [*list applicable Plans by market – e.g., HMO, QPOS, US Access, Open Access HMO, Medicare, Medicaid*]	NA
Non-HMO based Plans* Including, but not limited to, the following Plans: [*list applicable Plans by market – e.g., Managed Choice, Elect Choice, Open Choice, Traditional Choice, National Advantage*]	X

* Participating in only Non-HMO based Plans requires IPA to provide HMO non-referred and out-of-HMO-network services in accordance with the fees for non-HMO based Plans.

PRIMARY CARE PHYSICIAN
PARTICIPATION CRITERIA SCHEDULE

I. BUSINESS CRITERIA

A. Applicability

1. These criteria shall apply to each applicant for participation and each Primary Care Physician participating in Company* Plans and shall be enforced at the sole discretion of Company[1].

2. Each applicant for participation as a Primary Care Physician must satisfactorily document evidence meeting the criteria stated in item 4 for at least six (6) months prior to application, unless applicant has entered clinical practice or completed a residency or a fellowship program within the past six (6) months.

3. Each participating Primary Care Physician must continue to meet the following criteria for the duration of participation in the Company Plans.

4. A Primary Care Physician must be an internist, pediatrician, family and/or a general practitioner who for the two (2) years prior to applying for participation, unless Primary Care Physician has been in practice less than two (2) years or has had a hiatus in practice, and during his or her participation with Company performs the functions of a Primary Care Physician at least fifty percent (50%) of the time in which he/she engages in the practice of medicine. These functions shall include the supervision, coordination and provision of initial and basic care to patients, as well as referring patients for specialist care and maintaining the continuity of their care. The applicable network medical director will determine whether a physician satisfies the requirements of this section I.A.(4).

5. The applicant must be certified by a Board recognized by the American Board of Medical Specialties or the American Osteopathic Association unless the applicant meets an exception under the Company Board Certification Exceptions Policy (Credentialing Policy 97-08). All exceptions must be approved by the Aetna U.S. Healthcare Network Medical Director following the Company Board Certification Exceptions Approval Process.

6. If Primary Care Physician is part of a group practice, all Primary Care Physicians in the group must meet these Participation Criteria. If all physicians in the group do not meet these criteria, the group cannot participate.

7. Each applicant must fully complete the participation application form, and each applicant and participating Primary Care Physician shall periodically supply to Company all requested information, including the confidential information forms.

B. Office Standards

Each Primary Care Physician's medical office must:

1. Have a sign containing the names of all physicians practicing at the office. The office sign must be visible when the office is open.

2. Have a mechanism for notifying members if an Allied Health Professional (i.e., physician assistant, advanced practice nurse, nurse practitioner, nurse midwife) may provide care.

3. Be readily accessible to all patients, including but not limited to its entrance, parking and

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[1] "Company" is defined in the opening paragraph of the Agreement.

bathroom facilities.

4. Be clean, presentable, and have a professional appearance.

5. Provide clean, properly equipped patient toilet and handwashing facilities.

6. Have a waiting room able to accommodate at least five (5) patients.

7. Have at least two (2) examining rooms which are clean, properly equipped, and provide privacy for the patient.

8. Have a gynecology table and equipment for pelvic exams for acute conditions (except for pediatric age limit - newborn through 17).

9. Have a no-smoking policy.

10. Have an assistant in office during scheduled hours.

11. Require a medical assistant to attend specialized (e.g., gynecological) examinations, unless the patient declines to allow such assistant to be present.

12. Provide evidence that physician has a copy of current licenses for all Allied Health Professionals practicing in the office, including: state professional license, Federal Drug Enforcement Agency and State Controlled Drug Substance (where applicable).

13. Keep on file and make available to Aetna U.S. Healthcare any state required practice protocols or supervising agreements for Allied Health Professionals practicing in office.

14. Complete a Location Form, attached hereto, identifying the address(es) and physical location(s) of office(s).

15. Each Primary Care Physician must designate by age, according to Company guidelines, those Members for whom the physician will provide care.

16. Any use of an allied health professional (Advanced Practice Nurse or Physicians Assistant) by a Primary Care Physician must comply with Company's then current policies and all applicable legal requirements regarding practice of allied health professionals.

C. Coverage

1. Twenty-four (24) hours-a-day coverage for Members must be arranged with another Company Participating Primary Care Physician except as provided in Section C.4 below.

2. Covering physician office must be located within 25 minutes of the Primary Care Physician office.

3. Inpatient coverage must be arranged with a Participating Physician who has privileges at the same hospital as the covered physician.

4. A Primary Care Physician must submit for prior approval by Company any coverage arrangements made with a nonparticipating Primary Care Physician. Approval of coverage by a nonparticipating Primary Care Physician is subject to Company's sole discretion, and such approval must be in writing. If Primary Care Physician receives approval from Company for coverage by a nonparticipating Primary Care Physician, Primary Care Physician shall require such nonparticipating Primary Care Physician to comply with applicable terms of this Agreement. Primary Care Physician shall make suitable arrangements regarding the amount and

manner in which such covering nonparticipating Primary Care Physician shall be compensated, provided, however, that Primary Care Physician shall ensure that the covering physician will not under any circumstances bill Members (except for applicable Copayments, Coinsurance and Deductibles) for any Covered Services. 4-5-

D. Access

1. Each Primary Care Physician's medical office must throughout the term of participation with Company, have at least one (1) Primary Care Physician for every three thousand (3,000) active patients, defined as those patients seen within the past two (2) years.

2. Each Primary Care Physician's medical office must have, at a minimum, twenty (20) hours of regularly scheduled office hours for the treatment of patients (whether Members or other patients) over at least four (4) days per week.

3. If a Primary Care Physician has more than one office location participating with Company, then the Primary Care Physician must have, at a minimum, twenty (20) hours over at least four (4) days per week of regularly scheduled office hours for the treatment of patients in each location.

4. Each Primary Care Physician or his or her covering Primary Care Physician must respond to a Member within thirty (30) minutes after notification of an urgent call.

5. Each Primary Care Physician must schedule appointments with Members within the following time frames:

Emergency care:	must be seen immediately (or referred to ER, as appropriate)
Urgent complaint:	same day or within twenty-four (24) hours
Symptomatic/non-urgent acute complaint:	
(e.g., sore throat)	within three days
Routine care:	within seven days
Preventive routine care:	within four weeks
Follow-up visit:	within two weeks

6. Each Primary Care Physician shall have no more than an average of five (5) intermediate level patient visits (or no more than six (6) pediatric intermediate level visits), whether a Member or otherwise, per hour as documented from a fixed appointment schedule.

7. Each Primary Care Physician office must have adequate plans for managing an increase in patient load.

8. Each Primary Care Physician must have a reliable twenty-four (24) hours-a-day, seven (7) days-a-week answering service or machine with a beeper or paging system. A recorded message or answering service which refers Members to emergency rooms is not acceptable.

E. Hospital Care

1. At the time of application, a Primary Care Physician must show that during the six (6) months immediately prior to application, he/she had hospital privileges to admit his/her patients on his/her own service, unless such applicant has more recently entered clinical practice or completed his/her residency or fellowship training program. This showing may be in the form of:

   (a) A letter from the Chief of Staff of the admitting hospital; or

   (b) A letter from the Chief of Service of the admitting hospital.

   (c) A letter from the admitting hospital verifying privileges.

2. Throughout the term of the Agreement and participation with Company, a Primary Care Physician must have admitting privileges in good standing at a Participating Hospital.

3. A Primary Care Physician must admit Members whose conditions require hospitalization to said physician's own service or to the service of a plan participating physician if Member's condition is within said physician's range of expertise and scope of privileges.

4. Any exceptions to the above must be approved in advance by the applicable network medical director in accordance with relevant Company policies and procedures.

F. Office Procedures

Company representative must confirm during office site visits that:

1. Primary Care Physician does EKGs (except for pediatric age limit - newborn through age 17).

2. Primary Care Physician does pelvic exams for acute conditions in all offices caring for female Members over the age of seventeen (17).

3. Age appropriate immunizations are provided.

4. Primary Care Physician or staff draws blood in his/her office, uses "finger sticks" for hematocrits and hemaglobin (peds only), or uses a Company designated laboratory drawing station.

5. Primary Care Physician performs blood glucose monitoring on site.

G. Office Records

1. A Primary Care Physician must demonstrate, at the time of application and thereafter, that his/her medical records are legible, reproducible and otherwise meet Company's standards for confidentiality, medical record keeping practices, and that clinical documentation demonstrates comprehensive care. Members' medical records shall include reports from referred and/or referring providers, discharge summaries, records of emergency care received and such other information as Company may require from time to time.

2. Each Member encounter must be documented in writing and signed or initialed by the Primary Care Physician or as required by state law.

H. Professional Liability Insurance

1. During the entire term of this Agreement, Primary Care Physician shall maintain insurance at minimum levels required from time to time by Company, but in no event less than: (a) professional liability insurance at a minimum level of $1,000,000 per claim and $3,000,000 in the annual aggregate, except in cases where this level of insurance exceeds that required by applicable state law, in which instance Primary Care Physician shall maintain the maximum level of professional liability insurance required by law; and (b) comprehensive general liability insurance at a minimum level of $1 million dollars ($1,000,000) per claim and $3 million dollars ($3,000,000) in the annual aggregate. Primary Care Physician's insurance shall cover the acts and omissions of Primary Care Physicians, as well as Primary Care Physician's agents and employees. Memorandum copies of such policies shall be delivered to Company upon request. Primary Care Physician must notify Company at least thirty (30) days in advance of the cancellation, limitation or material change of said policies.

I. Philosophy

1. A Primary Care Physician must be supportive of the philosophy and concept of managed care and Company. A Primary Care Physician shall not differentiate or discriminate in the treatment of, or in the access to treatment of, patients on the basis of their status as Members, or other grounds identified in the Agreement.

2. Each Primary Care Physician shall have the right and is encouraged to discuss with his or her patients pertinent details regarding the diagnosis of the patient's condition, the nature and purpose of any recommended procedure, the potential risks and benefits of any recommended treatment, and any reasonable alternatives to such recommended treatment.

3. Primary Care Physician's obligations under the Agreement not to disclose Proprietary Information do not apply to any disclosures to a patient determined by Primary Care Physician to be necessary or appropriate for the diagnosis and care of a patient, except to the extent such disclosure would otherwise violate Primary Care Physician's legal or ethical obligations.

4. Primary Care Physician is encouraged to discuss Company's provider reimbursement methodology with Primary Care Physician's patients who are Members, subject only to Primary Care Physician's general contractual and ethical obligations not to make false or misleading statements. Accordingly, Proprietary Information does not include descriptions of the Quality Care Compensation System methodology under which Primary Care Physician is reimbursed, although such Proprietary Information does include the specific rates paid by Company due to their competitively sensitive nature.

II. PROFESSIONAL CRITERIA

A. Licensure

1. A Primary Care Physician must have a valid, unencumbered license to practice medicine or osteopathy in his/her state of practice, or in the case of a Primary Care Physician with an encumbered license, the applicant demonstrates to the applicable peer review committee's satisfaction that encumbered license does not raise concern about possible future substandard professional performance, competence, or conduct.

2. A Primary Care Physician must have an unrestricted DEA certification, and, where applicable, a state-mandated controlled drug certification.

B. Education

1. A Primary Care Physician must be a graduate of a school of medicine or osteopathy which is accredited by the Liaison Committee on Medical Education and is listed by the Association of American Medical Colleges or the American Osteopathic Association, or in the World Health Organization's directory *World Wide Medical Schools.*

C. Continuing Education

1. A Primary Care Physician shall meet the continuing medical education requirements of the American Medical Association (AMA), American Osteopathic Association (AOA), American Academy of Pediatrics (AAP), or American Academy of Family Physicians (AAFP), or as required by state law, if greater. Applicants for participation in Company must demonstrate that they have met such continuing education requirements for the three (3) years immediately prior to submitting his/her application for participation. If an applicant has been in practice less than three (3) years, or has had a hiatus in practice, the applicant need only demonstrate that he/she has met such continuing education requirements during the period of his/her practice.

III. PROFESSIONAL COMPETENCE AND CONDUCT CRITERIA

A. General

1. Primary Care Physician must be of sound moral character and must not have been indicted, arrested for or charged with, or convicted (i.e., finding of guilt by a judge or jury, a plea of guilty or nolo contendere, participation in a first offender program or any other such program which may be available as an alternative to proceeding with prosecution, whether or not the record has been closed or expunged) of any felony or criminal charge related to moral turpitude or the practice of medicine.

2. Primary Care Physician must not have engaged in any unprofessional conduct, unacceptable business practices or any other act or omission which in the view of the applicable peer review committee may raise concerns about possible future substandard professional performance, competence or conduct.

B. Professional Liability Claims History

1. Primary Care Physician must not have a history of professional liability claims, including, but not limited to, lawsuits, arbitration, mediation, settlements or judgments, which in the view of the applicable peer review committee may raise concerns about possible future substandard professional performance, competence or conduct.

C. History of Involuntary Termination or Restriction

1. Primary Care Physician must not have a history of involuntary termination (or voluntary termination during or in anticipation of an investigation or dismissal) of employment or any other sort of engagement as a health care professional, or reduction or restriction of duties or privileges, or of a contract to provide health care services, which in the view of the applicable peer review committee may raise concerns about possible future substandard professional performance, competence or conduct.

D. Notification of Adverse Actions or Limitations

1. Primary Care Physician shall provide immediate notice to Company of any adverse action relating to said physician's (i) hospital staff privileges; (ii) DEA or state narcotics numbers; (iii) participation in the Medicare, Medicaid, or other governmental programs, or (iv) state licensure including censure. Each applicant and Primary Care Physician shall inform the Company in writing of any previous adverse actions with respect to any of the above. For the purpose of this section, "adverse action" includes, but is not limited to, any of the following or their substantial equivalents (regardless of any subsequent action or expungement of the record): denial; exclusions; fine; monitoring; probation; suspension; letter of concern, guidance, censure, or reprimand; debarment; expiration without renewal; subjection to disciplinary action or other similar action or limitation; restriction; counseling; medical or psychological evaluation; loss, in whole or in part; staff privileges reduced, withheld, suspended, voluntarily surrendered, resigned, revoked or subject to any special provision; termination or refused participation; revocation; administrative letter; non-renewal; voluntary or involuntary surrender of licensure or status to avoid, or in anticipation of, any of the adverse actions listed regardless of whether said action is or may be reportable to the National Practitioner Data Bank or any other officially sanctioned or required registry; and initiation of investigations, inquiries or other proceedings that could lead to any of the actions listed, regardless of whether said action is or may be reportable to the National Practitioner Data Bank or any other officially sanctioned or required registry. Any such adverse actions may be grounds for action, including without limitation denial, termination or other sanctions imposed pursuant to Company's credentialing/quality improvement programs.

2. Primary Care Physician shall provide immediate notice to Company of any condition or

circumstance that impairs or limits his/her ability to perform the essential functions of a Participating Primary Care Physician. L.5.

3. Primary Care Physician shall provide immediate notice to Company of any condition or circumstance of which he/she is aware that may pose a direct threat to the safety of himself/herself, coworkers or patients.

4. Primary Care Physician shall provide immediate notice to Company and to Members of any condition or circumstance of which he/she is aware which law or regulation requires Primary Care Physician to report.

E. References

1. Each applicant for participation must supply references as requested by the applicable Company peer review committee.

2. The applicable Company peer review committee shall have the right to act on any reference or information received from a Primary Care Physician's colleagues. Primary Care Physician waives any and all rights to bring any legal action relating to such information or the collection or use thereof against Company, any Affiliates or related companies or any director, officer, employee or agent thereof, or any person or entity providing a reference or information at the request of the applicable Company peer review committee.

SPECIALIST PHYSICIAN
PARTICIPATION CRITERIA SCHEDULE

I. BUSINESS CRITERIA

A. Applicability

1. These criteria shall apply to each applicant for participation and each Specialist Physician participating in Plans and shall be enforced at the sole discretion of Company[1].

2. Each applicant for participation as a Specialist Physician must satisfactorily document evidence meeting the criteria stated in item 1.A.4 for at least six (6) months prior to application, unless applicant has entered clinical practice or completed a residency or a fellowship program within the past six (6) months.

3. Each participating Specialist Physician must continue to meet the following criteria for the duration of participation in the Company Plans.

4. A Specialist Physician must be an M.D. or D.O. who dedicates a significant portion (usually greater than 50%) of his or her professional services to non-primary care delivery. These services include providing consultation and treatment to members upon referral from primary care physicians in products which require referrals or to members who self-refer in PPO or POS products.

5. The applicant must be certified by a Board recognized by the American Board of Medical Specialties or the American Osteopathic Association, unless the applicant meets an exception under the Company Board Certification Exceptions Process Policy (Credentialing Policy 52-0502). All exceptions must be approved by the Aetna U.S. Healthcare Network Medical Director following the Company Board Certification Exceptions Approval Process.

6. If Specialist Physician provides Specialist Services at a Participating Facility, Specialist Physician must also meet, for the time periods set forth in Sections I.A.2 and I.A.3 above, any additional criteria applicable to Specialist Physician which are set forth in the Participation Criteria for the Participating Facility.

7. If Specialist Physician is part of a group practice, all specialist physicians in the group must meet these Participation Criteria.

8. Each applicant must fully complete the participation application form, and each applicant and participating Specialist Physician shall periodically supply to Company all requested information, including the confidential information forms.

B. Office Standards

Each Specialist Physician's medical office must:

1. Have a sign containing the names of all physicians practicing at the office. The office sign must be visible when the office is open.

2. Have a mechanism for notifying members if an Allied Health Professional (i.e., physicians assistant, advanced practice nurse, nurse practitioner, nurse midwife) may provide care.

3. Be clean, presentable, and have a professional appearance.

[1] "Company" is defined in the opening paragraph of the Agreement.

4. Be readily accessible to all patients, including but not limited to its entrance, parking and bathroom facilities.

5. Provide clean, properly equipped patient toilet and handwashing facilities.

6. Have a waiting room able to accommodate at least five (5) patients.

7. Have at least two (2) exam rooms which are clean, properly equipped, and provide privacy for the patient.

8. Have a no-smoking policy.

9. Have an assistant in office during scheduled hours.

10. Require a medical assistant to attend specialized (e.g., gynecological) examinations unless the patient declines to allow such assistant to be present.

11. Provide evidence that physician has a copy of current licenses for all Allied Health Professionals practicing in the office, including: state professional license, Federal Drug Enforcement Agency and State Controlled Drug Substance (where applicable).

12. Keep on file and make available to Aetna U.S. Healthcare any state required practice protocols or supervising agreements for Allied Health Professionals practicing in office.

13. Complete a **Location Schedule**, attached hereto, identifying the address and physical location(s) of the Provider's office(s).

C. Coverage

1. When applicable to the relevant Specialty, as determined by Company in its sole discretion, Specialist Physician shall ensure that twenty-four (24) hours-a-day coverage for Members is arranged with another Company Participating Specialist Physician, except as otherwise provided in subsection 3 of this section.

2. For outpatient services, the covering physician's office must be within sixty (60) minutes non--rush hour travel time from the office of the covered physician.

3. A Specialist Physician must submit for prior approval by Company any coverage arrangements made with a nonparticipating specialist physician. Approval of coverage by a nonparticipating specialist physician is subject to Company's sole discretion, and such approval must be in writing. If Specialist Physician receives approval from Company for coverage by a nonparticipating specialist physician, Specialist Physician shall require such nonparticipating specialist physician to comply with applicable terms of this Agreement. Specialist Physician shall make suitable arrangements regarding the amount and manner in which such covering nonparticipating specialist physician shall be compensated, provided, however, that Specialist Physician shall ensure that the covering physician will not under any circumstances bill Members (except for applicable Copayments, Coinsurance and Deductibles) for any Covered Services.

D. Access

1. Specialist Physician shall have a reliable twenty-four (24) hours, seven (7) days-a-week answering service or machine with a beeper or paging system. A recorded message or answering service which refers Members to the emergency room is not acceptable.

2. Specialist Physician shall make available at least an average of eight (8) hours a week for scheduling office appointments.

the access to treatment of, patients on the basis of their status as Members, or other grounds identified in the Agreement.

2. Each Specialist Physician shall have the right and is encouraged to discuss with his or her patients pertinent details regarding the diagnosis of the patient's condition, the nature and purpose of any recommended procedure, the potential risks and benefits of any recommended treatment, and any reasonable alternatives to such recommended treatment.

3. Specialist Physician's obligations under the Agreement not to disclose Proprietary Information do not apply to any disclosures to a patient determined by Specialist Physician to be necessary or appropriate for the diagnosis and care of a patient, except to the extent such disclosure would otherwise violate Specialist Physician's legal or ethical obligations.

4. Specialist Physician is encouraged to discuss Company's provider reimbursement methodology with Specialist Physician's patients who are Members, subject only to Specialist Physician's general contractual and ethical obligations not to make false or misleading statements. Accordingly, Proprietary Information does not include descriptions of the methodology under which Specialist Physician is reimbursed, although such Proprietary Information does include the specific rates paid by Company due to their competitively sensitive nature.

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2. When applicable to the relevant Specialty, as determined by Company in its sole discretion, a Specialist Physician must have an unrestricted DEA certification, and, where applicable, a state-mandated controlled drug certification.

B. Training

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A. General

1. A Specialist Physician must be of sound moral character and must not have been indicted, arrested for or charged with, or convicted (i.e., finding of guilt by a judge or jury, a plea of nolo contendere, participation in a first offender program or any other such program which may be available as an alternative to proceeding with prosecution, whether or not the record has been closed or expunged) of any felony or criminal charge related to moral turpitude or the practice of medicine.

2. Specialist Physician must not have engaged in any unprofessional conduct, unacceptable business practices or any other act or omission which in the view of the applicable peer review committee may raise concerns about possible future substandard professional performance, competence or conduct.

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1. Specialist Physician must not have a history of professional liability claims, including but not limited to lawsuits, arbitration, mediation, settlements or judgments, which in the view of the applicable peer review committee may raise concerns about possible future substandard professional performance, competence or conduct.

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2. A Specialist Physician shall provide immediate notice to Company of any condition or circumstance that impairs or limits his/her ability to perform the essential functions of a Participating Specialist Physician.

3. A Specialist Physician shall provide immediate notice to Company of any condition or circumstance of which he/she is aware that may pose a direct threat to the safety of himself/herself, coworkers or patients.

4. A Specialist Physician shall provide immediate notice to Company and to Members of any condition or circumstance of which he/she is aware which law or regulation requires Specialist Physician to report.

E. References

1. The applicable Company peer review committee shall have the right to act on any reference or information received from a Specialist Physician's colleagues. Specialist Physician waives any

and all rights to bring any legal action relating to such information or the collection or use thereof against Company, any Affiliates or related companies or any director, officer, employee or agent thereof, or any person or entity providing a reference or information at the request of the applicable Company peer review committee. L.S.

Ccpa
Effective Date: 10/01/2003
11-1-03
L.S.

PRIMARY CARE PHYSICIAN
SERVICES AND COMPENSATION SCHEDULE

COMPENSATION:

---:::<<<Table;3;Description:,Code:,Rate:;0;255;16711680>>>[]:::---

{{STANDARD VERSION-[Provider agrees to accept as payment in full 125% of the then current Aetna Market Fee Schedule for the PPO based plans.]-END STANDARD VERSION}}

SERVICES:

Provider will provide services that are within the scope of and appropriate to the Provider's license and certification to practice.

COMPENSATION TERMS AND CONDITIONS:

Definitions

"Aetna Market Fee Schedule" (AMFS) – A fee schedule that is based upon the contracted location where service is performed.

General

a) Rates are inclusive of any applicable Member Copayment, Coinsurance or Deductible. For procedures and/or services not specifically listed above, Provider agrees to accept then current AMFS as payment in full. Company will pay the lesser of the contracted rate or eligible billed charges. This fee schedule is updated annually.

Billing

b) Provider must designate the codes set forth in this Compensation Schedule when billing.

Coding

c) Company utilizes nationally recognized coding structures including, but not limited to, Revenue Codes as described by the Uniform Billing Code, AMA Current Procedural Terminology (CPT4), CMS Common Procedure Coding System (HCPCS), Diagnosis Related Groups (DRG), ICD-9 Diagnosis and Procedure codes, National Drug Codes (NDC) and the American Society of Anesthesiologists (ASA) relative values for the basic coding, and description for the services provided. As annual changes are made to nationally recognized codes, Company will update internal systems to accommodate new codes no later than July 1 of each year. Such changes will only be made when there is no material change in the procedure itself. Until updates are complete, the procedure will be paid according to the standards and coding set for the prior period.

Company will comply and utilize nationally recognized coding structures as directed under applicable Federal laws and regulations, including, without limitation, the Health Insurance Portability and Accountability Act (HIPAA).

Ccpa
Effective Date: ~~10/01/2003~~ 11-1-03

SPECIALIST PHYSICIAN
SERVICES AND COMPENSATION SCHEDULE

COMPENSATION:

---:::<<<Table;3;Description:,Code:,Rate:;0;255;16711680>>>[]:::---

{{STANDARD VERSION-[Provider agrees to accept as payment in full 125% of the then current Aetna Market Fee Schedule for the PPO based plans.]-END STANDARD VERSION}}

SERVICES:

Provider will provide services that are within the scope of and appropriate to the Provider's license and certification to practice.

COMPENSATION TERMS AND CONDITIONS:

Definitions

"**Aetna Market Fee Schedule**" (AMFS) – A fee schedule that is based upon the contracted location where service is performed.

a) Rates are inclusive of any applicable Member Copayment, Coinsurance or Deductible. For procedures and/or services not specifically listed above, Provider agrees to accept then current AMFS as payment in full. Company will pay the lesser of the contracted rate or eligible billed charges. This fee schedule is updated annually.

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Company will comply and utilize nationally recognized coding structures as directed under applicable Federal laws and regulations, including, without limitation, the Health Insurance Portability and Accountability Act (HIPAA).