Amendment to Participating Provider Agreement

WHEREAS, Cigna HealthCare of Illinois, Inc. ("Cigna") and Children's Community Physicians Asssociation have executed an Independent Provider Association (IPA) Services Agreement dated May 1, 2009 (the "Agreement"); and

WHEREAS, Cigna and Children's Community Physicians Asssociation mutually desire to amend the Agreement;

NOW, THEREFORE, pursuant to the Amendment Sections of the Agreement and in consideration of the mutual promises contained herein, the parties hereby agree as follows:

1. The effective date of this Amendment is February 1, 2020.

2. Rate Exhibits C and C1 of the Agreement are replaced in their entirety by the attached Exhibits C as of the effective date of this Amendment.

3. The following clause is added as Section 5.12 to the Agreement as of the effective date of this Amendment:

    Acquisitions and Other Arrangements
    This Agreement shall not, without Cigna's written consent, be applicable to any hospital, physician or physician group or ancillary provider that is acquired (directly or indirectly) by or enters into a management, co-management, professional services, leasing, joint venture or similar agreement or arrangement with a Represented Provider an affiliate of a Represented Provider. To the extent Group is notified of such acquisition or arrangement, Group will notify Cigna as soon as reasonably possible under the circumstances. Group understands and agrees, that when possible, it will notify Cigna 120 days in advance of any such acquisition or arrangement; provided, however that Group has adequate advance notice.

4. The State Addendum attached is hereby added to, or replaced, in the Agreement as of the effective date of this Amendment.

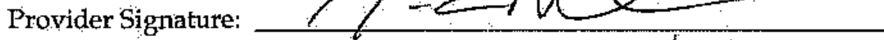
5. Except as modified herein, the Agreement remains in full force and effect. To the extent of a conflict between this Amendment and the Agreement, this Amendment shall control.

6. Any and all capitalized terms not defined herein shall have the same meaning as in the Agreement.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their duly authorized representatives below:

AGREED AND ACCEPTED BY:

Provider: Children's Community Physicians Association

Provider Signature: 

Printed Name: Jonathan Necheles

Provider Title: CCPA President

Provider Date Signed: 01/13/2020

Federal Tax ID: multiple

National Provider Identifier (NPID): multiple

Cigna: Cigna HealthCare of Illinois, Inc.

Cigna Signature:

Cigna Printed Name: Eric Stotvar

Cigna Title: VICE PRESIDENT

Cigna Date Signed: 1/27/2020

ADDENDUM TO PROVIDER GROUP AGREEMENT
FOR THE STATE OF ILLINOIS

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Illinois regarding provider contracts with providers rendering health care services in the State of Illinois. To the extent that such Illinois laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(A) Emergency Services shall mean, unless otherwise defined by applicable state laws and regulations, transportation services, including but not limited to ambulance services, and covered inpatient and outpatient hospital services furnished by a provider qualified to furnish those services that are needed to evaluate or stabilize an emergency medical condition. Emergency medical condition shall mean, unless otherwise defined by applicable state laws and regulations, a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, 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 placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(B) With respect to Covered Services rendered to Participants covered under an HMO Benefit Plan:

(1) Group or Represented Provider shall, upon request of Participant, provide Participant the following: (a) information related to provider's educational background, experience, training, specialty, and board certification, if applicable; (b) the names of licensed facilities on the provider panel where the provider presently has privileges for the treatment, illness or procedure that is the subject of the request; and (c) information regarding provider's participation in continuing education programs and compliance with any licensure, certification, or registration requirements, if applicable.

(2) a. Cigna must give Group at least 60 days' notice of nonrenewal or termination of the Agreement. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Cigna, the longer notification period will apply.

b. Group must give Cigna at least 60 days' notice for termination of the

Agreement for cause and at least 90 days' notice by Group for termination of the Agreement without cause. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Group, the longer notification period will apply.

(3) Cigna shall not retaliate against Group or its Represented Providers if Group or its Represented Providers advocate for appropriate health care services for Participants. To advocate for medically appropriate health care services means to appeal a decision to deny payment for health care services pursuant to the reasonable grievance or appeal procedure.

(4) a. Upon termination of the Agreement by Group, or upon termination of the Agreement by Cigna, if Cigna terminates the Agreement for reason(s) other than termination in situations involving imminent harm to a patient or a final disciplinary action by a state licensing board, Group's Represented Providers shall, at the Participant's option, continue to provide Covered Services to the Participant for up to 90 days following the date of the written notice of Group's termination, or if the Participant is in the third trimester of pregnancy, throughout the term of the Participant's pregnancy, including post-partum care directly related to the pregnancy. During the transitional period under this section, Group and Represented Providers shall agree: (1) to continue to accept reimbursement at the rates applicable prior to the start of the transitional period; (b) to adhere to the plan's quality assurance requirements and provide the necessary medical information related to such care; and (c) to otherwise adhere to the plan's policies and procedures, including but not limited to procedures regarding referrals and obtaining preauthorizations for treatment.

b. Participants shall not be liable to Group or Represented Providers for any amounts owed for Covered Services provided during the period of continued care other than Copayments, Deductibles or Coinsurance billed in accordance with the terms of a Benefit Plan.

c. Group's Represented Providers have no obligation under the Agreement to continue to provide Covered Services to individuals who cease to be Participants.

(5) Group shall give Cigna at least 15 days advance written notice of cancellation, modification or termination of general or professional liability insurance.

(6) The "Limitations on Billing Participants" provision is amended to add the following Participant hold harmless requirements:

a. the provision shall also apply to Group's assignees or subcontractors;

b. the Participant, persons acting on Participant's behalf (other than Payor) and the employer or group contract holder shall be third party beneficiaries of the provision; and

c. the provision supersedes any oral or written agreement now existing or hereafter entered into between Group or Represented Providers and Participant, person's acting on Participant's behalf (other than Payor) and the employer or group contract holder.

(7) Cigna or Payor shall not request recoupment or withhold an offset from future payments eighteen months or more after the original payment was made, except in cases in which: a court, government administrative agency, other tribunal, or independent third-party arbitrator makes or has made a formal finding or fraud or material representation; Cigna or Payor is acting as a plan administrator for the Comprehensive Health Insurance Plan under the Comprehensive Health Insurance Plan Act; or, Group or Represented Provider has already been paid in full by another payor, third party, or worker's compensation insurer.

(8) With respect to services rendered to Participants by a dentist:

Pursuant to § 215 ILCS 5/355.3, as may be amended from time to time, the rates set forth in the Agreement are only applicable to Covered Services under the applicable insured benefit plan.

Cigna

EXHIBIT C ________

Fee Schedule and Reimbursement Terms
OAP/PPO

This is an Exhibit to an Agreement between:
Provider: Children's Community Physicians Asssociation
Cigna Party: Cigna HealthCare of Illinois, Inc.
Effective Date of Base Agreement: May 1, 2009

This Rate Exhibit:
Applies to: Children's Community Physicians Asssociation
Federal Tax ID: multiple
National Provider Identifier: multiple
Effective Date: February 1, 2020

I. DEFINITIONS

Cigna Resource Based Relative Value Scale or Cigna RBRVS means the methodology designated by Cigna to produce the allowable fee for certain Covered Services rendered to Participants that uses the components of Relative Value Units (RVU's), geographic practice cost indices (GPCI's), conversion factor and base relativity factors, as defined by Cigna.

Cigna Standard Fee Schedule means the standard Cigna fee schedule applicable to the provider types (e.g. MD, DO, NP, PA etc.) as designated by Cigna in effect at the time of service and applicable to this Agreement for certain Covered Services provided to Participants. The Cigna Standard Fee Schedule is subject to change

II. FEE FOR SERVICE REIMBURSEMENT

A. Except as otherwise provided below, Covered Services will be reimbursed at the lesser of billed charges or the Cigna RBRVS allowable fee, less applicable Copayments, Deductibles and Coinsurance. The Cigna RBRVS allowable fees are updated periodically by Cigna to reflect new information regarding RVU's, GPCI's, conversion factor, and the addition of new codes and services. The GPCI locality used for this Agreement is Chicago, IL .

B. For Covered Services provided by a physician (provider types MD or DO), Cigna will apply the following base relativity factors in its Cigna RBRVS calculation to the services specified below ("Schedule A"). Provider agrees to identify the actual renderings provider's name that provided services to Participant on the claim submission to Cigna:

SCHEDULE A	
CPT4 Procedure Code Group	**Base Relativity Factor**
Surgery Codes	130 %
Evaluation & Management Codes	130 %
Medicine Codes	130 %
Physical Therapy	130 %
Radiology Codes, except high tech radiology including but not limited to MRI, PET and CAT	130 %

C. For Covered Services provided by a practitioner other than a provider type MD or DO, Cigna will apply the following base relativity factors in its Cigna RBRVS calculation to the services specified below ("Schedule B"). Additionally, Provider agrees to identify the actual rendering provider's name providing services to Participant on the claim submission to Cigna:

SCHEDULE B	
CPT4 Procedure Code Group	**Base Relativity Factor**
Surgery Codes	110 %
Evaluation & Management Codes	110 %
Medicine Codes	110 %
Physical Therapy	110 %
Radiology Codes, except high tech radiology including but not limited to MRI, PET and CAT	110 %

D. The following services, as defined within the Current Procedural Terminology (CPT) coding system published by the American Medical Association and the Healthcare Common Procedure Coding System (HCPCS) published by the Centers for Medicare & Medicaid Services, are excluded from the reimbursement methodology described above, and such Covered Services, if not specified above, will be reimbursed at the lesser of 50% of total billed charges or the applicable fee under the Cigna Standard Fee Schedule, less applicable Copayments, Deductibles and Coinsurance.

Injectable Drugs, Immunizations, Vaccines, Toxoids

American Society of Anesthesiologists (ASA) Procedure Codes

Immunization Administration

All High Tech Radiology (including but not limited to CAT Scans, Magnetic Resonance Imaging, Positron Emission Tomography)

Pathology and Laboratory Services

Routine Venipuncture

All Services (excluding injectable medications) defined within the Healthcare Common Procedure Coding System (HCPCS) Schedule.

E. All procedure codes for Covered Services for which reimbursement has not been established above, including but not limited to those for unlisted procedures as well as new Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) and/or American Society of Anesthesiologists (ASA) procedure codes, will be paid at a 50 % reduction from billed charges, less applicable Copayments, Deductibles and Coinsurance until such time as the applicable RVU's have been loaded into the appropriate claims systems.

F. Notwithstanding anything to the contrary set forth above, those services that are excluded from this Agreement under the Excluded Services section of the Agreement shall not be reimbursed and Participants shall not be billed for such services.

G. The reimbursement terms set forth in this Exhibit are applicable to all services rendered as part of your practice or scope of license. Any services provided by an out of network provider or vendor as part of your practice or scope of license are not separately reimbursable.

Cigna

EXHIBIT C 1

Fee Schedule and Reimbursement Terms
Local Plus

This is an Exhibit to an Agreement between:
Provider: Children's Community Physicians Asssociation
Cigna Party: Cigna HealthCare of Illinois, Inc.
Effective Date of Base Agreement: May 1, 2009

This Rate Exhibit:
Applies to: Children's Community Physicians Asssociation
Federal Tax ID: multiple
National Provider Identifier: multiple
Effective Date: February 1, 2020

I. DEFINITIONS

Cigna Resource Based Relative Value Scale or Cigna RBRVS means the methodology designated by Cigna to produce the allowable fee for certain Covered Services rendered to Participants that uses the components of Relative Value Units (RVU's), geographic practice cost indices (GPCI's), conversion factor and base relativity factors, as defined by Cigna.

Cigna Standard Fee Schedule means the standard Cigna fee schedule applicable to the provider types (e.g. MD, DO, NP, PA etc.) as designated by Cigna in effect at the time of service and applicable to this Agreement for certain Covered Services provided to Participants. The Cigna Standard Fee Schedule is subject to change

II. FEE FOR SERVICE REIMBURSEMENT

A. Except as otherwise provided below, Covered Services will be reimbursed at the lesser of billed charges or the Cigna RBRVS allowable fee, less applicable Copayments, Deductibles and Coinsurance. The Cigna RBRVS allowable fees are updated periodically by Cigna to reflect new information regarding RVU's, GPCI's, conversion factor, and the addition of new codes and services. The GPCI locality used for this Agreement is Chicago, IL .

B. For Covered Services provided by a physician (provider types MD or DO), Cigna will apply the following base relativity factors in its Cigna RBRVS calculation to the services specified below ("Schedule A"). Provider agrees to identify the actual renderings provider's name that provided services to Participant on the claim submission to Cigna:

SCHEDULE A	
CPT4 Procedure Code Group	**Base Relativity Factor**
Surgery Codes	115 %
Evaluation & Management Codes	115 %
Medicine Codes	115 %
Physical Therapy	115 %
Radiology Codes, except high tech radiology including but not limited to MRI, PET and CAT	115 %

C. For Covered Services provided by a practitioner other than a provider type MD or DO, Cigna will apply the following base relativity factors in its Cigna RBRVS calculation to the services specified below ("Schedule B"). Additionally, Provider agrees to identify the actual rendering provider's name providing services to Participant on the claim submission to Cigna:

SCHEDULE B	
CPT4 Procedure Code Group	**Base Relativity Factor**
Surgery Codes	98 %
Evaluation & Management Codes	98 %
Medicine Codes	98 %
Physical Therapy	98 %
Radiology Codes, except high tech radiology including but not limited to MRI, PET and CAT	98 %

D. The following services, as defined within the Current Procedural Terminology (CPT) coding system published by the American Medical Association and the Healthcare Common Procedure Coding System (HCPCS) published by the Centers for Medicare & Medicaid Services, are excluded from the reimbursement methodology described above, and such Covered Services, if not specified above, will be reimbursed at the lesser of 50% of total billed charges or the applicable fee under the Cigna Standard Fee Schedule, less applicable Copayments, Deductibles and Coinsurance.

Injectable Drugs, Immunizations, Vaccines, Toxoids

American Society of Anesthesiologists (ASA) Procedure Codes

Immunization Administration

All High Tech Radiology (including but not limited to CAT Scans, Magnetic Resonance Imaging, Positron Emission Tomography)

Pathology and Laboratory Services

Routine Venipuncture

All Services (excluding injectable medications) defined within the Healthcare Common Procedure Coding System (HCPCS) Schedule.

E. All procedure codes for Covered Services for which reimbursement has not been established above, including but not limited to those for unlisted procedures as well as new Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) and/or American Society of Anesthesiologists (ASA) procedure codes, will be paid at a 50 % reduction from billed charges, less applicable Copayments, Deductibles and Coinsurance until such time as the applicable RVU's have been loaded into the appropriate claims systems.

F. Notwithstanding anything to the contrary set forth above, those services that are excluded from this Agreement under the Excluded Services section of the Agreement shall not be reimbursed and Participants shall not be billed for such services.

G. The reimbursement terms set forth in this Exhibit are applicable to all services rendered as part of your practice or scope of license. Any services provided by an out of network provider or vendor as part of your practice or scope of license are not separately reimbursable.