PARTICIPATING PHYSICIAN AGREEMENT

THIS PARTICIPATING PHYSICIAN AGREEMENT (this **"Agreement"**) is made as of the **1st** day of , **December,, 2008** (the **"Effective Date"**) by and among **Children's Community Physicians Association,**, an individual or professional corporation (**"Physician"**), that provides or arranges to provide health care services, and PersonalCare Insurance of Illinois, Inc. (**"PersonalCare"**), First Health Group Corporation (**"First Health"**), and Coventry Health and Life Insurance Company (**"CHC"**) (PersonalCare, First Health, and CHC are collectively referred to herein as (**"Health Plan"**).

WHEREAS, Health Plan makes available to employers and individuals, or administers on behalf of employers or other entities, various health care benefit programs for the benefit of employees and their eligible dependents or individual participants and their eligible dependents, including a Health Plan product and such products listed in Exhibit A (**" Products"**); and

WHEREAS, Physician desires to, and Health Plan desires that Physician, participate in Health Plan's Products and networks of health care providers, subject to the terms and conditions set forth herein.

NOW, THEREFORE, in consideration of the mutual covenants herein contained and intending to be legally bound hereby, the parties hereto agree as follows:

General Terms and Conditions

1. DEFINITIONS

1.1 Clean Claim. Clean Claim shall have the meaning as set forth by law in the State of Illinois and shall include all information required to be submitted in accordance with Section 2.5.

1.2 Covered Services. All of the health care services and supplies that are Medically Necessary, that Physician is licensed to provide to Members and that are covered under the terms of the applicable Member Contract.

1.3 Emergency Services. Any transportation services, including but not limited to ambulance services, and covered inpatient and outpatient hospital services provided to a Member after the sudden onset of a medical condition that manifests 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: (i) placing the health of the Member (or, with respect to a pregnant Member, the health of the Member or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part. Emergency Services does not refer to post-stabilization medical services.

1.4 Medically Necessary. Medically Necessary shall mean those services, supplies, equipment and facilities charges that are not expressly excluded under the Member Contract and determined by Health Plan to be:

1.4.1 Medically appropriate, so that expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks;

1.4.2 Necessary to meet the health needs of the Member, improve physiological function and required for a reason other than improving appearance;

1.4.3 Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service;

1.4.4 Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are generally accepted as national authorities on the services, supplies, equipment or facilities for which coverage is requested;

1.4.5 Consistent with the diagnosis of the condition at issue;

1.4.6 Required for reasons other than the comfort or convenience of the Member or Member's physician; and

1.4.7 Not experimental or investigational as determined by Health Plan under its Experimental Procedures Determination Policy.

1.5 **Member.** An individual who is eligible to receive Covered Services under a Member Contract. Member includes the subscriber and any of the subscriber's eligible dependents.

1.6 **Member Companies.** Any corporate entity that, directly or indirectly, is a parent, subsidiary or affiliate of Coventry Health Care, Inc.; including, without limitation, First Health Group Corp., Coventry Health and Life Insurance Company and Coventry Healthcare Management Corporation.

1.7 **Member Contract.** The group or individual Subscription Agreement, Certificate of Insurance, Group Master Agreement, Evidence of Coverage or other contract as amended from time to time between a Payor and an employer, union or Member, which sets forth the terms of the health benefit program and the particular Product.

1.8 **Participating Physician.** A physician who has entered into a direct written agreement with the Health Plan to provide Covered Services to Members.

1.9 **Participating Provider.** A health care provider, including, but not limited to a physician, hospital, home health agency, laboratory or other professional, facility, supplier, or vendor that has entered into a direct or indirect written agreement with the Health Plan to provide Covered Services to Members.

1.10 **Payor.** An entity authorized by Health Plan to access one or more networks of Participating Providers and who or which is liable for funding or underwriting benefit payments under a Member Contract, which entity has a financial responsibility to pay for Covered Services rendered to Members. Payors include Health Plan, Member Companies, insurers, employers, unions and other entities. Payors/programs specifically excluded from this definition and, as such from this Agreement, are auto health insurance plans, discount card programs and other plans as identified in Exhibit A of this Agreement.

1.11 **Primary Care Physician**. A duly licensed doctor of medicine or osteopathy who is required to provide certain Covered Services to Members who have selected the Primary Care Physician and to assume primary responsibility for arranging and coordinating the overall health care of such members. Primary Care Physicians are limited to the specialties of Family/General Practice, Internal Medicine, and Pediatrics.

1.12 **Provider Manual**. The policies and procedures of Health Plan applicable to Participating Providers and Physicians. In the event of any conflict between policies and procedures of the Health Plan and this Agreement, the Agreement shall control.

2. PHYSICIAN OBLIGATIONS

2.1 Provision of Covered Services.

2.1.1 Physician shall provide to Members those Covered Services set forth in the Member Contract that are generally provided by Physician and for which Physician has been credentialed and/or approved by Health Plan. Such Covered Services shall be delivered in a prompt manner, consistent with professional, clinical and ethical standards and in the same manner as provided to Physician's other patients. Physician shall accept Members as new patients on the same basis as Physician is accepting non-Members as new patients. Physician shall provide health care services without discrimination against a Member on the basis of age, sex, ethnicity, national origin, religion, sexual preference, health status, disability, use of Covered Services, income level, source of payment, or on the basis that Member is enrolled in a managed care organization or is a Medicare or Medicaid beneficiary.

2.1.2 Physician shall be responsible for collecting applicable copayments, deductibles and/or coinsurance amounts from Members pursuant to the Members' evidence of coverage. Nothing in this Agreement is intended to prevent the collection by Physician of any co-payment, deductible, or coinsurance which is the Members payment responsibility at the time of service.

2.1.3 In the event that Physician provides Members non-covered services and to the extent Physician is aware that such services are non-covered services. Physician shall, prior to the provision of such non-covered services, use best efforts to inform the Member:

(1) of the service(s) to be provided;

(2) that neither Health Plan nor the applicable Payor will pay or be liable for said services; and

(3) that Member will be financially liable for such services.

All parties to this Agreement acknowledge that written notification provided to and signed off on by patient at time of registration indicating a potential financial liability of Member for any non-covered services provided, shall act to meet the requirements of this Section 2.1.3, so long as there is adherence to the provisions in the first sentence of Section 2.1.3.

2.1.4 Physician shall make Covered Services available and accessible to Members, including telephone access to Physician, on a twenty-four (24) hour, seven (7) day per week basis. Notwithstanding the foregoing, in the event that Physician cannot provide such coverage, Physician may arrange for a physician who is a Participating Physician to furnish coverage on Physician's behalf (a "**Covering Physician**") so long as Physician retains primary responsibility for Members' care. Physician shall make reasonable efforts to secure a Participating Physician for such back up coverage. In the event that Physician can only secure coverage for Members with a non-Participating Physician, Physician shall require the non-Participating Physician to comply with the terms of this Agreement.

2.1.5 For services rendered by any Covering Physician on behalf of Physician, it shall be Physician's sole responsibility to make suitable arrangements with the Covering Physician regarding the manner in which said Covering Physician will be reimbursed or otherwise compensated; provided, however, that Physician shall assure that the Covering Physician will not, under any circumstances, bill a Member for Covered Services (except as permitted under Sections 2.8 and 3.1 below), and Physician hereby agrees to indemnify and hold harmless Members and Health Plan against charges for Covered Services rendered by Covering Physicians.

2.1.6 Except when Physician determines an emergency situation renders it unsafe or impractical, Physician shall make reasonable efforts to refer Members to Participating Providers. Physician

shall only admit a Member for inpatient care and shall only refer Members for other care after obtaining authorization from Health Plan's Medical Director or Medical Director's designee, in accordance with the applicable Member Contract. For services that require prior authorization as stipulated in the Health Plan's Provider Manual, Physician agrees not to order or provide treatment until authorization has been received. Emergent services do not require prior authorization. Health Plan warrants that it, or its designee, shall respond to a request for authorization of non-emergent services within twenty four (24) hours or one (1) business day of receiving request from Physician.

2.1.7 Health Plan reserves the right to introduce new products in addition to the current Products while this Agreement is in effect and to designate Physician as a Participating Provider or non-participating provider in any product as directed by Physician to Health Plan. To the extent that the terms for the provision of Covered Services in new products are different than those contained herein, and should Physician choose to participate in such new products, the terms of this Agreement shall control unless and until an amendment to this Agreement is mutually negotiated and executed by the parties.

2.1.8 Physician agrees to make medical services available, pursuant to the terms of this Agreement, to participants in Member Companies and other health programs for which Health Plan has agreed to arrange for such medical services for those programs' members within Health Plan's service area. Any exclusions to this Section 2.1.8 are as specified in Exhibit A.

2.2 Programs, Policies & Procedures. Physician agrees to cooperate with Health Plan and reasonably comply with all administrative programs, policies and procedures that may be established by Health Plan, including, but not limited to, the following: provider manual, quality improvement, utilization review, peer review, grievance procedures, credentialing and recredentialing processes and procedures and any other policies and procedures that the Health Plan may implement, provided that compliance with existing or any future changes to the policies and procedures named above shall not place any undue burden upon the Physician. Physician further agrees to participate in and cooperate with the decisions, policies, processes and rules established by Health Plan's utilization management program, including, but not limited to, pre-certification of elective admissions and other certification procedures, concurrent and/or retrospective reviews and evaluations, referral processes and procedures, and reporting of clinical encounter data. Health Plan shall maintain an internal appeal procedure for policy or administrative decisions affecting Physician. Physician agrees to abide by all final determinations rendered by Health Plan in the above programs.

2.3 Open Practice. Physician may refuse to enroll additional Members in Physician's practice, if and only if: (i) Physician's practice as a whole is to be closed to additional patients; and (ii) Physician makes reasonable efforts to notify Health Plan sixty (60) days prior to the date of such refusal that Physician shall no longer be accepting Members for treatment. Physician may reopen his/her practice by giving Health Plan sixty (60) days' prior written notice. Health Plan reserves the right to initiate the administrative closure of a Physician practice.

2.4 Licensure & Liability Insurance. Physician shall be fully licensed to practice medicine in the State of Illinois and agrees to maintain in good standing all licenses, accreditations, and certifications required by law and Health Plan's credentialing requirements for so long as this Agreement is in effect. Physician shall also have admitting privileges in at least one hospital that is a Participating Hospital of Health Plan and shall be required to maintain staff membership and admission privileges in accordance with the rules and regulations of such hospital and be otherwise acceptable to such Participating Hospital. Physician shall submit evidence of such licensing, accreditations, certifications and privileges to Health Plan upon request. Physician agrees to procure and maintain in effect at all times during the term of this Agreement adequate professional liability and malpractice coverage through insurance, self-funding or other means satisfactory to Health Plan to protect against all allegations arising out of the rendering of professional services or the alleged failure to render professional services by Physician and Physician's employees (**"Professional Liability Insurance"**). Physician shall give Health Plan at least fifteen (15) days' advance written notice of cancellation of such insurance. Professional Liability Insurance coverage shall be maintained at levels of at least $1,000,000 per occurrence and $3,000,000 aggregate. Physician also agrees to procure and maintain comprehensive general and/or umbrella liability insurance in such amounts as Health Plan

deems appropriate. Physician shall provide Health Plan immediate notice of any change in Physician's insurance coverage (including reduction or cancellation of such coverage), licensure or certification status or Medicare qualification status. In addition, Physician shall notify Health Plan immediately of any changes in privileges at any hospital or admitting facility, including suspension or revocation.

2.5 Claim Submission. Physician shall submit claims and encounter data for all office visits and other services provided in the form and manner described herein regardless of the method of reimbursement. Physician shall submit claims for Covered Services directly to Health Plan within ninety (90) days of the date of service. Any claim submitted more than ninety (90) days following the date of service will be denied, unless the claim was returned to Physician for further information. Physician agrees to make reasonable efforts not to submit a duplicate claim for payment within sixty (60) days of Physician's original submission. Unless otherwise directed by Health Plan, Physician shall submit claim or encounter data using the current Centers for Medicare & Medicaid Services ("**CMS**") 1500 forms with current CMS coding, current International Classification of Diseases, Ninth Revision ("**ICD9**") and Current Procedural Terminology Fourth Edition ("**CPT4**") coding. Physician also shall include with the claim Physician's customary charge for the service rendered to the Member and the Member's identification number, and the Physician's federal tax ID number.

2.5.1 Health Plan may reduce or deny payment for services which are not submitted for payment in accordance with the provisions of this Section 2.5 or which are not billed or coded in accordance with CMS Guidelines for billing and coding practices, which may include the use of industry accepted software to edit claims to ensure appropriate billing and coding practices. Physician will have forty five (45) days to resubmit corrected claim.

2.5.2 Physician understands and agrees that services billed to Payors by any other health care practitioner in providing services to Members utilizing a federal tax ID number that is designated to or used by Physician may be reimbursed subject to the rates and terms of this Agreement.

2.6 Drug Formulary/Generic Substitutions. Physician shall use the drug formulary designated by Health Plan ("**Drug Formulary**") when prescribing medications for Members, a copy of which has been provided to Physician. Physician understands and agrees that the Drug Formulary may be modified from time to time by Health Plan. Any adjustment to the drug formulary shall be available on Health Plan's website.

2.7 Medical Records. Physician shall maintain a medical record for each Member in accordance with all requirements of the law. Physician understands and agrees that neither Health Plan nor Members shall be required to reimburse Physician for expenses related to providing copies of patient records or documents directly to any local, State or Federal agency pursuant to a request from any local, State or Federal agency (including, without limitation, CMS) or such agencies' subcontractors. For any other purpose, Health Plan shall reimburse Physician for copies of records or films of medical and billing records requested at the State of Illinois copying fee schedule.

2.8 Hold Harmless.

2.8.1 Physician agrees that in no event, including but not limited to nonpayment by the Health Plan of amounts due Physician under this contract, insolvency of the Health Plan or any breach of this contract by the Health Plan, shall Physician or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, a Member, persons acting on the Member's behalf (other than the Health Plan), the employer or group contract holder for services provided pursuant to this contract except for the payment of applicable co-payments, coinsurance or deductibles for services covered by the Health Plan or fees for services not covered by the Health Plan.

2.8.2 Physician further agrees that the requirements of this clause shall survive any termination of this contract for services rendered prior to such termination, regardless of the cause of such termination. The Health Plan's Members, the persons acting on the Member's behalf (other than the Health Plan) and the employer or group contract holder shall be third party beneficiaries of this clause. This clause supersedes

any oral or written agreement now existing or hereafter entered into between the Physician and the Member, persons acting on the Member's behalf (other than the Health Plan) and the employer or group contract holder.

2.8.3 Any modification, addition, or deletion to the provisions of this Section shall become effective on a date no earlier than sixty (60) days after the State Department of Insurance has received written notice of such change.

2.9 Practice of Medicine. Physician acknowledges that Health Plan does not practice medicine or exercise control over the methods or professional judgments by which Physician renders medical services to Members. Physician shall be responsible for clinical decisions regarding admission, discharge or other medical treatment of Members regardless of receipt by Physician of any recommendations, authorizations or denials of payment for treatment provided to Members from Health Plan, its agents or any other person or entity performing quality improvement or utilization management. Health Plan encourages Physician to communicate with patients regarding the treatment options available to them, including alternative medications, regardless of benefit coverage limitations.

2.10 Compliance With Government Requirements. Physician agrees to comply with all applicable requirements, laws, rules and regulations of CMS, any other Federal agencies and any State agencies of the State(s) in which Physician practices, including, without limitation, requirements that shall cause or require Health Plan to amend the terms and conditions of this Agreement and requirements related to the administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA). Physician understands and agrees that CMS and the appropriate State agencies may change or add to such requirements, laws, rules and regulations from time to time.

2.11 Marketing. Health Plan shall have the right to use the name, address, telephone number, specialty field and description of services of Physician for purposes of marketing, informing Members of the identity of Physician, and otherwise to carry out the terms of this Agreement.

3. HEALTH PLAN OR PAYOR OBLIGATIONS

3.1 Payment. Health Plan, or the applicable Payor, shall pay and Physician agrees to accept as payment in full for all Covered Services rendered to Members, payment as set forth in Exhibit B. Except for applicable copayments, coinsurance or deductibles, set forth in the applicable member contract, Physician shall look only to Health Plan or a Payor, when it is another Payor's obligation, for compensation for Covered Services provided to Members and will not seek reimbursement from anyone other than Health Plan or Payor. Physician agrees to look only to the applicable Payor for reimbursement when Payor is not Health Plan. Physician understands and agrees that neither Health Plan, Payor nor Member will be liable for services provided by Physician, which are determined by Health Plan not to be Medically Necessary. Health Plan agrees that a Physician claim for services provided shall not be retroactively denied after services were previously authorized, unless there exists a material difference in the information upon which the original decision was based and the medical record, or concurrent authorization has been provided.

3.1.1 Services rendered not in compliance with Health Plan's policies and procedures, including failure to obtain necessary authorizations, may be denied by Health Plan. These services are considered non-reimbursable, and the Member may not be billed pursuant to Sections 2.8 and 3.1 of this Agreement. Notwithstanding the above, if Physician inadvertently fails to follow required prior authorization, Physician may submit an appeal to Health Plan or Payor, as applicable. In considering such appeals, Health Plan shall consider such factors as whether the services in question (a) were Covered

Services, (b) were Medically Necessary and appropriate for the Member's condition, and (c) would have been authorized by Health Plan had Physician not failed to comply with such procedures. If in its evaluation of Physician's appeal, Health Plan reasonably determines that the services in question were Covered Services and were Medically Necessary and appropriate for the Member's condition, and would have been authorized by Health Plan had Physician complied with the preadmission authorization and eligibility verification procedures, then Health Plan shall reverse its denial and reimburse Physician in accordance with Exhibit B, herein.

It is further understood that Member's benefit plans may require the Participating Hospital or Member to themselves preauthorize or notify Health Plan or Payor of an admission or specialized services. In the event that Physician has failed to obtain authorization or certification but Participating Hospital or Member has provided or obtained authorization to Health Plan or Payor, the requirement of authorization and precertification by Physician will be deemed to have been met. In such circumstances reimbursement shall be due as long as services provided meet the criteria of being Covered Services and Medically Necessary.

3.1.2 Health Plan requires appropriate documentation and coding to support payment for Covered Services. Physician shall have the opportunity to correct any billing or coding error within forty five (45) days of denial related to any such claim submission. Health Plan shall have the right to recover payment or retain portions of future payments, subject to the provisions set forth below, in the event that Health Plan determines that an individual was not an eligible Member at the time of services, or in the event of duplicate payment, overpayment, payment for non-covered services or fraud. Health Plan shall have the right to request a refund within six (6) months in the event of overpayment or payment for non-covered services, or twelve (12) months in the event of an ineligible Member, duplicate payment or fraud, as long as such payment error has been identified to Physician in writing by Health Plan within the timeframe indicated above, from the date of service. Both parties agree to make payment or to dispute the validity of such recovery attempt within ninety (90) days of said notice to the other party.

3.2 **Prompt Pay**. Upon receipt of a Clean Claim, Health Plan shall make payments to Physician in accordance with all applicable state law requirements regarding prompt payments.

3.3 **Identification Cards.** Health Plan shall provide an identification card to Members which shall identify the Member's benefit plan, claim address and the telephone number that Physician may call during normal business hours to verify Member eligibility and obtain general information regarding the Member's benefit plan, including any limitations or conditions on such Covered Services. Identification shall also specifically identify Coventry or First Health by name or logo. Health Plan warrants that no other insurer shall be identified on ID card of Member. It shall be the Physician's sole responsibility to verify the enrollment and eligibility status of a Member with Health Plan. Neither Health Plan nor the applicable Payor shall be liable to Physician for any services rendered to persons not enrolled in Health Plan or who are otherwise ineligible to receive benefits, except as indicated in Section 3.1.2. At such time as Health Plan receives an inquiry from Physician regarding a Member's benefit plan or Covered Services, Health Plan shall use information given to Health Plan by Physician to make preliminary benefit decisions.

4. TERM AND TERMINATION

4.1 **Term of Agreement.** The Initial Term of the Agreement shall be for two (2) years from the Effective Date set forth above ("Initial Term"). Following the Initial Term, the Agreement will be automatically renewed for one-year periods unless earlier terminated as set forth below.

4.2 **Termination without Cause.** Either Party may terminate this Agreement with ninety (90) days' prior written notice following the Initial Term. Health Plan may terminate an individual Physician's participation under a group practice agreement with ninety (90) days' prior written notice.

4.3 **Termination For Breach.** Either Party may terminate this Agreement during the Initial Term for the breach of a material term, condition or provision of this Agreement, after sixty (60) days' prior written notice to the other Party, specifying such material breach. The breaching Party shall have a minimum of thirty (30) days or such longer reasonable period agreed to by the Parties to correct or cure such material breach. If the breaching Party fails or refuses to cure the material breach within such time, then the non-breaching Party may elect to terminate this Agreement effective the last day of the month following the end of the notice period. The remedy herein provided shall not be exclusive of, but shall be in addition to, any remedy available at law or in equity to the non-breaching Party.

4.4 **Immediate Termination by Health Plan.** Health Plan may immediately terminate an individual physician from providing Covered Services to Members, and the individual physician shall immediately cease providing Covered Services, for the following reasons:

4.4.1 Termination, revocation, suspension or other limitation of individual physician's license or certification.

4.4.2 Termination, revocation, suspension or other limitation of medical staff privileges at any hospital.

4.4.3 Conviction of, or plea of no contest to, a felony or any criminal charge.

4.4.4 Physician's suspension or termination from participation in Medicare or Medicaid.

4.4.5 Health Plan determines in good faith that the physician's continued provision of services to Members may result in, or is resulting in, danger to the health, safety or welfare of Members.

4.4.6 Health Plan determines in good faith that, after notice to physician and opportunity to cure, the physician has not materially complied with the provisions of the Health Plan's Provider Manual and is unwilling or unable to work cooperatively in a managed care environment.

4.5 **Immediate Termination by Physician**. Physician may terminate this Agreement due to Health Plan's loss of its Certificate of Authority to perform its business as a licensed managed care organization; provided Physician shall be subject to medical practice standards regarding abandonment of patients.

4.6 **Continuation of Benefits.** Unless this Agreement is terminated pursuant to Section 4.4 above, upon termination of this Agreement, Physician shall continue to provide Covered Services to Members who are receiving active treatment at the time of termination or who are hospitalized on the date the Agreement terminates or expires, until the course of treatment is completed or through the date of each such Member's discharge or until Health Plan makes reasonable arrangements to have another physician provide the service, but in no event beyond ninety (90) days past the date of termination and/or expiration. Such continuation of services shall be made in accordance with the terms and conditions of the Agreement as it may be amended and in effect at the time, including but not limited to the compensation rates and terms set forth therein. This Section shall survive termination of the Agreement.

5. GENERAL REQUIREMENTS

5.1 **Assignment.** This Agreement is intended to secure the services of and be personal to the Physician. Therefore, the rights and responsibilities under this Agreement cannot be sold, leased, assigned, transferred or otherwise delegated by either party and without the prior written and informed consent of both parties. Nothing herein shall prohibit Health Plan's assignment of this Agreement to an affiliate or delegation of any administrative obligations hereunder to another entity, including, but not limited to, Payor or its designee.

5.2 **Amendments**. Any amendment to this Agreement beyond that indicated in Section 2.10 shall be mutually agreed upon in writing by both parties. Aside from regulatory amendments as discussed in Section 2.11, neither party shall have the right or authority to unilaterally amend this Agreement without the written consent of the other party.

5.3 **Dispute Resolution and Arbitration.**

5.3.1 **Provider Dispute Resolution**. Except for disputes, claims, questions, or differences related to medical malpractice, terminations of an individual provider's participation pursuant to Health Plan's Credentialing Policies and Procedures, termination without cause, or as otherwise provided herein, if any dispute arises out of or relates to this Agreement, Physician shall follow the Provider Appeal procedure(s) described in the Provider Manual or other Health Plan policies and procedures. In the event that the process outlined in the Provider Manual or other policies and procedures, fails to resolve the dispute, or the matter is of a nature not addressed in said materials, the aggrieved party shall notify ("**Notice #1**") the other, in writing, of the dispute, claim, question, or difference. Both parties shall meet and negotiate, in good faith, to attempt to reach a solution satisfactory to both parties within sixty (60) days of receipt of Notice #1. If efforts are unsuccessful, then upon further notice ("**Notice #2**") by either party to the other, all said disputes, claims, questions, or differences shall be submitted to mediation.

5.3.2 **Mediation**. All mediation proceedings shall be administered through the American Arbitration Association ("**AAA**") under its Commercial Mediation Rules. In the event that the mediation process fails to resolve the dispute, claim, question, or difference within sixty (60) days of the receipt of Notice #2 then all said disputes, claims, questions, or differences may be submitted to binding arbitration for resolution upon election of and notice ("**Notice #3**") by either party.

5.3.3 **Arbitration**. Any unresolved disputes, claims, questions, or differences arising from or relating to this Agreement or breach thereof, which remain unsettled after attempts at negotiation and mediation, shall, upon election, be settled by arbitration administered by the AAA. The dispute shall be settled strictly in accordance with this Agreement and the substantive laws of the State of Illinois, unless such state laws are otherwise preempted by Federal law, or as otherwise provided herein. The rules of the arbitration shall be the Commercial Arbitration Rules of the AAA using a three-member panel of arbitrators. Within fifteen (15) days after receipt of the notice of arbitration, each party shall select a person to act as arbitrator and the two selected shall select a third arbitrator within ten (10) days of their appointment. If the arbitrators selected by the parties are unable or fail to agree upon the third arbitrator, the third arbitrator shall be selected by the AAA. The decision(s) of the arbitrators shall be final and binding. Judgment upon the award rendered by the arbitrators may be entered and enforced in any court of competent jurisdiction.

5.3.4 **Location**. The place of mediation and, if necessary, arbitration shall be DuPage County, Illinois.

5.3.5 **Costs**. In the event that either party institutes any mediation, arbitration, suit or proceeding to enforce or interpret the provisions of this Agreement, each party shall be responsible for its own costs and expenses, including but not limited to attorney's fees. Each party shall be responsible for an equal share of the mediators', arbitrators', and/or administrative fees of mediation and/or arbitration associated with such an action.

5.3.6 **Relief**. The parties further agree that in no event shall the mediators or arbitrators have authority to award punitive or other damages not measured by the prevailing party's actual damages, unless specifically required by statute. Notwithstanding the foregoing, no party shall be precluded from seeking injunction or other equitable relief in court in connection with those sections of this Agreement that specifically permit actions for said relief.

5.4 **Group Practice.** In the event that Physician is a professional corporation, association, partnership or other corporate entity, Physician hereby represents and warrants to Health Plan that: (i) each physician that provides Covered Services on behalf of Physician is licensed to practice medicine or osteopathy in the state in which Physician practices; and (ii) each physician that provides Covered Services on behalf of Physician has agreed to be bound by the terms and conditions of the Agreement and that Physician has the authority to bind said physician(s). Notwithstanding the foregoing, Physician understands and agrees that a physician may not provide Covered Services on behalf of Physician unless and until such physician has been accepted as a Participating Physician by Health Plan, which acceptance shall be in writing. Physician shall provide Health Plan with a listing of providers who have agreed to participate under this Agreement: a) on the Effective Date; and b) as providers are added and providers leave.

5.5 **Confidentiality.** Physician and Health Plan agree to maintain the privacy and confidentiality of all information and records regarding Members, including but not limited to medical records, in accordance with all State and Federal laws, including the regulations promulgated under HIPAA. In addition, each Party shall maintain the confidentiality of the other Party's proprietary information that is not otherwise public information including the terms of reimbursement, provided Health Plan may disclose reimbursement terms to prospective and current employer groups. In the event that either party violates its duties under this provision, the other party may seek injunctive relief. This section shall survive the termination of the Agreement.

5.6 **Names, Symbols, Trademarks.** Except as provided in Section 2.12, Health Plan and Physician each reserve the right to and control of the use of their name, symbols, trademarks, and service marks presently existing or later established. In addition, except as provided in Section 2.12, neither Health Plan nor Physician shall use the other Party's name, symbols, trademarks, or service marks in advertising or promotional materials or otherwise without the prior written consent of that Party and shall cease any such usage immediately upon written notice of the Party or on termination of this Agreement, whichever is sooner. Further, Physician agrees that Health Plan's interior and exterior identification at Physician's office shall be at least equal in prominence to that of any other plan.

5.7 **Access to Records and Audit.** Physician shall provide Health Plan with access to such medical, and billing records as may be necessary for compliance by Health Plan with applicable State and Federal law, including, but not limited to, those laws related to the privacy and confidentiality of medical records, or for agency accreditation purposes. Physician shall also make Member medical records available to Health Plan for the purpose of determining, on a concurrent or retrospective basis, the medical necessity and appropriateness of care provided to Health Plan Members. In addition, Physician further agrees to allow Health Plan and appropriate State and Federal agencies and their agents such access to medical records of Members as is needed to make assessments regarding the quality of care rendered to Members, the accessibility and availability of care, the investigation of Member grievances or complaints or for other State and Federal purposes. Finally, Physician shall allow Health Plan to audit Physician's billing records for payment purposes associated with a specific Member. Health Plan shall not be granted rights under this Agreement to audit general billing records of Physician for overall payment or reimbursement purposes. This Section shall survive the termination of this Agreement.

5.8 **No Solicitation of Members**. Either party may notify Members in the event that Physician is no longer a Participating Physician. Both parties shall notify Members of Physician's termination as required by law, regulation, and/or National Committee on Quality Assurance ("NCQA") guidelines. In the event that either party violates its duties under this provision, the other party may seek injunctive relief.

5.9 **No Third Party Beneficiaries**. Other than the Parties expressly set forth in the Agreement, no third persons or entities are intended to be or are third party beneficiaries of or under the Agreement, including, without limitation, Members. Nothing in the Agreement shall be construed to create any liability on the part of

Health Plan, Physician or their respective directors, officers, shareholders, employees or agents, as the case may be, to any such third parties for any act or failure to act of any Party hereto.

5.10 Notice. Any notice, request, demand or communication required or permitted hereunder (**"Notices"**) shall be given in writing by certified mail, return receipt requested, to the Party to be notified. All Notices shall be deemed given and received three (3) days after mailing to the address specified as follows:

Health Plan
PersonalCare Insurance of Illinois, Inc.
2110 Fox Drive
Champaign, IL 61820
ATTN: Network Development

Physician
Address as on Signature Page.

5.11 Relationship. None of the provisions of this Agreement is intended to create, or shall be deemed or construed to create, any relationship between the Parties hereto other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Neither Physician nor Health Plan shall be liable to any other party for any act, or any failure to act, of the other Party to this Agreement. This Agreement shall not be interpreted so as to find the Member Companies jointly and severally liable hereunder. The parties agree that this Agreement shall be interpreted to be between Physician and whichever of the Member Companies is a party to the Member Contract under which the Member related to the then instant matter is receiving Covered Services.

5.12 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Illinois.

5.13 Severability. In the event any portion of this Agreement is found to be void, illegal, or unenforceable, the validity or enforceability of any other portion shall not be affected.

5.14 Waiver. The waiver by either party of any breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach of the same or other provision.

5.15 Entire Agreement. This Agreement, together with Exhibits, Attachments and Health Plan's Provider Manual and policies and procedures, constitute the entire understanding of the Parties with respect to the subject matter and supersedes any prior agreements.

INTENDING TO BE BOUND, the authorized representatives of the Parties have duly executed this Agreement as set forth below as of the date first written above.

The undersigned Physician certifies that s/he has not changed or modified any portion of this Agreement.

~~PHYSICIAN~~ ORGANIZATION

By: Kathleen M'Tigue

Print Name: Kathleen M'Tigue

~~Title: Tax ID#~~: Executive Director, CCPA

Date: July 16, 2008

Address for Notice:

CCPA: attn: Kathleen M'Tigue
Children's Memorial Hospital
2300 Children's Plaza Box #113
Chicago, IL 60614-3394

HEALTH PLAN

By: [signature]

Print Name: Paul T.Eisenstat

Title: Chief Operating Officer

Date: 8-6-08

EXHIBIT A

Products

Health Plan may designate Physician as a participating provider in one or more of its Products based upon the following designs:

1. HMO – Health benefit plan that provides health care services in a specific geographic area, through Participating Providers, for an agreed upon set of basic and supplemental health maintenance and treatment services to Members.

2. POS – Same as HMO above except that Members may receive care from both Participating Providers and non-Participating Providers.

3. PPO – Members may receive care from both Participating Providers and non-Participating Providers with financial incentives to encourage utilization of Participating Providers.

4. Payor Products administered by Health Plan and Member Companies.

5. Payor Products administered by Payors other than Health Plan and Member Companies.

Programs/Products for which this Agreement shall not be applicable are as follows:

1. Workers' Compensation - Members may receive services from both Participating Providers and non Participating Providers from compensable injuries or diseases arising in the course of employment.

2. Medicare Advantage – Any network-based Medicare risk product including Medicare+ Choice, Medicare Advantage HMO, Medicare Advantage PPO and similar plans.

3. Any discount card programs or other products with are designed to provide discounts but which are not specifically insurance products.

4. Any automobile coverage/benefit plans.

5. Any products whose benefit plans do not provide a minimum coinsurance differential of at least ten percent (10%) differential between in network and out of network providers.

6. All indemnity based health care programs. In order for a product not to be considered an Indemnity plan, a plan/product shall be required to have a specific and identifiable network of contracted providers with specific reference to benefits applicable to out of network providers. The plan shall also have specified in network/out of network differentials for deductibles and copayments, if they are included in the plan, as well as a minimum of (10%) coinsurance differential for all in network and out of network services.

EXHIBIT B

Physician Compensation

I. REIMBURSEMENT RATE FOR ALL PRODUCTS UNDERWRITTEN OR ADMINISTERED BY HEALTH PLAN & MEMBER COMPANIES.

A. Health Plan or the applicable Payor shall pay Physician the following rates for Covered Services rendered to Members enrolled through all programs underwritten or administered by Health Plan as described in Exhibit A Sections 1-5. Effective July 1 of each year, Health Plan shall use the then current Medicare RBRVS fee schedule, geographically-adjusted for Medicare locality 0095216. In the event, Physician provides a service that does not have an assigned relative value unit (RVU) according to the Medicare RBRVS fee schedule in use by Health Plan, Health Plan or Payor may use the Complete St. Anthony's RBRVS geographically adjusted fee schedule, or its successor, as a gap fee schedule. In the event neither CMS nor St. Anthony's has a published RVU, Health Plan or Payor shall pay Physician 60% of billed charges.

1) Physician Services: Health Plan will reimburse Physician for Physician Services, excluding Preventive Codes and Immunization Codes at 128% of the Medicare rate.

2) Preventive Codes: Health Plan will reimburse Physician for Preventive Codes (99381-99385, and 99391-99395) at 140% of the Medicare rate.

3) Laboratory Services: Health Plan will reimburse Physician 100% of the Medicare rate.

4) HCPCS: HCPCS fees will be paid according to the Health Plan's current fee schedule.

5) Immunization Codes: Health Plan will reimburse Physician for Immunization Codes (86500-86599, 90600-90699, & 90700-90779, and their successor codes) at 85% of billed charges.

6) Anesthesia Physician Services: Health Plan will reimburse Physician for time-based anesthesia Physician services $48 per fifteen (15) minute unit of time.

For services provided by a Nurse Practitioner or Physician Assistant the name of the Nurse Practitioner or Physician Assistant must appear on the bill and reimbursement will be:

1) All Services, except HCPCs: Health Plan will reimburse Physician 85% of the current Medicare rate.

2) HCPCS: HCPCS fees will be paid the Health Plan's current fee schedule.

II. REIMBURSEMENT RATE FOR ALL NETWORK RENTAL PAYORS.

A. Payor shall pay Physician the following rates for Covered Services rendered to Members enrolled in Self-funded Payor Products administered by Payors other than Health Plan and Member Companies as described in Exhibit A Section 6. Effective July 1 of each year, Payor shall use the then current Medicare RBRVS fee schedule, geographically-adjusted for Medicare locality 0095216. In the event, Physician provides a services that does not have an assigned relative value unit (RVU) according to the Medicare RBRVS fee schedule in use by Payor, Payor may use the Complete St. Anthony's RBRVS geographically adjusted fee schedule, or its successor, as a gap

fee schedule. In the event neither CMS nor St. Anthony's has a published RVU, Payor shall pay Physician 60% of billed charges.

1) Physician Services: Payor will reimburse Physician for Physician Services, excluding Immunization Codes 140% of the Medicare rate.

2) Laboratory Services: Payor will reimburse Physician 110% of the Medicare rate.

3) HCPCS: HCPCS fees will be paid according to the Health Plan's current fee schedule.

4) Immunization Codes: Health Plan will reimburse Physician for Immunization Codes (86500-86599, 90600-90699, & 90700-90779, and their successor codes) at 85% of billed charges

5) Anesthesia Physician Services: Health Plan will reimburse Physician for time-based anesthesia Physician services $48 per fifteen (15) minute unit of time.

For services provided by a Nurse Practitioner or Physician Assistant the name of the Nurse Practitioner or Physician Assistant must appear on the bill and reimbursement will be:

1) All Services, except HCPCs: Health Plan will reimburse Physician 94% of the current Medicare rate.

2) HCPCS: HCPCS fees will be paid the Health Plan's current fee schedule.

III. COMPENSATION METHODOLOGY.

The compensation for Covered Services, payable by Health Plan and/or Payor, as appropriate, to Physician, subject to the terms of this Agreement, the applicable Group Membership Agreement and corresponding coordination of benefit terms, shall be equal to:

A. The lesser of:

1. The Reimbursement Rate specified in this Exhibit B; or

2. Physician's billed charges;

B. Minus any applicable copayments, coinsurance and/or deductible amounts.

Physician agrees that it will not bill Members for amounts in excess of the copayments, coinsurance or deductible provided for in Member's Group Membership Agreement, except as provided in this Agreement.