ONE HEALTH PLAN OF INDIANA, INC.

CHILDREN'S COMMUNITY PHYSICIANS ASSOCIATION

MEDICAL GROUP FEE FOR SERVICE AGREEMENT

(HMO/PPO/POS)

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ONE HEALTH PLAN OF INDIANA, INC.
MEDICAL GROUP FEE FOR SERVICE AGREEMENT

This is an Agreement by and between Children's Community Physicians Association ("Group"), and One Health Plan of Indiana, Inc. ("Plan"), entered into as of the **1st day of June, 2000** ("Effective Date").

WHEREAS, Plan or Affiliate will operate as a health maintenance organization ("HMO") under the Indiana Insurance Code and the rules and regulations there under ("Act") as well as a managed care organization in the State of Indiana and will provide or arrange for health care services and perform administrative services for individuals and for employee welfare benefit plans;

WHEREAS, Payors maintain insurance policies, health maintenance organizations, preferred provider organization ("PPO") and point of service ("POS") plans or arrangements whereby persons covered by such policies, plans or arrangements are entitled to receive, or are entitled to indemnification or reimbursement of the cost of health care services rendered by health care providers; and are entitled to a higher level of service, payment or reimbursement if they use certain designated health care providers, thereby encouraging the covered person to use the designated providers; and

WHEREAS, Plan maintains contracts with such Payors whereby those Payors are entitled to designate Plan's Contracting Providers as described in the above paragraph. Plan desires to contract with Group in order to enable Payors to designate Group. Group desires to contract with Plan in order to obtain designation from Payors.

WHEREAS, Group means the above-referenced Group, which is a partnership, association, corporation or other legally constituted entity existing under the laws of the State of Indiana organized to provide professional medical services whose Group Physicians share equipment, facilities, records, administrative services and/or personnel in such a manner as is deemed acceptable to Plan and which can bind its Group Physicians to the terms of this Agreement; and

WHEREAS, Plan desires to contract with Group on behalf of Plan and Group desires to contract with Plan to provide licensed health care professionals to render medical and health care services to Members;

NOW THEREFORE, in consideration of the premises and the mutual covenants and undertakings hereinafter set forth, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1. DEFINITIONS. For purposes of Agreement:

(a) "Act" means the Indiana Insurance Code and the rules and regulations thereunder.

(b) "Affiliates" means any entity controlled by or which controls Plan or Group. Control will mean the right to direct the management of the affairs of the other entity.

(c) "Agreement" means this Medical Group Agreement by and between Group and Plan, any Exhibits or amendments thereof, and any applicable state or federal requirements required by law to be incorporated as a part of this Agreement.

(d) "Clean Claim" means a properly completed claim for payment for Covered Services received by Plan from Group that requires no further information, documentation, adjustment or alteration by Group in order to be processed or paid, is not reasonably contested or denied by Plan, and is not subject to appeal or grievance procedures.

(e) "Contract Year" means a period of twelve (12) months commencing on either the Effective Date of Agreement or any subsequent anniversary of the Effective Date of Agreement.

(f) "Contracting Provider" means any medical group or medical organization, physician (also referred to herein as "Contracting Physician"), hospital (also referred to herein as "Contracting Hospital") and other health care providers selected by Plan, who are duly licensed under Indiana law and who have entered into a written agreement with Plan to provide Covered Services to Members.

(g) "Covered Services" means only such medical care, treatment and supplies that are provided by licensed health care providers to Members and (1) are benefits under the terms of such Members' Group Subscriber Contract, or (2) are services mandated by the Act now or in the future to be benefits of such Member's Group Subscriber Contract. Provision of Covered Services must comply with all utilization management procedures as defined in Exhibit VII.

(h) "Credentialing" or "Credentialing Program" means the processes or programs established by Plan or Payors under which the professional and other credentials and qualifications of Contracting Providers are reviewed to determine whether or not they meet Plan's or Payors' requirements.

(i) "Emergency" means the sudden, unexpected onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to jeopardize life, cause serious injury or impairment of bodily functions, or cause serious injury to or permanent dysfunction of any bodily organ or part. All determinations of whether or not an emergency exists will be subject to

retrospective review and approval or disapproval by Plan Medical Director pursuant to the Utilization Management Program.

(j) "Fee Schedule" means the applicable schedule of maximum allowable fees payable to Contracting Providers for Covered Services. Fee Schedules are established by Plan and may be revised from time to time.

(k) "Group Medical Director" means a licensed physician appointed by Group to be responsible for managing and directing Group Physicians rendering Covered Services to Members.

(1) "Group Physician" means a physician who is a member of or is employed by or has contracted with Group and has agreed to provide Covered Services pursuant to this agreement. Group Physician includes any physicians not contracting with or employed by Group who have agreed to temporarily cover Group Physician's practice.

(m) "Group Subscriber Contract" means any contract issued by Plan or Payor that is in effect between Plan or Payor and any employer, labor union, association or trust under which payment for health care services is provided.

(n) "Member" means any individual covered under a Group Subscriber Contract or other contract issued or administered by Plan or Payor.

(o) "Payor" means any self-insured employer, preferred provider organization, health maintenance organization, network organization, insurance company, third party administrator, or any other entity and/or the clients of any of these entities who have been authorized by Plan to designate one or more of Plan's Contracting Providers, who have agreed to provide certain financial incentives for Members to use designated Contracting Providers, and who have financial responsibility for payment of Covered Services.

(p) "Plan Medical Director" means a licensed physician engaged by Plan to ensure the proper administration of Plan's health benefit program as well as supervise and direct the conduct of the Utilization Management and Quality Assurance Programs in the geographic area that includes Hospital's Service Area.

(q) "Payment Rates" means the rates paid to the Group for Covered Services rendered by the Group to Member.

(r) "Pre-Certification" means a determination by Plan, in accordance with Plan's Utilization Management Program.

(s) "Primary Care Physician" means a Contracting Physician approved by Plan who practices as an Internist, Pediatrician, Family Practitioner or General Practitioner,

and with whom a Member has established a physician-patient relationship pursuant to which that physician has responsibility for the first contact and ongoing care of that Member in both health maintenance and therapy for illness or injury, for maintaining overall coordination and continuity of patient care and for initiating referrals for specialist care for that Member.

(t) "Quality Assurance" or "Quality Assurance Program" means the processes and programs established by Plan or Payors to monitor, maintain and improve the quality of services provided to Members.

(u) "Service Area" means the geographic are within a fifty (50) air mile radius of Group's primary admitting hospital. In no event, however, will Service Area include any area outside Plan's approved service area.

(v) "Utilization Management" or "Utilization Management Program" means the processes or programs administered by Plan or Payors with the specific goal of determining whether or not care or treatment meets the requirements of utilization management, prospective review, concurrent review, retrospective review, and/or case management standards established by Plan or Payors.

2. TERM AND TERMINATION. The initial term of this Agreement begins on the Effective Date of this Agreement and will continue in effect for a period of twelve (12) months. Thereafter, this Agreement will automatically be renewed for successive one (1) year terms until terminated as herein provided. This Agreement will terminate as specified within the initial term or thereafter upon the occurrence of any of the following events, subject to the provisions of applicable law:

(a) Automatically and without notice upon the cancellation of Group's general or professional liability insurance maintained in accordance with Sections 12(a) and 12(b); or upon Group's suspension by a state or the federal Government from participation in the Medicare or Medicaid programs.

(b) Immediately upon written notice from Plan if Plan determines, in its reasonable judgment, that Group's continued participation as a Contracting Provider may jeopardize the health or safety of Members.

(c) Upon thirty (30) days prior written notice from Plan to Group if any action is initiated against Group or any Group Physician of a kind specified in Sections 6(s) or 6(t) hereof and if no bona fide attempt by Group is made to rectify the action initiated against Group or any Group Physician, and the conditions giving rise to the action, during such thirty (30) day period.

(d) Upon sixty (60) days prior written notice from Plan to Group if Group or any Group Physician changes affiliations, admitting privileges or specialty status in

such a way as to substantially limit Group's range of services or access to a Contracting Hospital.

(e) By either party, by written notice thereof, if the other party commits a material breach of any warranties, covenants, or obligations, provided that the breaching party fails to cure that breach within sixty (60) days after the written notice of default is given by the terminating party.

(f) Automatically and without notice on such date as either party becomes insolvent, or is adjudicated as bankrupt, or its business comes into possession or control, even temporarily, of any trustee in bankruptcy, or a receiver is appointed for it, or it makes a general assignment for the benefit of creditors. No interest in this Agreement will be deemed an asset or liability of either party, nor will any interest in this Agreement pass by the operation of law without the consent of the other party.

(g) By either party if at least sixty (60) days prior written notice is given that it rejects any modification of Section 3 Group Compensation and elects to terminate this Agreement, such termination to be effective at the end of the last day before such modified rates or factors would become effective.

(h) Immediately upon written notice from Plan if Group makes or has made any untrue statements of material fact or any intentional misrepresentation of any fact, whether or not material, in any claim for payment, in any application or credentialing form or in any statement made by Group to Plan.

(i) Upon ninety (90) days prior written notice, given with or without cause by either party to the other.

(j) If any action of a kind specified in Section 6(s) or 6(t) is initiated against a Group Physician, Plan may, in lieu of or in addition to terminating Group as provided in Section 2 herein, terminate such Group Physician's authority to provide Covered Services under this Agreement effective immediately upon notice thereof.

(k) Immediately upon written notice if Group fails to comply with Section 6(m).

(1) Following the effective date of termination of this Agreement, this Agreement will be of no further force or effect except that each party will remain liable for any obligations or liabilities arising from activities undertaken prior to the effective date of termination. Upon any termination or withdrawal of the Group, whether by termination of this Agreement or otherwise, the Plan shall continue to be liable to pay in accordance with Section 3 hereof and the Fee Schedule in effect immediately prior to such termination for Covered Services rendered by the Group under the terms and conditions of this Agreement to any Member who is under the care of the Group at the time of such termination or withdrawal, and the

Group shall continue to provide such Covered Services until the current episode of care is completed, unless reasonably and medically appropriate arrangements for the assumption of such care by another provider are made. The Group shall make reasonable and medically appropriate arrangements for the assumption by other Group Physicians for the care of Members who are under the care of any terminated or withdrawn Group Physician.

(m) A Payor's removal of the Group's or a particular Group Physician's designation under a Group Subscriber Contract, as described in Section 6(a) of this Agreement, or the Plan's termination of a particular Group Physician from participation in Plan's provider network, as described in Section 8(b) of this Agreement, shall not constitute a termination of this Agreement between Group and Plan.

(n) In the event Group provides thirty percent (30%) or more of Plan's services, Group must give Plan one hundred twenty (120) days advance notice before terminating this Agreement.

3. GROUP COMPENSATION. Plan will compensate Medical Group as described in Exhibit II. Where Plan has contracted on behalf of an employee welfare benefit plan, that employee welfare benefit plan will be solely responsible for compensation payable under this paragraph.

4. MODIFICATION OF RATES AND FACTORS. Plan may propose changes to the rates or factors in Section 3 Group Compensation by giving written notice of at least ninety (90) days. If the proposed rates are unsatisfactory to Group, the parties agree to meet and discuss in good faith the proposed changes. If no agreement can be reached, either party may elect to terminate this Agreement pursuant to Section 2(g).

5. RESPONSIBILITIES OF THE PLAN.

(a) Regulatory Compliance. Plan will comply with all requirements of the law and regulations of governmental agencies relating to the business of health maintenance organizations and any other business in which Plan is engaged relating to this Agreement, and will obtain and maintain in effect all permits, licenses and governmental approvals necessary for that purpose.

(b) Promotion. Plan, Payor, or Affiliate will make available and promote Plan's Group Subscriber Contracts, subject to the standards of lawfulness, reasonableness, and protection of the health and interests of Members.

(c) Enrollment Requirements. Plan will provide in its Group Subscriber Contracts, as applicable, that Members will be required to enroll to receive all Covered Services from or through one medical organization that is a Contracting Provider such as Group and Members will be permitted to change their enrollment from one such

medical organization to another, or from one Primary Care Physician to another, upon formal notice or contact with Plan, and subject to the standards of lawfulness, reasonableness, and protection of the health and interests of Members.

(d) Utilization Management Program. Plan will conduct a Utilization Management Program which may include prospective review, concurrent review, retrospective review, and/or case management.

(e) Quality Assurance Program. Plan will establish and conduct a Quality Assurance Program.

(f) Credentialing-Program. Plan will establish and conduct a Credentialing Program for the credentialing and recredentialing of Group Physicians and other Contracting Providers.

(g) Member Access. Plan will use its best efforts to contract with sufficient physicians and other health care providers to allow Members access to medical services to the extent required by applicable law and regulations of governmental agencies relating to the business of health maintenance organizations and any other business in which Plan is engaged relating to this Agreement.

(h) Enrollment Reports. Plan will arrange to prepare and furnish to Group monthly enrollment reports of Members assigned to Group on or about the fifteenth (15th) day of each month.

(i) Member Identification. Plan will supply Members with a means of identifying themselves to Group and/or a Group Physician (e.g., an identification card) which indicates the Member's participation in a Group Subscriber Contract. Group and each Group Physician will make a good faith effort in using the Eligibility/Benefit Verification telephone number of the identification card to confirm that the individual presenting a Plan identification card is in fact the Member whose name appears on Plan identification card and is eligible for coverage.

(i) In the event Member eligibility information furnished by Plan or Payor to Group is inaccurate and a person Plan or Payor identifies to be a Member was not in fact a Member at the time of such identification, Plan or Payor shall notify Group of such fact. Thereafter, neither Plan nor Payor shall be responsible for payment for health care services provided to such person.

(j) Designation. Plan will provide written notice to Group of all Payors which have designated Group.

6. RESPONSIBILITIES OF THE GROUP.

(a) Participation in Group Subscriber Contracts. Group and Group Physicians agree that the determination to designate Group and/or Group Physicians to participate in a Group Subscriber Contract shall be made in Payor's discretion based solely upon criteria determined to be relevant or appropriate by Payor, including, without limitation, Payor's need for Covered Services, the Service Area and Group Subscriber Contracts. Nothing in this Agreement shall be construed as imposing any duty or otherwise requiring Plan or Payors to designate Group and/or Group Physicians under any Group Subscriber Contract. Group and Group Physicians agree that Payor shall have the right, subject to the provisions of applicable law, to terminate Group's and/or Group Physicians' participation with or without cause; provided, however, that any removal without cause shall require at least sixty (60) days advance written notice to Group. Such action by Payor shall not terminate this Agreement between Plan and Group.

(b) Enrollment. Group will accept enrollment of any and all Members who select Group. Group may request authorization from Plan to decline to render care to any Member for the Member's misrepresentation, fraud, or non-payment of amounts due from the Member or other responsible party. No such authorization will be granted unless and until Group will have given the Member a reasonable opportunity, given all of the circumstances, to correct the situation that is the subject of such a request. Group will not request, demand, or require the removal of any Member based on such Member's needs or utilization of services. Upon the receipt of authorization from Plan, Group must notify Member that he or she must select another physician not affiliated with the Group within thirty-one (31) days. Group is responsible for continuing to provide urgent or Emergency care until the earlier of thirty-one (31) days or the selection of another Group by the Member.

(c) Member Access. Unless otherwise approved by Plan Medical Director, Group will by staffing, contracting or referral provide medically appropriate access in accordance with applicable laws and regulation in all parts of Group's Service Area to the services of Group Physicians who are board certified or eligible and practicing in the full range of medical specialties. As part of Plan's credentialing process, the names, addresses, medical specialties and medical license numbers of all Group Physicians in addition to all tax identification numbers under which each such physician bills for medical services, and updates thereof, must be supplied to Plan in written documentation or material. If a Member requires Covered Services that cannot be provided directly by Group Physicians, the Member's Primary Care Physician will refer the Member to a Contracting Provider able to provide such services. These provisions will not be construed to obligate Group to indemnify or otherwise hold harmless any Member from the charges of any provider who is not a Group Physician if the Member obtains services from such provider without being first referred or otherwise directed thereto by Group or a Group Physician. In the event that Group plans to close enrollment to new Members, Group will provide Plan with at least sixty (60) days

prior written notice of such plans. Group may not discriminate against Members by closing enrollment to Plan unless Group has closed enrollment of new members for all health plans participating with Group. Group will provide notice to Plan as soon as it opens enrollment to new members of any health plan.

(d) Quality of Care. Group will ensure that medical and health care services are rendered by Group Physicians in a manner which assures availability, adequacy and continuity of care to Members, both during the term and as required after termination hereof, and that all decisions pertaining to health care services to be rendered by Group Physicians to Members are based on such Members' medical needs and are made by or under the supervision of licensed physicians. Group will remain solely responsible for the quality of medical and health care services provided by Group Physicians and will ensure such services are rendered in accordance with professionally recognized standards. In the event that Group denies services to any Member or any Member experiences an adverse outcome, Group will make best efforts to notify Plan promptly.

(e) Hours of Coverage. Group will ensure that Covered Services are available within the Service Area from Group Physicians or by referral to other physicians by keeping office hours of at least forty (40) hours per week. Group also will ensure that Members have access by phone to Group Physicians twenty-four (24) hours per day and seven (7) days per week. When a Group Physician is unavailable to a Member, Group will arrange for coverage from other Group Physicians.

(f) Appointments. Group will make best efforts to ensure that Members are able to receive an elective appointment with a Primary Care Group Physician within seven (7) days of a Member Request and an elective appointment with a Specialty Care Group Physician within ten (10) days of referral. Group will provide or arrange for immediate attention to Emergency care needs and same day attention to urgent care needs.

(g) Member Referral and Transfer. When referrals are appropriate, Group and each Group Physician will follow the procedures in the Physician Group Handbook and will exercise best efforts to refer Members to other Contracting Providers, and to admit Members to Contracting Hospitals. In the event a Member requires transfer to a Contracting Hospital, Group will cooperate with such transfer provided that such activity is consistent with good medical judgment and applicable law.

(h) Referrals Among Groups. Group will accept non-Emergency or specialty referrals from other medical groups participating with Plan and such other medical groups will be required to accept non-Emergency and specialty referrals from Group. Payment to Group will be at rates not to exceed those in the Fee Schedule shown in Exhibit III.

(i) Hospital Privileges. Group will ensure that Group Physicians have admitting privileges at Contracting Hospitals which meet the requirements for the hospital services to which Members are entitled. Alternatively, Group will arrange for the provision of such services.

(j) Group Medical Director. Group will appoint a licensed physician to serve as Group's Medical Director and to be responsible in such capacity for managing and directing Group Physicians' rendering of Covered Services to Members.

(k) Prescription Drugs. Group Physicians will exercise best efforts to prescribe generic drugs and pharmaceutical products and to comply with Plan's formulary.

(1) Primary Care Physician-Authorization. If any aspect of Covered Services required any Primary Care Physician authorization, documentation of that authorization will be promptly made available to Plan.

(m) Collection from Members.

(i) Except as described in Section 9 herein, neither Group nor any Group Physician will seek or require any Member to tender a deposit or similar payment during the Member's course of treatment with Covered Services rendered pursuant to this Agreement, other than any applicable deductibles, coinsurance or copayments specified in the applicable Group Subscriber Contract. Except for copayments and non-covered services, Group will not bill Member prior to receipt of Plan's Explanation of Benefits. Group and/or Group Physician will fully advise Members of their financial responsibility prior to rendering any services that are not covered. Group may look to Member for payment for services which are not Covered Services only if: (a) the Group and/or Group Physician informs the Member, in writing and before services are rendered, that the services are not Covered Services, and (b) the Member agrees, in writing and before the services are rendered, to be fully responsible for the payment of such services.

(ii) Notwithstanding anything in this Agreement to the contrary, in no event, including, but not limited to nonpayment by Plan or Payor, the insolvency of Plan or Payor, or breach of this Agreement, will any Member be liable for any amount owing to Group or any Group Physician by Plan or Payor, and Group and any Group Physician will not bill, charge, collect a deposit or other sum, or seek compensation, remuneration or reimbursement from, or maintain any action or have any recourse against, or make any surcharge upon a Member or any person acting on a Member's behalf. Whenever any such charge has occurred, Group will refund such charge to the Member within thirty (30) days of discovering, or receiving notification of, the charge. Plan or Payor may take appropriate action to remedy the situation,

including, without limitation, offsetting any such charge against amounts due to Group or Group Physician and/or immediate termination pursuant to this Agreement. The obligations set forth in this paragraph will survive the termination of this Agreement regardless of the cause giving rise to termination and will be construed to be for the benefit of the Members.

(n) Sub-Contracting. In the event that Group makes arrangements with other health professionals to fulfill Group's obligations under this Agreement, Group will obtain written contracts with such health professionals, which will include a provision substantially similar to that contained in Section 6(m) herein, and in which they agree to abide by all the obligations of Group under this Agreement. Group's contracts with other providers will be subject to the express written approval of Plan. Group will remain responsible for the quality of medical and health care services provided by other health professionals pursuant to this Section, and will ensure such services are rendered in accordance with professionally recognized standards.

(o) Equitable Treatment. Neither Group nor any Group Physician will differentiate or discriminate against Members, and each will render health services to all such patients in the same manner, in accordance with the same standards and with the same time availability as offered Group's and each Group Physician's other patients. In the event that access to Group's Primary Care Physician panel becomes limited or specific primary Care Physicians close their practices, such limitations and practice closures will be applicable to Members covered under Group Subscriber Contracts represented under this Agreement only to the extent applicable to individuals covered under plans sponsored by all other Payors. In such circumstances, Plan must be promptly notified of primary care practice limitations and closures.

(p) Quality of Care System. Group will demonstrate promptly and to the reasonable satisfaction of Plan that it has established and implemented effective, documented systems to direct and monitor Group's and its Group Physician's compliance with the Primary Care Physician authorization requirements and with all other aspects of Plan's Utilization Management Program. Group will also demonstrate that it has established, implemented, and documented effective peer review and Quality Assurance protocols to assure compliance with utilization and quality of care standards consistent with professionally recognized standards of care, local practice patterns and Plan's Quality Assurance Program. Group will continue to conduct such systems through the initial term and any renewal term of this Agreement.

(q) Compliance with Plan's Utilization Management and Quality Assurance Programs. Group will cooperate and comply fully with Plan's Utilization Management and Quality Assurance Programs, and policies and procedures in the Physician Group Handbook, including updates thereof. Any failure to do so will

be deemed a material breach of this Agreement. Group must comply with Plan's pre-authorization and Pre-Certification procedures. For services which require pre-authorization by a Member's Primary Care Physician, or by Plan, Group must ensure that such authorization is obtained prior to rendering services. For services requiring Pre-Certification, Group must obtain such Pre-Certification from the Plan. If the Group fails to comply with Plan's Utilization Management Program or process by, including but not limited to, failing to obtain Pre-Certification or failing to obtain length of stay extension, the noncompliance may result in loss of reimbursement to Group. The Plan will determine whether to certify the services based on whether the services meet all the following criteria:

(i) They are appropriate given the symptoms and patient history, and are consistent with the diagnosis, if any, of the Member. "Appropriate" means that the type, level and duration of services, and setting are necessary to provide safe and adequate care and treatment;

(ii) They are rendered in accordance with professionally recognized standards;

(iii) They are not generally regarded as experimental or unproven by recognized medical professionals or appropriate governmental agencies; and

(iv) They are permitted by the licensing statutes which apply to the provider who renders that service.

(r) Compliance with Plan's Credentialing Program. Group and Group Physicians will cooperate and comply with the requirements of Plan's Credentialing Program regarding the credentialing and recredentialing of Group Physicians and other Contracting Providers.

(s) Notice of Impairment of Group. As soon as it receives notice thereof, Group will send written notice to Plan of any action undertaken with respect to Group or any Group Physician, which action could materially impair the ability of Group to carry out the duties and obligations of this Agreement, including, but not limited to, actions related to: cancellation of Group's general and professional liability insurance maintained in accordance with Section 12; Group's suspension from participation in any Medicare or Medicaid program; or the indictment, arrest or conviction of any Group Physician for any felony or any criminal charge.

(t) Notice of Impairment of Group Physician. As soon as it receives notice thereof, Group will send written notice to the Plan of any action undertaken with respect to any Group Physician related to any such physician's ability to provide care to Members, including, but not limited to: the termination, probation or suspension of any license of a Group Physician relating to the practice of medicine; any termination or limitation in staff privileges; any disciplinary action taken by a

hospital; the suspension of a Group Physician's participation in any Medicare or Medicaid program; or a Group Physician's indictment, arrest, or conviction for any felony or any criminal charge.

(u) Notice of Ownership or Financial Interests. Group shall notify Plan of any ownership or other financial interest that it or its Group Physicians may have or acquire, now or in the future, in any other health care provider. Where such an interest exists, Group and Group Physicians further agree to abide by any guidelines established by Plan and/or federal or state regulations regarding referrals between Group or Group Physicians and that health care provider.

(v) Grievances. Group agrees to cooperate in resolving all grievances relating to the provision of medical services to Members in accordance with the grievance procedures established by Plan. In the event Group receives any complaint regarding Plan, Payor or a Group Physician, Group agrees to promptly notify Plan concerning all details of such complaint. Conversely, if Plan directly receives a complaint regarding Group, Plan will promptly notify Group of such complaint.

(w) Regulatory Compliance. Group and each Group Physician will comply with all requirements of the law relating to the furnishing of medical and health care services to the public, and now has and will obtain and maintain in effect all permits, licenses and governmental or board approvals which may from time to time be necessary for that purpose.

(x) Orientation. Upon request, Group will provide orientation time to Plan and assist in coordination of in-service training for Group's staff and Group Physicians.

(y) Transfer of Member. Upon the effective date of termination of this Agreement or upon the transfer of a Member to another Group, at the request of Plan, Group will, at its own expense, copy all medical files of Member and forward such files to the succeeding provider of Covered Services.

(z) Application and Credentialing Forms. Group and each Group Physician will complete application and credentialing forms within ten (10) days of Agreement's execution by Group. Group and each Group Physician will notify Plan within ten (10) days of any changes.

(aa) Medical Records and Confidentiality Procedures. Group and each Group Physician agree to comply with Plan's medical records procedure, to treat Member records as confidential and to comply with all federal and state confidentiality laws. Subject to confidentiality requirements, Group and each Group Physician agree to provide for a system, to the extent feasible, for the sharing of medical records with other treating providers. Group and each Group Physician agree, subject to confidentiality requirements, to make medical records available upon request with reasonable notification by Plan, or governmental regulatory authority

to determine that the content and quality are acceptable, as well as for peer review or grievance review.

(bb) Compliance with Payors' Programs and Requirements. Group and each Group Physician will cooperate and comply with Payors' Utilization Management Programs, Quality Assurance Programs, Credentialing Programs, grievance procedures, notification requirements, billing requirements, medical records and confidentiality requirements, and any other programs, processes and standards as required under federal and state laws and regulations, or the agreements between Plan and Payors.

(cc) Performance by Group Physicians. The Group either employs or has a duly executed contract with each Group Physician so that each Group Physician is bound to perform its duties and discharge its obligations under this Agreement, and Group can, and shall, cause each Group Physician to perform its duties and discharge its obligations under this Agreement.

(dd) Transfer of Files. Upon request of Plan, Group at its own expense will copy all medical files of Members and forward such files to the succeeding provider of Covered Services.

7. UTILIZATION MANAGEMENT. All Covered Services furnished to Members will be subject to the procedures and guidelines of the Utilization Management Program attached as Exhibit VII. Such procedures and guidelines may be modified by Plan from time to time upon thirty (30) days written notice.

8. SELECTION AND TERMINATION OF PARTICIPATING PHYSICIAN.

(a) Initial Physician Designation. After consultation with Plan, Group will designate those physicians who are members of or are employed by Group and are authorized to act as Group Physicians and Primary Care Physicians hereunder. Such designation, if not already made, will be made in writing and attached to this Agreement as Exhibit I.

(b) Physician Selection and Termination. After consultation with Group, and subject to the provisions of applicable law, the Plan may make additional selections or terminate any Group Physician from participation in Plan's provider network within the initial term or thereafter, upon ninety (90) days written notice or, in the case of termination of this Agreement, at such earlier time as may be permitted under Section 2 hereof.

(c) Notification. Group will notify Plan at least sixty (60) days in advance of the effective date of any withdrawal or termination of a Group Physician. Group will notify Plan of the addition of a new Group Physician within ten (10) days after such addition.

(d) Transfer of Care. Upon the termination or withdrawal of a Group Physician, Group agrees to arrange for the transfer of all care and treatment of any affected Members including, but not limited to, identifying Members undergoing acute care and/or treatment and assuming responsibility for the transfer of care to another appropriate Group Physician.

9. COORDINATION OF BENEFITS AND SUBROGATION/RIGHT OF RECOVERY.

(a) Cooperation. Group will cooperate with Plan to identify any and all parties, other than Plan or Payor, which may be responsible for payment of, or reimbursement for, Covered Services, and for the purpose of coordinating benefits with other Payors.

(b) Coordination of Benefits. When a party other than Plan or Payor is identified as having primary responsibility for payment of or reimbursement for Covered Services under the Coordination of Benefits provision of a Member's Evidence of Coverage, Group will bill and make all reasonable efforts to collect from such party for the value of Covered Services.

(c) Subrogation/Right of Recovery. When a party other than Plan or Payor is identified as a party with respect to whom the Subrogation/Right of Recovery provision of a Member's Evidence of Coverage applies, Plan or Payor will be responsible for using its best efforts to obtain any and all recoveries allowable under such provision. After application of such recoveries to reimburse Plan or Payor for any and all amounts paid or payable by Plan or Payor with respect to the injury or illness giving rise to the recovery, Plan or Payor will pay the remaining amount, if any, to Group to compensate Group for the value of services rendered by Group with respect to the injury or illness giving rise to the recovery.

10. RIGHT TO AUDIT AND ACCESS INFORMATION.

(a) Member Records. Group and each Group Physician will prepare and maintain appropriate financial and medical records on Members in accordance with Plan policies, and federal and state law. Such records will be maintained in accordance with generally accepted medical, accounting and bookkeeping practices and will be maintained as may be necessary for compliance with the provisions of the Act.

(b) Inspection. Plan shall have the right to conduct medical, financial, and other audits, inspections and evaluations of Group's and Group Physician's records and facilities with respect to Covered Services provided to Members under this Agreement. Subject to any applicable legal restrictions, Group and each Group Physician agrees to allow inspection and duplication by Plan, by the State of Indiana Department of Insurance, and by any other properly identified governmental regulatory authority of all billing and other financial records and all

medical records maintained on Members under this Agreement. Plan will have access at all reasonable times upon demand to the books, records and papers of Group and each Group Physician relating to the health care services provided to Members, to the cost thereof, to payments received by Group and each Group Physician from Members (or from others on their behalf). Plan will protect the confidentiality of such records in accordance with applicable legal standards. Such inspection and duplication will occur during regular working hours upon receipt of three (3) days prior written notice from Plan. Plan and Group shall share all reasonable copying costs incurred by Group as a result of said record inspection and duplication. Group will notify Plan of any adverse report that results from an inspection by a governmental regulatory authority.

(c) Financial Statements. Upon request, Group will provide Plan copies of its quarterly financial statements inclusive of Group's balance sheet and statements of income and cash flows within forty-five (45) days of the end of each fiscal quarter. Also upon request, Group will provide Plan copies of its audited annual financial statements within ninety (90) days of the end of the Group's fiscal year. All financial statements will be prepared in accordance with generally accepted accounting principles and will be certified by Group's chief financial officer as accurately reflecting the financial condition of Group for the period.

(d) Record Retention. All records required to be maintained by Group and each Group Physician under this Agreement will be retained by Group and each Group Physician for at least five (5) years. The obligation under Sections 10(b) and 10(d) will not terminate upon the termination of this Agreement, whether by rescission or otherwise.

(e) Consent to Access Members' Medical Records. To the extent required by law, the party requesting access to a Member's medical records shall be required to furnish Group and/or Group Physician with an appropriate Member consent form in order to obtain access. Group and Group Physicians shall cooperate with Plan and/or governmental authorities in obtaining and maintaining the proper consent forms from Members.

11. INDEPENDENT CONTRACTOR. Group is an independent contractor relative to Plan or Payor. Nothing in this Agreement will be construed as, or be deemed to create, a relationship of employer and employee, or principal and agent, or any relationship other than that of independent parties contracting with each other solely for the purpose of carrying out the provisions of this Agreement. It is understood that each Group Physician will maintain a physician-patient relationship with Members and will be responsible to the Members for medical care and treatment. Neither Plan nor any Payors shall have or exercise any control or supervision over any professional aspect of Group or Group Physician's practice, including, but not limited to, the exercise of professional medical judgment by Group Physicians or other matters requiring professional medical skills,

training, experience, discretion and judgment, and the supervision, control and discretion of all persons assisting Group Physicians in rendering Covered Services.

12. LIABILITY INSURANCE.

(a) General Liability Coverage. In order to protect the other party, each party, at its sole cost and expense, will procure and maintain a policy of general liability insurance or maintain adequate resources to insure itself and its respective officers, agents and employees against any liability or claims or damages arising by reason of personal injuries or death occasioned directly or indirectly by such party or its officers, agents or employees in connection with the performance or nonperformance of such party's responsibilities under this Agreement.

(b) Professional Liability Coverage. Group or each of the Group Physicians individually will maintain professional liability insurance, with limits of at least one million dollars ($1,000,000) per occurrence and at least three million dollars ($3,000,000) in the aggregate covering Group and each of the Group Physicians.

(c) Third Party Liability. Nothing in this Agreement will be construed to make Plan, Group, or the Group Physicians, or their respective agents or representatives, liable to persons not parties hereto. Nor will anything herein be construed as, or be deemed to create, any rights or remedies in any third party, including, but not limited to, any Members or hospital. Notwithstanding the preceding, a contract between Plan and a Payor may, by its express terms, grant a Payor rights to enforce the terms of this Agreement and other third party beneficiary rights with respect to those Group Subscriber Contracts adopted, sponsored, maintained or administered by such Payor.

(d) Plan Professional Liability Coverage. Plan maintains professional liability insurance covering the utilization management function with current limits of ten million dollars ($10,000,000) per occurrence and ten million dollars ($10,000,000) in the aggregate.

13. INDEMNIFICATION. Each party will indemnify the other and hold the other harmless from and against any and all losses and liabilities (including reasonable attorneys' fees and related legal expenses) arising from any third party claim, action, cause of action, contest or dispute to the extent the losses or liabilities are the result of the indemnifying party's negligent or intentional act or omission. This provision shall survive the termination of this Agreement.

14. NON-EXCLUSIVITY. Nothing herein will be construed to restrict the rights of Group and Group Physicians or Plan to participate in other comparable provider plans, such as, but not limited to, preferred provider plans, health care maintenance organizations or other managed care systems. Nothing herein will be construed to restrict the rights of

Plan to enter into contracts or arrangements for services with any other health care provider serving any geographic area.

15. PROPRIETARY INFORMATION: TRADEMARKS.

(a) Plan's and Payor's Proprietary Information. All information and materials provided by Plan or Payor to Group remain proprietary to Plan or Payor, as the case may be, including, but not limited to, subscriber lists, contracts, fee schedules, the "Physician Group Handbook" and any other operations manuals. Neither Group nor the Group Physicians will disclose any of such information or materials or use them except as may be required to carry out their respective obligations hereunder. Group and Group Physicians will use best efforts to prevent unauthorized disclosure of all such information and materials.

(b) Trademarks. Neither Group nor Plan will use each other's trademarks, name or symbols without express written permission; provided however, that Group agrees that Plan and Payors may use the Group's and the Group Physician's name, office address, telephone number, specialty and factual description of practice in directories and other promotional materials.

(c) Group's Proprietary Information. All information and materials provided by Group to Plan will remain proprietary to Group, including, but not limited to, contracts, fee schedules, utilization management procedures and administrative procedures. Plan will not disclose any such information or materials or use them except as may be required to carry out its respective obligations hereunder. Plan will use best efforts to prevent unauthorized disclosure of all such information and materials.

(d) Non-Solicitation. Group and Group Physicians will not directly or indirectly solicit Plan's or Payor's Group Subscribers or Members during the term of this Agreement and for a period of twelve (12) months after the termination of this Agreement. Solicitation will mean any act or practice designed to encourage Plan's or Payor's Group Subscribers or Members to terminate their coverage with Plan.

16. GENERAL PROVISIONS.

(a) Scope of Agreement; Governing Law; Severability; Amendment; Waiver. This Agreement, together with all Exhibits attached hereto, constitute the entire Agreement between Plan and Group. It will be construed and governed in accordance with the Act. Any provision required to be in this Agreement by the Act will bind Plan and Group whether or not provided in this Agreement. Any provision herein inconsistent therewith will be of no effect and will be severable without affecting the validity or enforceability of the remaining provisions of this

Agreement. Except as otherwise specified herein, this Agreement may not be modified or amended except by mutual consent in writing by the duly authorized representatives of Plan and Group. Waiver of breach of any provision of this Agreement must be in writing and will not be deemed a waiver of any other breach of the same or a different provision.

(b) Replacement of Other Contracts. This Agreement supersedes any and all prior agreements, either oral or in writing, between Group and/or Group Physicians and Private Health Care Systems which were negotiated on behalf of Great-West Life & Annuity Insurance Company and/or The New England. Group and Group Physicians represent that they have taken all steps necessary to terminate such agreements and that such agreements have been terminated. Group and Group Physicians hereby agree to indemnify Plan and hold it harmless from and against any and all losses (including reasonable attorneys' fees and related legal expenses) arising from any claim, action, cause of action, contest or dispute brought by Private Health Care Systems, The New England or Great-West Life & Annuity Insurance Company against the Plan. This provision shall survive the termination of this Agreement.

(c) Assignment and Subcontracting. No assignment, subcontracting or delegation of the rights, duties or obligations of this Agreement will be made by either party (except for Group's delegation to Group Physicians of responsibility for providing Covered Services and except as otherwise specifically provided herein) without the express written approval of a duly authorized representative of the other party; provided, however, that Plan or Payor may assign any or all of its rights and obligations hereunder to an Affiliate.

(d) Arbitration. Any controversy or claim arising out of or relating to this Agreement, or the breach thereof, will be settled by arbitration in accordance with the Rules of the American Arbitration Association (Commercial Rules), and judgment upon the award rendered by the Arbitrator(s) may be entered in any court having jurisdiction thereof. In all cases submitted to arbitration, the parties agree to share equally the arbitration and administration fees, if any, unless otherwise assessed by the Arbitrator(s). Notwithstanding anything to the contrary in this Agreement, the initiation of any and all arbitration proceedings initiated pursuant to this Agreement will be approved by Group's risk carrier(s) prior to the initiation of said proceedings. If not so approved, within thirty (30) days of the demand or request for arbitration, this provision will be of no force and effect and either party may file an action in a court of competent jurisdiction to resolve the dispute. Any arbitration proceeding instituted under this Agreement shall be in Indianapolis, Indiana, and each party hereby waives any right of venue such party may have.

(e) Amendments. This Agreement is subject to the amendments as found in Exhibit V. The parties agree to comply with any and all provisions in Exhibit V, and further agree that, in the event of any conflict between the provisions in Exhibit V

and any provisions elsewhere in this Agreement, the provisions in Exhibit V will take precedence. All amendments required by the State of Indiana Department of Insurance will be deemed effective upon receipt by the Group from the Plan and incorporated into and made part of this Agreement without either party's execution. This Agreement may be amended by Plan at any time by giving thirty (30) days written notice to Group. Such notice shall be conclusive evidence of receipt and acceptance of the amendments, unless, within that period, Group provides written notice of its rejection of the amendments. In the event Group rejects the amendments within the thirty (30) day period described above, Plan shall have the right, exercisable at its option, to terminate this Agreement or to continue this Agreement in effect without such amendment. If such amendment does not become effective and this Agreement is continued, Group shall not be required to comply with such proposed amendment. Except as otherwise provided in this section, no amendment or modification will be effective unless made in writing and signed by both parties.

(f) Change in Law or Programs. In the event there is a change in federal or state laws, or regulations governing the delivery of medical care by physicians, such that the provision of any services or the payment of any compensation or benefits pursuant to this Agreement would violate applicable law, regulations, or governmental policy, or impose unreasonable burdens on either party not existing on the date of this Agreement, Plan and Group agree to negotiate in good faith to restructure their relationship to comply with any such change. If any such restructuring is not feasible, either party may terminate this Agreement upon written notice thereof, notwithstanding any other provision of this Agreement.

(g) Headings. The headings of the various sections of this Agreement are merely for convenience and do not, expressly or by implication, limit, define, or extend the terms of the sections to which they apply.

(h) Conditions Precedent to the Implementation of this Agreement. All provisions within this Agreement relating to the HMO product are contingent upon Plan receiving licensure from the Indiana Department of Insurance to operate as an HMO and conditioned upon provider's availability in the approved service area.

(i) Notices. Any notice required to be given pursuant to the terms and provisions of this Agreement will be in writing, postage prepaid, and will be sent by certified mail, return receipt requested, to Group at the following address:

Children's Community Physicians Association
2300 Children's Plaza, no. 49
Chicago, IL 60614-3394
Attn: Maureen Murphy

and directly to COMPANY at the following address:

One Health Plan Of Illinois, Inc.
6250 River Road,
Suite 6050
Rosemont, Illinois 60018
Attn: Director, Provider Relations

or at such other address as the parties may designate by written notice. Any such notice will be effective upon receipt at such address.

IN WITNESS WHEREOF, COMPANY and GROUP have executed this Agreement through their duly authorized representative as of the date last entered below.

COMPANY: **One Health Plan Of Illinois, Inc.**

By: _____

Print Name: Kevin Dorsey

Title: Vice President, Network Development & Provider Relations

Date: 9-1-00

By: _____

Print Name: Patrick Neary

Title: Director, Network Development & Provider Relations

Date: 9-1-00

GROUP: **Children's Community Physicians Association**

By: _____

Print Name: Jo T. Letwaitis

Title: Executive Director

Date: 5.11.00

EXHIBIT I

Designation of Participating Physicians

EXHIBIT II

Claim Submission and Payment

(a) Group Physician will submit claims for Covered Services within thirty (30) days after Covered Services were rendered in a manner and format prescribed by Plan and/or Payor. At Plan's request, Group may be required to submit claims electronically. If a timely submitted claim from Group Physician is not a Clean Claim, Plan shall so notify Group Physician and specify the missing information or documentation which Group must submit within thirty (30) days of receipt of notice from Plan.

(b) Plan will pay Group Physician as full compensation for any Covered Services provided to Members and for which Group Physician has properly and timely submitted a Clean Claim, the lesser of Group's usual and customary charge and Fee Schedule, as shown in Exhibit III, less any applicable deductibles, copayment or coinsurance specified in the Member's Group Subscriber Contract. Group may bill Member for such deductibles, copayments or coinsurance but may not bill Member for any additional charges unless provided for in the Member's Group Subscriber Contract.

(c) Neither Plan nor Payor shall be liable for payment for: (1) any claim for Covered Services not submitted by Group Physician within thirty (30) days after the Covered Services were rendered; (2) any claim for Covered Services for which Group Physician fails to submit missing information or documentation within thirty (30) days after notice that the original claim was not a Clean Claim; (3) any claim for Covered Services for which Group failed to receive Primary Care Physician authorization as described in Exhibit IV of this Agreement; (4) any claim for services which are not Covered Services; or (5) any deductibles, coinsurance, copayments or charges required to be paid by a Member.

(d) Group shall be solely and exclusively responsible for compensating any Group Physicians or other Group Affiliates who provide Covered Services to Members under this Agreement, and shall indemnify and hold Plan and/or Payor harmless from any liability, cost or expense related to or arising from any claim for payment or other compensation by a Group Physician or other Group Affiliate made against Plan or Payor.

(e) When the Plan or Payor compensates another Contracting Provider on an all inclusive per diem, program or other fixed amount basis that makes such other Contracting Provider responsible for the payment of Covered Services rendered to a Member by Group, a Group Physician, or any Group Affiliate, Group Physician

shall look solely to such other Contracting Provider for payment and shall not be entitled to payment from Plan or Payor.

(f) When the Plan or Payor compensates the Group Physician on an all inclusive per diem, program or other fixed amount basis that makes the Group Physician responsible for the payment of Covered Services rendered to a Member by a Contracting Provider, the Contracting Provider shall look solely to the Group Physician for payment and shall not be entitled to payment from Plan or Payor and Group Physician shall indemnify and hold Plan and/or Payor harmless from any liability, cost or expense related to or arising from any claim for payment or other compensation by a Contracting Provider.

(g) Where Plan has contracted on behalf of an employee welfare benefit plan, that employee welfare benefit plan will be solely responsible for compensation payment under this paragraph.

(h) Plan shall have no obligation to pay Group Physician for Covered Services rendered pursuant to a particular Payor's Group Subscriber Contract upon that Payor's default in payments due to Plan. In such instance, Group Physician shall look solely to the Payor for payment for Covered Services.

EXHIBIT III

Fee Schedule

A representative sample of the Fee Schedule is attached and subject to amendment. In no event will Plan pay more than the lesser of the Fee Schedule or Contracting Provider's usual billed charges.

HMO FEE SCHEDULE:
Fee Schedule (including Immunizations and Radiology) is 135% of 1999, Chicago Locality 16, Resource Based Relative Value Scale (RBRVS). All laboratory services will be reimbursed at 110% of the 1999 RBRVS except as noted otherwise below. Anesthesia will be reimbursed at $35.00 per fifteen (15) increments. For services not included in RBRVS, Fee Schedule will be of 70% of billed charges.

POS FEE SCHEDULE:
Fee Schedule (including Immunizations and Radiology) is 135% of 1999, Chicago Locality 16, Resource Based Relative Value Scale (RBRVS). All laboratory services will be reimbursed at 110% of the 1999 RBRVS except as noted otherwise below. Anesthesia will be reimbursed at $35.00 per fifteen (15) increments. For services not included in RBRVS, Fee Schedule will be of 80% of billed charges.

PPO FEE SCHEDULE:
Fee Schedule (including Immunizations and Radiology) is 145% of 1999, Chicago Locality 16, Resource Based Relative Value Scale (RBRVS). All laboratory services will be reimbursed at 110% of the 1999 RBRVS except as otherwise noted below. Anesthesia will be reimbursed at $35.00 per fifteen (15) increments. For services not included in RBRVS, Fee Schedule will be the 90% of billed charges.

Immunization Exceptions:

CPT Code	HMO/POS Reimbursement	PPO Reimbursement
90669	$64	$67
90707	$29	$31
90712	$17	$17
90716	$47	$49
90720	$22	$23
90721	$25	$27
90733	$60	$63
90746	$42	$44

HMO/POS Lab Exceptions: CPT Codes 81000, 81002, 86588, 87081 will be reimbursed at 135% of 1999, Chicago Locality 16, RBRVS.

PPO Lab Exceptions: CPT Codes 81000, 81002, 86588, 87081 will be reimbursed at 145% of 1999, Chicago Locality 16, RBRVS.

EXHIBIT IV

Group Utilization Management

Utilization Review consists of pre-treatment and concurrent review of proposed treatment for maternity, medical, surgical, pediatric psychiatric, and chemical dependency cases. Pre-Certification for treatment (except Emergency procedures) is required in advance. Emergencies require authorization within twenty-four (24) hours or by the next regular working day.

The Utilization Review Process

1. The process is initiated by the admitting or Primary Care Physician or a representative of his/her office who calls the toll-free number listed on the Member's identification card for Pre-Certification. A registered nurse reviewer collects information during the call and certifies that the proposed treatment, location of service (inpatient or outpatient) and length of stay are medically appropriate.

   Cases that cannot be certified are referred to the Medical Review department for more in-depth review.

2. Emergency cases are defined as those cases determined by the Physician to have life threatening or catastrophic health consequences if the treatment plan is not initiated within a twenty-four (24) hour period. The Physician is required to call the Review Service within twenty-four (24) hours of admission or by the next working day in those circumstances.

3. If the reviewer and the Physician agree on the necessity, location and duration decisions, the case is certified.

4. For selected cases, the registered nurse review contacts the Physician by phone to verify that the Member will be discharged on the expected day and to encourage the Physician to call if a length of stay extension if it is needed.

5. If the physician fails to comply with the Utilization Management program or the Utilization Review process by (1) failing to call for Pre-Certification or (2) failing to obtain length of stay extension, then the non-compliance may result in loss of payment and/or imposition of sanctions against Group or Group Physicians.

Appeals Process:

1. If the proposed treatment is not certified and the Physician does not agree with the determination, the case is referred for physician review.

2. If the review physician and Physician cannot reach an agreement, the case is referred for a second review by a review physician of a relevant specialty. If the second

reviewer agrees with the proposed treatment, such treatment will be certified. If disagreement still exists, the case will be reviewed by Plan Medical Director.

3. If the Physician completes the entire Physician Appeals Process, and the Physician and Member agree after the Member has been fully informed by the Physician of the outcome of each stage of the Utilization Review and Physician Appeals Process, that they nonetheless wish to proceed with the service in question, Plan will normally waive the utilization review requirement, if the service is otherwise reimbursable under the terms of the Member's Benefit Contract.

EXHIBIT V

Amendments

The terms and conditions specified in the One Health Plan of Indiana, Inc. HMO/PPO/POS Medical Group Fee for Service Agreement with Group are further subject to the amendments put forth herein as Exhibit V.

Page 1, Paragraph 3. Delete "policies, plans or arrangements" and replace it with "Benefit Plans."

Page 1, Paragraph 5. Delete this section and replace it with the following: "WHEREAS, Group means the above-referenced Group, which is a partnership, association, corporation or other legally constituted entity organized to provide professional medical services which can bind its Group Physicians to the terms of this Agreement; and"

Secton 1 (d). DEFINITIONS. Delete this section and replace it with the following: "Clean Claim" means a request for payment for Covered Services submitted by GROUP or GROUP Physician, its assignees or subcontractors which is on a UB-92, or its successor, is complete and accurate, does not involve coordination of benefits, third party liability, or subrogation, and otherwise leaves no issues regarding COMPANY's or Payor's responsibility for payment.

Section 1 (k). Delete this section in its entirety.

Section 1 (o). Delete this section and replace it with the following: "Payor" means any entity or person, including employee welfare benefit plans, authorized by COMPANY to designate one or more of COMPANY's Contracted Providers and who has financial responsibility for payment of Covered Services.

Section 1 (q). Delete "Group" and replace it with "GROUP Physcian" throughout section.

Section 1. Add subsection (r) as follows: "Payor Agreements" means those agreements between COMPANY and Payors pursuant to which Payor has agreed to pay for covered services rendered to its Members by GROUP Physicians, including GROUP's participating providers."

Section 1. Add subsection (w) as follows: "Medically Necessary" means any medical or surgical treatment which is determined in accordance with the Utilization Management program agreed to in this Agreement to be:

(a) Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition of a Member:

(b) Provided for the diagnosis, direct care and treatment of the medical condition of a Member.

(c) Within standards of good medical practice within the community;

(d) Not primarily for the convenience of the Member, a physician, Hospital or other health care provider, and

(e) The most appropriate supply and level or service which can safely be provided.

Section 2 (a). TERM AND TERMINATION. Delete this section and replace it with the following: "Automatically and without notice upon the cancellation of GROUP's Director's and Officer's insurance maintained in accordance with Section 12(a) and individually, each Group Physicians professional

liability insurance maintained in accordance with Section 12(b); or upon GROUP's suspension by a State or the Federal Government from participation in the Medicare or Medicaid programs due to fraud or abuse."

Section 2 (b). Delete this section and replace it with the following: "Immediately upon thirty (30) days written notice from Plan if Plan determines, in its reasonable judgment, that Group's continued participation as a Contracting Provider may jeopardize the health or safety of Members."

Section 2 (h). Delete this section and replace it with the following: "Immediately upon thirty (30) days written notice from COMPANY or GROUP if either party makes or has made any untrue statements of material fact or any intentional misrepresentation of any fact, whether or not material, in any claim for payment, in any application form or Quality Assessment Questionnaire, or in any statement made by either party to the other party."

Section 2 (k). Delete this section and replace it with the following: " Immediately upon written notice if Group fails to comply with Section 6(m)."

Section 2. Add subsection (o) as follows: "Effect of Termination. Upon the expiration or termination of this Agreement for any reason, Providers shall, at COMPANY's request, continue to furnish Covered Services to any Member who is then under Provider's care until such time, not later than sixty (60) days from expiration or termination, that COMPANY is able to arrange for another Provider to furnish Covered Services to such Member. COMPANY or GROUP shall use its best efforts to arrange for substitute coverage so that Provider's post-termination services will not be required.

If a Member, under a Provider's care, is hospitalized on the date of expiration or termination of this Agreement, Provider will continue to provide care for such Member until they are discharged or until the 61st day after expiration or termination, whichever occurs first. COMPANY will review the possibility for provision of Covered Services rendered to Members after termination on a case by case basis. Providers will not be required to accept Members after termination of this Agreement. Provider will not be required to accept contracted rates after sixty (60) days from the termination of this Agreement."

Section 3. Change the title of this section from **GROUP COMPENSATION** to **GROUP PHYSICIAN COMPENSATION.** In the 1st sentence, delete "Medical Group" and replace it with "GROUP Physician".

Section 4. MODIFICATION OF AGREEMENT. Add the following to the end of this section: "COMPANY agrees that, changes in the rates of compensation accepted GROUP constitutes an amendment to this Agreement and shall not be effective except upon written notice to GROUP and written acceptance by GROUP."

Section 5 (d). Utilization Management Program. Add the following paragraph to the end of this section: "COMPANY/Payor will not retrospectively deny coverage for any pre-authorized services on the grounds that such services were not Medically Necessary, unless subsequent review of the medical records disclose that (a) the clinical findings prior to authorization vary materially from the clinical findings presented to the COMPANY/Payor or (b) the treatment plan varied from the plan certified."

Section 5 (i). Member Identification. Add the following paragraph to the end of section (i), before subsection (i): "COMPANY or Payor shall furnish each Member with an identification card which clearly indicates: (1) the name and address of the COMPANY , Payor and employer; (2) type of product (HMO,

EPO, PPO, POS, etc.); and (3) a toll-free number for GROUP Physicians to use to determine and comply with any pre-certification, pre-authorization or other utilization management requirements; and (4) a toll-free number for GROUP Physicians to use to verify Member's coverage and eligibility for benefits; and (5) appropriate claims billing address and a toll-free number for GROUP Physicians to use for claims and billing inquiries and problems; and (6) co-payments, coinsurance, and deductibles."

Section 5 (i). Member Identification. Add subsection (ii) as follows: "COMPANY or Payor is responsible for communicating and educating the Member regarding insurance benefits. COMPANY OR Payor shall communicate to members the importance of presenting insurance card information prior to or at time of service."

Section 5. Add subsection (k) as follows: "Notification. COMPANY agrees to notify its Participating Payors, Members and COMPANY providers of this Agreement and to distribute material, when made available, to its Payors, Members and COMPANY providers about the services of GROUP. Nothing in this Agreement shall be construed as interfering with the freedom of choice of eligible Members."

Section 5. Add subsection (l) as follows: "Authorization. COMPANY represents and warrants that it is authorized to execute this Agreement on behalf of each Payor, COMPANY or Payor Agreement (as applicable), and each Payor, COMPANY or Payor Agreement hereby agrees to the terms of this Agreement."

Section 5. Add subsection (m) as follows: "Licensure. COMPANY represents and warrants that it is duly licensed by the Indiana Department of Insurance and/or by other appropriate regulatory or governmental agencies, covering the provision of medical and health care services."

Section 5. Add subsection (n) as follows: "ERISA. In the event a PLAN, Payor or Payor Agreement is regulated under the Employee Retirement Income Security Act of 1974 ("ERISA") or state legislation of a similar nature, PLAN, Payor and Payor Agreement and not GROUP shall be responsible for complying with all requirements of ERISA and/or such state legislation. GROUP shall reasonably cooperate with PLAN, Payor or Payor Agreement by furnishing such material or information as it has access to and control of to aid PLAN, Payor or Payor Agreement in meeting statutory and regulatory reporting requirements. For the purposes of ERISA and any applicable state legislation of a similar nature, neither GROUP nor any of its Participating Providers shall be designated or deemed to be an administrator or named fiduciary of the Benefit Plan offered by PLAN, Payor or Payor Agreement."

Section 5. Add subsection (o) as follows: "Payor Agreements. COMPANY represents and warrants to GROUP that the COMPANY, or any claims paying organization with which it is affiliated by ownership or contract, or any Payor (or agent of Payor) shall abide by the applicable provisions of this Agreement. COMPANY agrees to provide written notification to GROUP and Participating Providers identifying Payors (and their respective Beneficiary identification cards) as participants in the Plan at least thirty (30) days prior to effective date of this Agreement. COMPANY agrees to notify GROUP and Group Physicians of any changes to Payor listing or material changes in Payor's Benefit Plan within thirty (30) days of changes thereof. Upon request, COMPANY agrees to provide GROUP and Group Physicians written updated Payor listings as modifications occur."

Section 5. Add subsection (p) as follows: "Notice of Impairment of COMPANY. As soon as it receives notice thereof, COMPANY will send written notice to GROUP of any action undertaken with respect to COMPANY or any PAYOR, which action could materially impair the ability of COMPANY or PAYOR to carry out the duties and obligations of this Agreement, including but not limited to actions related to:

(1) cancellation of COMPANY's license and insurance maintained in accordance with this agreement (2) COMPANY's suspension from participation in any Medicare or Medicaid program due to fraud or abuse; or (3) upon the indictment, arrest or conviction of any COMPANY staff for any felony which would inhibit COMPANY's ability to abide by the terms of this Agreement."

Section 5. Add subsection (q) as follows: "Medical Records. No GROUP Physician shall be required to release information from, or permit inspection or copying of, a Member's medical record unless Participating provider is first presented with a properly executed authorization or certified copy thereof consenting to the release of such information and records. If Medical Records are requested by COMPANY or Payor, COMPANY or Payor shall pay GROUP Physician as compensation, twenty-five (25) cents per page, not to exceed $20.00."

Section 5. Add subsection (r) as follows: "Changes in Status. COMPANY will enforce the terms of this Agreement and COMPANY agrees to actively monitor Payors (or any agents of Payor) for compliance with the terms of this Agreement. COMPANY shall notify GROUP as soon as possible, but within fifteen (15) working days of any legal, financial or government action, other problem or situation which may impair the ability of the COMPANY to carry out its obligation and duties under this Agreement, including but not limited to: (1) Changes in ownership or equity partnerships, (2) Changes or notification of possible changes in licensure, NCQA or similar accreditation, or HCFA or similar certification; (3) Financial solvency of Plan or of the individual products offered by Plan or Payors; (4) New product development from Plan; and (5) Employee strikes or walkouts or damage to the physical plant resulting in any interruption of Plan's service."

Section 5. Add subsection (s) as follows: "Automatic Down Coding. COMPANY or Payor (or any agent of Payor) will follow generally accepted Medicare coding practices and will not inappropriately down code."

Section 5. PPO/POS only Add subsection (t) as follows: "Financial Incentives. COMPANY represents and warrants to GROUP that each Payor, Benefit Plan or Payor Agreement and Members have significant financial incentives to obtain Covered Services from Plan's providers (including GROUP Participating Providers) in preference to providers not participating in the Plan's network. Such incentives shall include, at a minimum:

(a) a limited number of Benefit Plan offerings to Beneficiaries;
(b) a twenty percent (20%) point increase in the Member's coinsurance obligations when Covered Services are obtained from non-PLAN providers; and
(c) a substantial increase in both the deductible and co-payment obligations of the Member when services are obtained from non-PLAN providers.

In the event a Member is covered under a Benefit Plan which does not provide for the above minimum benefit differentials, then COMPANY or Payor shall reimburse GROUP Participating Providers for 100% of billed charges as provided under each Benefit Plan, and the COMPANY or Payor or Members which are a party to such arrangements shall not be entitled to the negotiated rates provided herein."

Section 6 (d). RESPONSILITIES OF THE GROUP. Quality of Care. Delete the last sentence in its entirety.

Section 6 (h). Referrals Among GROUPs. Delete this section and replace it with the following: "GROUP Physicians will accept non-Emergency or specialty referrals from other medical GROUPs

participating with COMPANY and such other medical GROUP Physicians will be required to accept non-Emergency and specialty referrals from GROUP. Payment to GROUP Physicians will be at rates not to exceed those in the Fee Schedule as shown in Exhibit III."

Section 6 (m) (i). Collections from Members. Delete the last sentence and replace it with the following: "GROUP and GROUP Physicians shall have the right to bill Members directly and collect: (1) copayments, deductibles and/or coinsurance; (2) payment for any Covered Services delivered to Member after the expiration of that Member Benefits; (3) non-Covered Services; and (4) services for which the Member otherwise has agreed, to be financially responsible."

Section 6 (m) (ii). Collections from Members. Delete the 2nd sentence and replace with the following: "If COMPANY or Payor receives notice of any such charge, COMPANY or Payor may take appropriate action to remedy situation, including, without limitation, offsetting any such charge againsts amounts due to GROUP Physician. Upon confirmation by Physician that refund is due to Member, GROUP Physician agrees to refund such charge within time allowed herein. If, after time allowed, Group Physician has not refunded charges, Plan agrees to use best efforts to discuss with Group Physician the policies outlined herein. If no resolution is reached, Plan may immediately terminate Group Physician."

Section 6 (n). Sub-contracting. Delete the 2nd sentence in its entirety.

Section 6 (r). Compliance with Plan's Credentialing Program. Delete this section in its entirety. Refer to Exhibit VII.2.

Section 6 (s). Notice of Impairment of Group. In this section, delete "cancellation of Group's general and professional liability insurance" and replace it with "cancellation of Group's Directors and Officers insurance."

Section 6 (v). Grievances. In the 2nd sentence delete "agrees to promptly notify" and replace it with "agrees to use best efforts to promptly notify".

Section 6 (y). Transfer of Member. Delete "at its own expense" from this section.

Section 6 (y). Transfer of Member. Add the following to the end of this section: "COMPANY shall reimburse GROUP twenty-five (25) cents per copy not to exceed $20.00 for copying medical files."

Section 6 (z). Application and Credentialing Forms. Delete this section in its entirety. Refer to Exhibit VII.2.

Section 6 (bb). Compliance with Payors' Programs and Requirements. Add the following to the end of this section: "Group Physicians shall be notified by PLAN of any program changes thirty (30) days in advance."

Section 6 (dd). Transfer of Files. Delete "at its own expense" from this section.

Section 6 (dd). Transfer of Files. Add the following to the end of this section: "If requested by COMPANY, COMPANY shall reimburse GROUP twenty-five (25) cents per copy not to exceed $20.00 for transferring Member's medical files."

Section 8 (d). **SELECTION AND TERMINATION OF PARTICIPATING PHYSICIANS. Transfer of Care.** Delete "GROUP agrees" and replace it with "COMPANY and GROUP agree".

Section 9 (b). **COORDINATION OF BENEFITS AND SUBROGATION/RIGHT OF RECOVERY. Coordination of Benefits.** Add the following to the end of this section: "GROUP and its GROUP Physicians shall have no right or obligation to determine the relative payment or reimbursement obligations between COMPANY or a Payor and any third party. Although GROUP and its GROUP Physicians shall cooperate in the resolution of payment obligations, the effectuation of such resolution shall be the sole responsibility of PLAN and/or Payor. In the event COMPANY or a Payor is the primary Payor under applicable COB provisions with respect to any claim, COMPANY or Payor shall compensate GROUP Physician for the full amount due under this Agreement for such claim without reduction or offset for amounts which may be payable from another source."

Section 10 (b). **RIGHT TO AUDIT AND ACCESS INFORMATION. Inspection.** Add the following between the 4th and 5th sentence: "Such compensation shall be made at twenty-five (25) cents per page, not to exceed $20.00."

Section 10 (c). **Financial Statements.** Delete this section in its entirety.

Section 12 (a). **LIABILITY INSURANCE. General Liability Coverage.** Delete "general liability insurance" and replace it with "Directors and Officers insurance".

Section 12 (b) **Professional Liability Coverage.** Delete this section and replace it with the following: "Each of the Group Physicians individually will maintain professional liability insurance, with limits of at least one hundred thousand ($100,000) per occurrence and at least three hundred thousand dollars ($300,000) in the aggregate covering Group and each of the Group Physicians.

Section 16 (c) **GENERAL PROVISIONS. Assignment and Subcontracting.** Delete this section and replace it with the following: "No assignment, subcontracting or delegation of the rights, duties or obligations of this Agreement will be made by either party (except for the GROUP's delegation to GROUP Physicians of responsibility for providing Covered Services and except as otherwise specifically provided herein) without the express written approval of the other party."

Section 16 (e). **Amendments.** Delete the 4th sentence and replace it with the following: "This Agreement may be amended by either party at any time by giving sixty (60) days written notice to the other party."

Section 16 (e). **Amendments.** Delete the 5th sentence and replace it with the following: "Acceptance and/or rejection of any amendment must be make in writing."

EXHIBIT II (a). **CLAIM SUBMISSION AND PAYMENT.** In the 1st sentence, delete "thirty (30) days" and replace it with "forty-five (45) days".

EXHIBIT II (a). Add the following paragraph to the end of this section: "COMPANY or Payor shall pay all clean claims concerning health care services shall be paid within forty-five (45) days after receipt of the clean claim. If Plan fails to make payment within forty-five (45) days, Plan will pay usual billed charges. COMPANY or Payor must notify GROUP Physician of any known failure to provide sufficient documentation for a due proof of loss within thirty (30) days after receipt of the claim."

EXHIBIT II (b). Delete the last sentence and replace it with the following: "GROUP Physician may bill Member for such deductibles, copayments or coinsurance but may not bill Member for any additional charges unless provided for in the Member's Benefit Contract or otherwise provided in Exhibit VII Amendments, Section 6 (i) (iii)."

EXHIBIT II (d). Delete this section in its entirety.

Add the following Exhibit: "**EXHIBIT VII.1 CARRIERS/PAYORS"**

Add the following Exhibit: "**EXHIBIT VII.2 CREDENTIALING AND RECREDENTIALING DELEGATION AGREEMENT"**

COMPANY: **One Health Plan Of Illinois, Inc.**

By: _____

Print Name: Kevin Dorsey

Title: Vice President, Network Development & Provider Relations

Date: 9-1-00

By: _____

Print Name: Patrick Neary

Title: Director, Network Development & Provider Relations

Date: 8-24.00

GROUP: **Children's Community Physicians Association**

By: _____

Print Name: Jo T. Letwaitis

Title: Exeative Director

Date: 5.11.00

EXHIBIT VII.1
CARRIERS/PAYORS

Great-West Life & Annuity Insurance Company

New England Financial (formerly known as The New England Mutual Life Insurance Company)

ALTA (formerly AH&L, formerly Anthem Health & Life Insurance Company)

EXHIBIT VII.1
AMENDMENT

The POS Medical Group Agreement between **CHILDREN'S COMMUNITY PHYSICIANS ASSOCIATION** ("Group") and **ONE HEALTH PLAN OF ILLINOIS, INC.** ("Company") entered into as of the **1st day of June, 2002** (the "Effective Date") is hereby Amended as of the **1st day of July, 2002** as follows:

EXHIBIT III

Delete Exhibit III and replace with the attached Exhibit III.1.

IN WITNESS WHEREOF, Company and Group have executed this Amendment through their duly authorized representative as of the date last entered below.

COMPANY: **One Health Plan of Illinois, Inc.**

By: _____

Print Name: Kevin Dorsey

Title: Vice President, Network Development & Provider Relations

Date: 9-9-02

By: _____

Print Name: Patrick Neary

Title: Director, Network Development& Provider Relations

Date: 9-2002

GROUP: **Children's Community Physicians Association**

By: Teresa Chan

Print Name: TERESA CHAN

Title: Executive Director

Date: July 25, 2002

EXHIBIT III.1

Fee Schedule is the lesser of billed charges or 135% of the 2002 Region 16 RBRVS based fee schedule. All laboratory services will be reimbursed at the lessor of billed charges or 110% of the 2002 Region 16 RBRVS based fee schedule. Anesthesia will be reimbursed at $35.00 per fifteen (15) minute increments. For Services not included in RBRVS, Fee Schedule will be the lesser of 80% of billed charges or the COMPANY's usual and customary charges.

The following services will be paid as follows:

90647	$	30.00
90669	$	69.00
90700	$	33.00
90701	$	27.00
90702	$	25.00
90703	$	18.00
90705	$	28.00
90706	$	27.00
90707	$	48.00
90712	$	30.00
90713	$	39.00
90716	$	65.00
90718	$	30.00
90720	$	47.00
90721	$	79.00
90723	$	20.00
90724	$	18.00
90732	$	30.00
90733	$	77.00
90737	$	71.00
90744	$	60.00
90746	$	60.00
90747	$	60.00
90748	$	50.00

EXHIBIT VII.3
AMENDMENT

The PPO Medical Group Agreement between **CHILDREN'S COMMUNITY PHYSIICANS ASSOCIATION** ("Group") and **GREAT-WEST HEALTHCARE OF ILLINOIS, INC.** (formerly known as ONE HEALTH PLAN OF ILLINOIS, INC.) ("Company") entered into as of the **1st day of June, 2000** (the "Effective Date") is hereby amended as of the **1st day of April 2005** as follows:

Delete Exhibit III.2 and replace with the attached Exhibit III.3.

IN WITNESS WHEREOF, Company and Group have executed this Amendment through their duly authorized representative as of the date last entered below.

COMPANY: **Great-West Healthcare of Illinois, Inc.**

By: Donald A. Franke

Print Name: Donald A. Franke

Title: President

Date: 4/19/05

GROUP: **Children's Community Physicians Associations**

By: Terry Chan Teresa Chan

Print Name: TERESA CHAN

Title: Executive Director

Date: April 4, 2005

EXHIBIT III.3
FEE SCHEDULE

Company or Payor will pay Group as full compensation for any Covered Services provided to Members and for which Group has submitted a properly submitted claim, (1) the lessor of Company's Current Fee Schedule, based on the 145% of 2005 adjusted Resource Based Relative Value Schedule (RBRVS) for Locality 16 or physician's billed charges; (2) the lessor of 110% of 2005 adjusted Resource Based Relative Value Schedule (RBRVS) or physician's billed charges for laboratory and pathology services; (3) the lessor of Company's Default Fee Schedule, when applicable, based upon 2005 RBRVS for Locality 16 or physician's billed charges; or (4) 20% discount off Physician's billed charges for codes not included in the fee schedule. Such compensation shall be reduced by any applicable copayments, coinsurance, or deductibles. Group may bill Member for such deductibles, copayments or coinsurance but may not bill Member for any additional charges unless provided for in the Member's Benefit Contract. Anesthesia will be reimbursed at $35.00 per fifteen (15) minute increments.

Codes falling outside the Fee Schedule shall be reimbursed at Company's default Fee Schedule in effect at the time services are rendered. Company utilizes nationally recognized coding structure including, but not limited to, AMA Current Procedural Terminology (CPT-4), CMS Common Procedure Coding System (HCPCS), ICD-9 Diagnosis and Procedure codes, National Drug Codes (NDC) and the American Society of Anesthesiologists (ASA) relative value for basic coding and description of services provided.

As annual changes are made to nationally recognized codes, Company shall update internal systems to accommodate the currents years RBRVS new codes effective July 1, 2005. Until updates are complete, the procedure will be paid according to the standards and coding set previously in effect.

All immunizations will be reimbursed at the AWP (Average Wholesale Price) for the region as determined by the Company with the following carve outs:

CPT Codes	Reimbursement Rates
90471	$ 15
90472	$ 8
90657	$ 10
90669	$ 89
90702	$ 25
90707	$ 57
90712	$ 30
90713	$ 39
90716	$ 82
90718	$ 30
90721	$ 79
90723	$ 94
90725	$ 17
90727	$ 19
90732	$ 30
90733	$ 83
90743	$ 62
90744	$ 62

90748	$ 65
90647	$30
90700	$33
90701	$27
90703	$18
90705	$28
90706	$27
90720	$47
90746	$60
90747	$60