CCPA's MASTER PAYOR AGREEMENT FOR PPO/EPO AND NON-CAPITATION ARRANGEMENTS

CONTRACT BETWEEN: **MCS Patient Centered National Healthcare Network**

PRODUCT: **PPO (national PPO network rental)**

EFFECTIVE DATE: **October 1, 1999 – December 31, 2000** (then, annual renewals)

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EXHIBITS

IPA-PLAN Agreement
For
PPO and FFS Managed Care Products
Between
Children's Community Physicians Association and PLAN

This agreement (the "Agreement") is effective as of **October 1, 1999** and is entered into between Children's Community Physicians Association ("CCPA") a for-profit Independent Physician Association located in Chicago, Illinois, **MCS Patient Centered National Healthcare Network**, a Florida-based PPO network rental corporation ("PLAN").

WITNESSETH:

WHEREAS, CCPA arranges for the provision of health services through a network of health care providers which includes physicians, ancillary providers, and certain Allied Health Practitioners in Illinois;

WHEREAS, PLAN is a duly licensed insurance company or is an employer or an organization which is in the business of marketing and arranging for and coordinating the provision of health care services to participants of health benefit plans ("Beneficiaries") sponsored and underwritten by employers, insurers, health maintenance organizations, and other parties to payor agreements with PLAN.

WHEREAS, PLAN and CCPA desire to enter into this Agreement so that CCPA's network of health care providers will be available to render their respective health care services to Beneficiaries in PLAN's PPO products, Beneficiaries of other PPOs with which PLAN is or may become affiliated, and Beneficiaries of other PPO arrangements which PLAN may administer on behalf of self-insured employers;

NOW, THEREFORE, for and in consideration of the mutual covenants and conditions hereinafter contained and for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged by the parties hereto upon the execution of this Agreement, the parties hereby agree as follows:

Article 1
Definitions

Section 1.1 Certain Defined Terms. When used in this Agreement and any attachment hereto, the following capitalized words and phrases shall have the following meanings assigned to them:

(a) **"Allied Health Practitioner"** means those providers who are skilled members of the health care team who are qualified by academic and clinical education to provide patient services those providers who are skilled members of the health care team who are qualified by academic and clinical education to provide patient services under the supervision or in collaboration with Participating Providers. Allied Health Practitioners may include optometrists, chiropractors, physician assistants, nurse practitioners, certified nurse midwives, clinical psychologists, social workers, master's prepared counselors, and psychiatric nurses.

(b) **"Benefit Plan"** means, when used with respect to a particular Payor, a Payor's group insurance policy, self-funded benefit plan, or other written documents which set forth the eligibility criteria for Beneficiaries and the health care benefits that Beneficiaries are entitled to receive.

(c) **"Beneficiaries"** means, when used with respect to a particular Payor Agreement, all individuals who are eligible under the terms of the Benefit Plan for coverage and designated by Payor as covered and entitled to benefits for Covered Services under the Benefit Plan, and "Beneficiary" means any one of such beneficiaries.

(d) **"Clean Claim"** means a claim electronic or manual if accurate and complete in accordance with billing forms UB-92 and HCFA 1500, and after beneficiary has been properly identified.

(e) **"Covered Services"** means, when used with respect to a particular Payor, those Health Care Services and supplies received by Beneficiaries for which a Payor is obligated to pay pursuant to the terms of a Benefit Plan as then in effect.

(f) **"Health Care Services"** means those inpatient (including ancillary), outpatient and emergency hospital services and other medical services provided by Participating Providers.

(g) **"Medically Necessary"** means, with respect to each Beneficiary, services or supplies which, under the terms and conditions of this Agreement are determined through utilization review to be:

(i) Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition of the beneficiary;

(ii) Provided for the diagnosis or direct care and treatment of the medical condition of the Beneficiary;

(iii) Within standards of good medical practice within the community in which services are provided;

(iv) Not primarily for the convenience of the Beneficiary, the Beneficiary's physician or other provider; and

(v) The most appropriate supply or level of service or supplies which can safely be provided, which, in the case of Health Care Services, means that care as an inpatient is necessary due to the kind of services the Beneficiary is receiving or the severity of the beneficiary's condition, and that the Beneficiary's medical condition is such that it cannot be treated safely in an outpatient or less intensified medical setting.

(h) **"Participating Providers"** means those physicians and other health care service providers with whom or which CCPA has contracted for the provision of their respective health care services and who or which are identified on Exhibit A hereto, as supplemented and amended from time to time by CCPA as provided herein. Certain Participating Providers may also be referred to as "Participating Physician" or "participating Hospital" as the context may require.

(i) **"Participating Provider Agreement"** means the CCPA Provider Master Agreement and the CCPA Product Description for provider services.

(j) **"Payor"** means an employer, insurance company, association, trust fund, health maintenance organization, government entity, or competitive medical plan that provides health benefits pursuant to one or more Benefit Plans and with whom (or on whose behalf) PLAN has entered into a Payor Agreement.

(k) **"Payor Agreements"** means those agreements between PLAN and Payors pursuant to which Payor has agreed to pay for Covered Services rendered to its Beneficiaries by PLAN providers, including CCPA Participating Providers.

(l) **"Payor Effective Date"** means, with respect to a particular Payor Agreement, the date mutually agreed to by the parties hereto as the date on which Beneficiaries may have access to services provided by Participating Providers.

(m) **"Physician Provider"** means a Participating Provider who is a licensed physician.

(n) **"PLAN" or "Product Description"** means a written description, approved by CCPA and incorporated by reference herein, of a fee-for-service, prepaid or capitated product which is offered and financed by a Payor. The Product Descriptions include terms and conditions under which Participating Providers shall provide Covered Services to Beneficiaries enrolled in that Product.

(o) **"Utilization Review"** means a program to review the necessity, appropriateness and/or quality of Covered Services rendered to Beneficiaries pursuant to this Agreement.

Section 1.2 **References.** All references in this Agreement to "Sections" or "Articles" shall be to sections or articles of this Agreement unless otherwise noted. The words "hereof", "herein", "hereby", "hereinafter", "heretofore", "hereunder", and words of similar import also shall refer to material set forth in this Agreement as a whole and not to any particular subdivision unless expressly so limited.

Article 2
Term and Termination

Section 2.1 **Initial Term.** The initial term ("Initial Term") of this agreement shall be for a fourteen (14) month period commencing on the Effective Date specified in Section 7.14.

Section 2.2 **Renewal Term(s).** This Agreement shall automatically renew for successive one (1) year terms ("Renewal Terms"), unless either party gives written notice of non-renewal to the other party at least ninety (90) days prior to any anniversary of the Effective Date. Collectively, the Initial Term and any Renewal Terms will be referred to herein as the "Term" of this Agreement. If this Agreement is not renegotiated by the anniversary of the Effective Date, the Agreement will continue under the existing rates and terms.

Section 2.3 **Early Termination.** Notwithstanding Sections 2.1 and 2.2 above, the parties agree that:

(a) Either party may terminate this Agreement with or without cause at any time upon ninety- (90) days' prior written notice to the other party.

(b) Either party may terminate this Agreement effective upon notice in the event that the other party files or becomes subject to a petition in bankruptcy, becomes insolvent or is otherwise unable to pay its debts as they mature.

(c) Either party may terminate this Agreement for cause due to a material breach by giving thirty (30) days advance written notice. The notice of termination for cause shall not be effective if the breaching party cures the breach to the satisfaction of the other party within the thirty- (30) day notice period.

Section 2.4 **Effect of Termination.** Upon the expiration or termination of this Agreement for any reason, Participating Providers shall, at Payor's request, continue to furnish Covered Services to any Beneficiary who is then under Participating Provider's care until such time, not later than sixty (60) days from expiration or termination, that Payor is able to arrange for another Participating Provider to furnish Covered Services to such Beneficiary. Payor or CCPA shall use its best efforts to arrange for substitute coverage so that Participating Provider's post-termination services will not be required.

If a Beneficiary, under a Participating Provider's care, is hospitalized on the date of expiration or termination, Participating Provider will continue to provide care for such Beneficiary until they are discharged or until the 61st day after expiration or termination, whichever occurs first. If a Beneficiary is receiving ongoing ambulatory treatment, CCPA will require Participating Provider to promptly notify Beneficiary that this Agreement has expired or been terminated. Participating Providers shall be compensated at the then-effective rates for Covered Services rendered to Beneficiaries, even if Beneficiary is discharged after the sixty-(60) day period. Reimbursement for Covered Services rendered to Beneficiaries after termination will be 100% of billed charges. Participating Providers will not be required to accept Beneficiaries after termination of this Agreement.

CCPA agrees that upon such expiration or termination it shall use reasonable efforts to ensure that Participating Providers inform Beneficiaries who subsequently seek to receive Covered Services from Participating Providers that such Participating Providers are no longer providing services to Beneficiaries in connection with this Agreement. However, neither this Section nor the fact of the expiration or termination of this Agreement shall be construed to bar CCPA Participating Providers from continuing to maintain professional relationships with persons who are Beneficiaries as such persons may request, to bill such persons for services rendered subsequent to the expiration or termination of this Agreement, or to collect payment from such

persons for such services. Termination of this Agreement shall not affect the rights, duties and obligations of the parties arising out of transactions occurring prior to the effective date of termination.

Article 3
Relationship Between CCPA and PLAN

Section 3.1 **Scope of Agreement.** It is understood and agreed that all Benefit Plans are and shall be group health benefit plans of the type commonly referred to as "preferred provider organization" plans. PLAN shall advise CCPA of the identity of each Payor and Benefit Plan to which this Agreement pertains at least thirty (30) days prior to the Payor Effective Date and (if not prohibited by law or contract) shall use its best efforts to inform CCPA of the identity of prospective Payors which are likely to be of significance to CCPA.

Section 3.2 **Independent Contractors.** It is understood that Participating Providers shall be responsible to Beneficiaries for medical care and treatment and PLAN does not direct Participating Providers' acts and decisions in connection therewith. PLAN is an entity independent from CCPA and Participating Providers. Nothing in this Agreement shall be construed or deemed to create a relationship of employer and employee, or principal and agent, joint ventures, or partners between PLAN and CCPA and/or Participating Providers or any relationship other than that of independent parties contracting with each other solely for the purposes of carrying out the provisions of this Agreement.

Section 3.3 **Remedies and Obligations.** Nothing in this Agreement shall be construed or deemed to create any right or remedies in any third party. Neither party shall have any express or implied right or authority to assume or create any obligation or responsibility on behalf or in the name of the other party, except as set forth herein.

Article 4
Representations, Warranties and Responsibilities of CCPA

Section 4.1 **Authorization.** CCPA hereby represents and warrants that its duly authorized representative has executed this Agreement. CCPA represents and warrants that each Participating Provider listed on Exhibit A from time to time has a contract with CCPA (a "Participating Provider Agreement" which consists of a Provider Master Agreement plus related Product Descriptions for provider services) and that such Participating Provider Agreement does not conflict in any material way with the provisions of this Agreement. CCPA agrees to provide copies of its Participating Provider Agreements to PLAN on request.

Section 4.2 **Amendments of Participating Provider Agreements.** CCPA shall give PLAN timely notice of all material amendments, modifications or supplementation of its Participating Provider Agreements, and CCPA shall not amend, modify or supplement the terms or provisions of its Participating Provider Agreements in any manner that would or could be expected to conflict with the terms of this Agreement without the specific written consent of PLAN to the furnishing of medical and health care services to the public. CCPA represents and warrants that it is in good standing under applicable laws and regulations governing its existence and operation (including antitrust laws), and will maintain in effect all permits, licenses and governmental approvals which may from time to time be necessary for furnishing medical services to Beneficiaries.

Section 4.3 **Provision of Medical Services.** CCPA and each Participating Provider shall provide medical and health care services set forth from time to time as Covered Services in the Benefit Plans for this product which are Medically Necessary, are within the type Participating Provider's field of practice, and are services of the type which Participating Provider customarily provides to other patients.

CCPA and Participating Providers shall be responsible for the provision of medical and health care services pursuant to the Benefit Plans, including any clinical decisions regarding the admission, treatment or discharge of a Beneficiary under Participating Provider's care, provided pursuant to this Agreement. CCPA and Participating Providers agree not to discriminate in the provision of such services to Beneficiaries due to the Beneficiary's race, color, national origin, ancestry, disability, religion, health status, sex, marital status, age or source of payment. *The preceding sentence shall not limit a Participating Provider's ability to restrict the scope of his/her practice based on specialization, nor shall it be interpreted to require any Participating provider to provide or participate in the provision of services that he/she in good faith finds to be in violation of his/her professional medical standards.*

Section 4.4 **Compliance and Participation.** Prior to the date any Beneficiary is to receive Covered Services from a Participating Provider, CCPA shall cause the Participating Provider to agree to use best efforts to cooperate and comply with (subject to applicable laws) the written policies, procedure and guidelines adopted by the PLAN for use in connection with its Payor Agreements including written policies and procedures for utilization review, quality assurance, coordination of benefits, maintenance of records, and billing and payment of charges for Covered Services rendered by Participating Providers; provided that:

(a) PLAN has provided such written policies, procedures and guidelines to CCPA at least thirty (30) days prior to the effective date hereof; and

(b) PLAN's written policies, procedures and guidelines are compatible with the terms of this Agreement (where this Agreement supersedes the PLAN's policies, procedures and guidelines); and

(c) PLAN shall provide written changes made to such policies, procedures and guidelines to CCPA at least thirty (30) days prior to the effective date thereof.

Section 4.5 **Provider Credentialing.** CCPA (or its designated vendor) shall maintain an organized program for the credentialing of Participating Providers. With respect to each person or entity who is or will be a Participating Provider hereunder, CCPA agrees at its sole expense, to perform a credentialing review where Participating Providers will satisfy minimum participation criteria.

Section 4.6 **Re-Credentialing.** CCPA (or its designated vendor) shall re-credential each Participating Provider not less than every two- (2) years. CCPA (or its designated vendor) shall maintain an organized program for the re-credentialing of Participating Providers where such Participating Providers will satisfy minimum re-credentialing criteria.

Section 4.7 **Roster of Participating Providers.** CCPA authorizes PLAN to include Participating Provider's name, address, telephone number, specialties, medical and other educational information, hospital or health facility affiliations, and other similar information in PLAN's roster of Participating Providers.

Prior to the effective date of this Agreement, CCPA shall provide PLAN with a complete roster of Participating Providers for this product and thereafter, from time to time, CCPA shall notify PLAN within fifteen (15) working days of any addition or subtraction to the roster.

Section 4.8 **Data to be Furnished to PLAN by CCPA.** CCPA shall provide the following information to PLAN:

(a) CCPA Federal Employer Identification Number;

(b) CCPA Provider Participation Agreements (Provider Master Agreement and applicable Product Description);

(c) CCPA's credentialing policies and procedures; and minimum participation criteria by type of provider;

(d) CCPA's re-credentialing policies and procedures, and minimum re-credentialing criteria;

(e) A list of CCPA's Participating Providers showing:

- Full or legal name of provider
- Taxpayer Identification Number
- Office/service address(es)
- Office/service telephone number(s)
- Billing address
- Telephone number
- Primary specialty
- Secondary specialty(ies)
- Medical degree or designation

Changes to the above shall be provided in a timely manner, but not more than thirty (30) days after any changes. CCPA must notify PLAN within fifteen (15) working days of any addition or subtraction to the roster of Participating Providers.

Section 4.9 Changes in the Status of Participating Provider.

(a) CCPA agrees to actively monitor Participating Providers during the Term of this Agreement and to ensure that each Participating Provider continues to meet the minimum participation criteria and shall notify PLAN as soon as possible but, in any event, within fifteen (15) business days of any event which has caused, or will cause but for the passage of time, a Participating Provider to no longer meet such minimum participation criteria, including (without limitation) any change in a Participating Provider's medical staff privileges, licensure, insurance, certification, accreditation, malpractice or disciplinary status, or physical or mental health status. To the extent permitted by law and to the extent such information is not privileged, protected from discovery, or subject to a contractual or judicial prohibition on disclosure, upon receipt of such notice, PLAN shall have the right to request additional information as it deems necessary which CCPA will provide or cause Participating Provider to furnish promptly.

(b) Upon review of the information, PLAN will advise CCPA whether it believes the Participating Provider's participation in the arrangement covered by this Agreement should be restricted or suspended. CCPA shall initiate appropriate action with regard to such Participating Provider in accordance with its Operation Agreement, and PLAN shall have a right to be heard in any proceedings with respect to the rendering of Covered Services to Beneficiaries. In the event that CCPA and PLAN disagree as to the action to be taken in regard to such Participating Provider, the matter shall be submitted within five (5) days to a committee of two representatives from each party. If such committee concludes that it is unable to resolve the matter, this Agreement shall terminate thirty (30) days thereafter.

(c) CCPA warrants to PLAN that, during the term of this Agreement it will vigorously enforce those sections of its Operating Agreement and Provider Participation Agreements that provide for immediate suspension or termination (upon notice) in case of any of the following:

- A suspension or revocation of the Participating Provider's license, certificate or other legal credential authorizing Participating Provider to provide health services;

- Revocation of privileges at a participating Hospital (excluding temporary suspension for failure to complete medical records on a timely basis), to the extent that such privileges are a criterion of Participating Provider's participation in this Agreement;

- An indictment, arrest or conviction of a felony or for any criminal charge related to the rendering of health services;

- The cancellation or termination of the professional liability insurance required by this Agreement without replacement coverage having been obtained;

- When CCPA otherwise determines that immediate termination is in the best interests of the Beneficiaries. Action taken here shall be solely and exclusively because of actions based on inappropriate or excessive uses of medical or health services, substandard medical or health care or any other activity which would be construed to not be in the best interest of Beneficiaries.

CCPA shall promptly notify PLAN of any proposal to amend such sections in any material way.

(d) In the event of the occurrence of a termination of a Participating Provider as provided for in this Section 4.9, CCPA shall promptly notify the terminated Participating Provider of such termination and cooperate with PLAN in the removal of the Participating Provider's name from the current roster of Participating Providers for purposes of this Agreement.

Section 4.10 **Disciplinary Action.** CCPA shall notify PLAN in writing as soon as possible, but in any event within fifteen (15) business days, after becoming aware of any of the following with respect to a Physician Provider who is a Participating Provider:

(a) Any disciplinary proceedings against the Physician Provider of sufficient gravity to warrant formal investigation by the appropriate state licensing board, DEA or other government regulatory agency;

(b) Any civil complaints brought against the Physician Provider as a result of the Physician Provider's medical practice; or

(c) Any criminal charges filed against the Physician Provider for any reason.

CCPA's failure to notify PLAN of such occurrences in accordance with this Section 4.10 shall constitute grounds for termination of this Agreement by PLAN upon thirty (30) days written notice to CCPA.

Section 4.11 **Coverage Verification and Recoveries from Third Parties.** Except in emergency situations, prior to providing services to any patient who presents himself/herself as a Beneficiary, Participating Provider shall verify a Beneficiary's coverage with the PLAN according to information printed on Beneficiary's identification card or as required by the applicable Product Description.

Participating Provider agrees to cooperate with PLAN or Payor in verification of a Beneficiary's eligibility and benefits coverage, but PLAN or Payor shall agree to no retroactive denials of benefits coverage once PLAN or Payor has verified and approved Beneficiary's benefits coverage to Participating Provider's office at the time of service. Once benefits coverage has been verified and approved by PLAN or Payor, such provider services are deemed to be Covered Services.

Participating Provider shall cooperate with the PLAN or Payor in determining if the Beneficiary's illness is covered by other health insurance or otherwise gives rise to a claim by a PLAN or Payor by virtue of coordination of benefits or subrogation. Participating Provider agrees to assist the PLAN or Payor in obtaining recoveries from third parties, including executing any and all documents that reasonably may be required to enable PLAN or Payor to bill and/or collect payments from any third parties or assigning payments to PLAN or Payor; however, Participating Provider will be compensated, as required, at market rates for costs incurred in rendering such assistance.

While Participating Provider agrees to cooperate with PLAN or Payor in recovery efforts, PLAN or Payor agrees that recovery of payments from either Participating Provider or Beneficiary shall be limited to six (6) months after the date of claims submission from Participating Provider. If after six (6) months it is revealed that a payment was made erroneously for any reason, Payor shall be liable for such fee(s) rather than Beneficiary or Participating Provider.

Section 4.12 **Insurance.**

(a) CCPA shall maintain an appropriate policy of insurance coverage for services to be performed hereunder.

(b) Each Participating Provider in CCPA shall, throughout the term of this Agreement, procure and maintain such policies of comprehensive general liability, professional liability and other insurance necessary to insure the Participating Provider against any claim or claims for damages arising out of personal injuries or death occasioned directly or indirectly in connection with the provision of services pursuant to this Agreement.

The minimum required professional liability insurance coverage shall be $1,000,000 per claim and $3,000,000 per annual aggregate for physicians or minimum requirement for other states including Indiana. Other providers are required to carry minimum professional liability coverage in the amounts required by CCPA, or in the minimum amounts required by law, whichever is higher. In the absence of CCPA or statutory requirement, no less than $1,000,000 per claim and $3,000,000 per annual aggregate will be required.

Participating Providers are required to notify CCPA of any material adverse change in professional liability coverage within ten (10) working days of receiving notice of such charge. CCPA shall notify PLAN as soon as possible but within fifteen (15) working days of any adverse change in professional liability coverage for Participating Providers.

Article 5
Representations, Warranties and Responsibilities of PLAN

Section 5.1 **Notification.** PLAN agrees to notify its Participating Payors, Beneficiaries and PLAN providers of this Agreement and to distribute material, when made available, to its Payors, Beneficiaries and PLAN providers about the services of CCPA. Nothing in this Agreement shall be construed as interfering with the freedom of choice of eligible Beneficiaries.

Section 5.2 **Authorization.** PLAN represents and warrants that it is authorized to execute this Agreement on behalf of each Payor, PLAN or Payor Agreement (as applicable), and each Payor, PLAN or Payor Agreement hereby agrees to the terms of this Agreement.

Section 5.3 **Licensure.** PLAN represents and warrants that it is duly licensed by the Illinois and Indiana Department of Insurance and/or by other appropriate regulatory or governmental agencies, covering the provision of medical and health care services.

Section 5.4 **Insurance.** PLAN represents and warrants that it procures and maintains such policies of stop-loss coverage, comprehensive general liability, professional liability and other insurance necessary to protect PLAN from catastrophic losses and against any claim(s) for damages arising out of personal injuries or death occasioned directly or indirectly in connection with the provision of services in this Agreement.

Section 5.5 **Financial Stability.** PLAN represents and warrants that PLAN and each Payor (and any agent of Payor) is financially stable. PLAN agrees to provide historical and current pro-forma financial statements and Department of Insurance financial statements and historical medical loss ratios.

Section 5.6 **Insolvency.** PLAN represents and warrants that neither CCPA nor any Participating Provider shall be financially responsible for the provision of services to Beneficiaries should the PLAN or Payor fail. PLAN agrees that if the PLAN fails, then CCPA and Participating Providers will not be held to the terms of its agreement with insolvent PLAN or Payor. PLAN agrees to provide all necessary documentation and allows CCPA and Participating Provider to conduct a financial due diligence of PLAN or Payor.

Section 5.7 **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 CCPA shall be responsible for complying with all requirements of ERISA and/or such state legislation. CCPA 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 CCPA 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 5.8 **Benefit Differential.** PLAN represents and warrants to CCPA that each Payor, Benefit Plan or Payor Agreement and Beneficiaries have significant financial incentives to obtain Covered Services from PLAN providers (including CCPA 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 ten to twenty percentage point increase in the Beneficiary's coinsurance obligations when Covered Services are obtained from non-PLAN providers; and

(c) a substantial increase in both the deductible and copayment obligations of the Beneficiary when services are obtained from non-PLAN providers.

Section 5.9 **Payor Agreements.** PLAN represents and warrants to CCPA that the PLAN, or any claims paying organization with which it is affiliated by ownership or contract, or any Payor (or agent of Payor) shall enter into Payor Agreements which obligate such parties to abide by the applicable provisions of this Agreement.

PLAN agrees to provide CCPA with necessary information relating to Payor Agreements upon request and to provide written notification to CCPA and Participating Providers identifying Payors (and their respective Beneficiary identification cards) as participants in PLAN at least thirty (30) days prior to effective date of this Agreement. PLAN agrees to notify CCPA and its Participating Providers of any changes to Payor listing or material changes in Payor's Benefit Plan within thirty (30) days of changes thereof. PLAN agrees to provide CCPA and its Participating Providers written updated Payor listings monthly or as such modifications occur.

PLAN agrees that CCPA may terminate its participation with a particular Payor in the event the appropriate benefit differentials, as stipulated in Section 5.8, are not implemented by an individual Payor, given thirty (30) days prior written notice by PLAN. Any services without the required benefit differentials shall be reimbursed at 100% of Participating Provider's billed charges.

Section 5.10 **Beneficiary Identification.** PLAN represents and warrants that PLAN or Payor shall furnish each Beneficiary with an identification card which clearly indicates:

(a) The name and address of the PLAN, Payor and employer; and

(b) The type of Benefit Plan or product (HMO, EPO, PPO, POS, etc.); and

(c) Pre-certification, pre-authorization and any other utilization management requirements; and

(d) A toll-free number for CCPA Participating Providers to use to determine and comply with any pre-certification, pre-authorization or other utilization management requirements; and

(e) A toll-free number for CCPA Participating Providers to use to verify Beneficiary's coverage and eligibility for benefits; and

(f) Appropriate claims billing address and a toll-free number for CCPA Participating Providers to use for claims and billing inquiries and problems; and

(g) Any coinsurance and copayment obligations for beneficiary.

PLAN agrees to provide an electronic media to verify Beneficiary's eligibility on a 24 hours per day, 7 days per week basis.

PLAN or Payor is responsible for communicating and educating the Beneficiary regarding insurance benefits. PLAN or Payor shall communicate to Beneficiaries the importance of presenting insurance card information prior to service. Beneficiary should be informed by PLAN or Payor that failure to provide an insurance identification card at the time of service (inpatient or outpatient) shall result in a waiver of the negotiated rates provided herein, and the Payor shall reimburse Participating Provider for 100% of billed charges.

Where a CCPA Participating Provider has complied with the pre-certification or pre-authorization requirements, with the verification of Beneficiary's coverage and benefits eligibility requirements, PLAN or Payor shall not retroactively deny coverage, as per terms in Section 4.10.

Section 5.11 **Repricing Turnaround.** If and to the extent claims will be submitted to PLAN for repricing, PLAN shall cause claims for Covered Services to be repriced and submitted to Payor within five (5) business days of submission to PLAN.

Section 5.12 **Clean Claims Payment.** In order to obtain the benefit of any negotiated rate herein, PLAN or Payor shall pay clean claims to the extent of its liability within thirty (30) days of receipt. For purposes of the foregoing sentence, a "clean" claim shall be one that is accurate and complete in all material aspects. For all claims not paid within such period, settlement shall be at 100% of billed charges for Covered Services rendered.

Section 5.13 **Coordination Of Benefits.** CCPA and its Participating Providers shall not be deemed parties to or obligated under any of the PLAN's or Payor's Coordination Of Benefits ("COB") provisions, and shall have no right or obligation to determine the relative payment or reimbursement obligations between a Payor and any third party. Although CCPA and its Participating Providers shall cooperate in the resolution of payment obligations, the effectuation of such resolution shall be the sole responsibility of PLAN and/or Payor. The existence of a COB dispute shall not relieve any Payor of any obligation to make timely payment under the applicable Payor agreement, nor relieve Participating Providers of any obligation to furnish Covered Services. In the event a Payor is the primary payor under applicable COB provisions with respect to any claim, Payor shall compensate CCPA Participating Providers for the full amount due under this Agreement for such claim without reduction or offset for amounts which may be payable from another source.

PLAN or Payor agrees that the CCPA Participating Provider shall not be required to bill another party prior to billing the PLAN or Payor if the PLAN or Payor is the primary carrier. If, however, the Participating Provider is required to assist in attempts to collect from secondary carriers or a Beneficiary, the Participating Provider shall obtain a fee for this service and be allowed to collect up to its billed charges from the secondary carrier or the Beneficiary, if applicable. In addition, the Payor shall reimburse the CCPA Participating Provider at 100% of billed charges if the Participating Provider is unable to collect from the secondary carrier within sixty (60) days.

Section 5.14 **Medical Records.** No CCPA Participating Provider shall be required to release information from, or permit inspection or copying of, a Beneficiary'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. To the extent PLAN and/or Payors require access to medical or other patient information maintained by a Participating Provider, and to the extent such access requires patient authorization beyond that normally obtained by such Participating provider in the ordinary course of business, PLAN and/or Payor shall be responsible for furnishing a legally sufficient authorization for access to such information.

CCPA and its Participating Providers agree to permit appropriate CCPA, PLAN or payor representatives to have access to Participating Provider's medical records and shall allow CCPA, PLAN or Payor to secure copies of any needed medical records. PLAN or Payor shall compensate CCPA and/or Participating Provider for the costs of copies of medical records. Such compensation shall be made at actual cost, not to exceed seventy-five (75) cents per page, plus a processing fee of five dollars ($5.00) per record. Special requests for inspection of financial information will not be made available to PLAN or Payor, however, PLAN or Payor may obtain billing records specific to a Beneficiary.

PLAN and/or Payor shall provide at least three (3) business days notice to Participating Providers to review medical records. PLAN and/or Payor agree that medical record reviews for UR/QA compliance will not delay payment on the individual accounts selected for audit.

PLAN and Payor shall indemnify and hold harmless CCPA and its Participating Providers for a claim by a Beneficiary in whom Beneficiary claims lack of good faith in breach of confidentiality resulting from CCPA or its Participating Provider's compliance with this section.

Participating Provider and CCPA agree to maintain the confidentiality of Beneficiary's medical records in accordance with the provisions of federal and state law, and the release of information reflected in such records shall require the consent of the Beneficiary unless otherwise permitted or required by law. CCPA Participating Providers agree to cooperate in the transfer of Beneficiary's medical information to other Participating Providers as necessary for the continued care of such Beneficiaries.

Section 5.15 Utilization Review.

(a) If an to the extent Payor is responsible for Utilization Review:

- PLAN or Payor agrees to delegate performance of Utilization Review responsibilities to CCPA to the extent of CCPA's ability and qualifications from time to time.

- For any periods in which such responsibilities are not delegated to CCPA, PLAN or Payor shall afford CCPA an ongoing opportunity to participate in the development of, review, request modifications to, and obtain resolution of disputes concerning utilization review policies, procedures and guidelines, including the opportunity to review changes in such policies, procedures and guidelines prior to their implementation. The PLAN or Payor's utilization review plan and any subsequent amendments shall be forwarded to CCPA and shall become effective if CCPA does not object in writing within thirty (30) days after receipt. If CCPA rejects such plan or amendments thereto, PLAN or Payor may at its option terminate this Agreement for such reason upon thirty (30) days written notice to CCPA.

- Participating Providers shall be entitled to rely conclusively upon approvals obtained in accordance with PLAN or Payor's Utilization Review program, and PLAN or Payor shall not retroactively deny any claim for services that have been so approved on the basis of medical necessity or otherwise.

(b) If and to the extent any Payor (or agent of the Payor) is responsible for Utilization Review:

- PLAN agrees to assist CCPA in communicating with Payor and resolving disputes regarding Utilization Review matters. In the event of an irreconcilable dispute between CCPA and a Payor (or the agent of Payor) concerning the Payor's Utilization Review policies and procedures or the implementation thereof, PLAN shall terminate such Payor's participation under this Agreement. PLAN's obligation to terminate a Payor pursuant to the preceding sentence shall be conditional upon CCPA's cooperation and participation in PLAN's reasonable dispute resolution procedures (but which shall not include binding arbitration), provided that such procedures shall not extend beyond sixty (60) days duration without CCPA's consent.

- If a Participating Provider disputes a Payor's Utilization Review determination as to any specific claim and Payor fails to resolve such disputed claim within one hundred twenty (120) days for reasons other than the Participating Provider's failure to furnish reasonably requested documentation, Participating Provider shall be entitled to hold Payor financially responsible

for services rendered pursuant to this Agreement and shall be entitled to bill at 100% of Provider's usual charges for Covered Services.

(c) PLAN or Payor (or the agent of Payor) conducting Utilization Review:

- PLAN agrees to provide all applicable and written UR programs and Provider Manuals prior to Agreement acceptance. The written materials should specify by product (i) the parties responsible for obtaining authorization; (ii) the telephone number(s) and contact individual(s); (iii) all services requiring authorization (inpatient/outpatient/ observation/ambulatory surgery); (iv) financial penalties for non-compliance; and (v) specialized providers for specific services such as outpatient surgery, MRI or CT scans.

- For any changes or modifications to UR programs or the Provider Manual, PLAN agrees to provide written modifications from PLAN or Payor (or agent of payor) at least forty-five (45) days prior to their implementation. These modifications shall become effective if CCPA does not object in writing within thirty (30) days after receipt.

- PLAN agrees that pre-certification requirements will be limited to inpatient admissions and outpatient surgeries. PLAN recognizes that given the high volume of outpatients it is not reasonable to require Participating Providers to pre-certify eligibility and obtain authorization for specified diagnostic/ancillary/ outpatient services.

- If Participating Provider is required to verify authorization, a phone number and a contact person must be available 7 days per week and 24 hours per day. PLAN agrees that the notification timeframe is within 24 hours of an elective admission or the next business day provided that complete insurance information was presented upon admission. If the Beneficiary identification card was not presented to the Provider at the time of service, this precludes Participating Provider from providing timely pre-certification/authorization. PLAN agrees that late notification shall never result in payment denial if Covered Services were deemed to be medically necessary.

  PLAN or Payor agrees that pre-certification/UR departments must have an alternative method of notification when phone lines are busy (i.e., confidential voice mail or fax). Required information shall be stated at the beginning of the voice mail greeting. PLAN or Payor agrees to have this option be available 24 hours per day, 7 days per week for all services requiring pre-certification or payor notification. PLAN or Payor agrees that if an attempt (e.g., fax receipt) to pre-certify was made with no response from Payor, then no retroactive denial of payment shall be allowed.

  PLAN or Payor agrees that pre-certification requirements for psychiatric services must be identified separately if the pre-certification agency and psych service providers are different from the medical service.

- PLAN or Payor agrees to provide timely notification, as soon as possible but not greater than 24 hours, for reviews, authorizations, denials, pended reviews, etc. to all Participating Providers and Beneficiary in writing via facsimile or e-mail. PLAN or Payor and CCPA understand and agree that some cases shall require communication via telephone, but that general acute cases shall be responded to via written notification.

- PLAN or Payor agrees that authorized admissions and outpatient services shall not be retroactively denied for medical necessity. Additionally, Beneficiaries whose eligibility and benefits have been verified shall not be retroactively denied for eligibility or benefit coverage reasons. PLAN or Payor agrees that Beneficiary shall be financially responsible for denied claims as a result of Beneficiary non-compliance. Timely notification to the provider regarding the Beneficiary's loss of eligibility is required or there shall be no retroactive payment denial by Payor.

- PLAN or Payor agrees to allow the Participating Provider to notify the PLAN or Payor of an emergency admission within at least 48 hours or two business days from the point the Participating Provider can identify the Beneficiary as a PLAN enrollee. If the CCPA Participating Provider is required to verify an authorization, a phone number shall be available 7 days per week and 24 hours per day. If the Beneficiary's primary care physician has approved emergency services, PLAN or Payor agrees that there shall be no retroactive denial of payment based on the Payor's decision that services were not medically necessary.

- When Payor determines through the UR Program that it will not accept financial liability for initial or continued inpatient hospitalization, outpatient diagnostic or treatment procedure, or when a more appropriate setting is available, Payor shall provide timely and written notification of its determination to all appropriate Participating Providers and the Beneficiary. For those cases involving continued inpatient hospitalization, the notification shall include a date after which PLAN will no longer accept financial liability for inpatient services provided by Participating Provider to the Beneficiary.

- Participating Provider may bill a Beneficiary for services provided following a determination by Payor that it will not accept financial responsibility provided that Participating Provider first obtains from the Beneficiary, or his or her financial guarantor, a signed notice of personal financial responsibility on a form to be provided by PLAN.

- Should Participating Provider or the Beneficiary's attending physician disagree with Payor's determination not to accept financial liability for initial or continued inpatient hospitalization, outpatient diagnostic or treatment procedure, or that a more appropriate setting is available, Participating Provider or the Beneficiary's attending physician may appeal Payor's determination to the Payor's Medical Director or his or her designee. Such an appeal must be made no later than ten (10) working days following notification by Payor of its determination. The decision of the Medical Director, or designee, shall be binding on Payor.

- When the Payor's Medical Director's, or designee's, decision upholds Payor's initial determination, Participating Provider or the Beneficiary's attending physician may request that the matter be reviewed by a Payor physician consultant. Such request must be made no later than ten (10) working days following Medical Director's, or designee's decision. Payor will refer the matter to an appropriate physician consultant no later than the next working day following the request for determination review. The appeal shall be conducted by a telephone conference between the Beneficiary's Attending Physician and Payor physician consultant. The decision of Payor physician consultant shall be binding upon Payor, Participating Provider, Physician, and the Beneficiary with respect to Payor's financial liability for

initial or continued inpatient hospitalization, outpatient diagnostic or treatment procedure, or that a more appropriate setting is available.

- In rendering services to Beneficiaries of this Product, Participating Provider will comply with Payor's Utilization Review Program for this Product as set forth in Exhibit C, including such amendments as may be applicable to specific Payors. If, in the professional judgment of Physician, it is medically necessary, timely and appropriate to deliver health care services in a manner which differs from the UR Program, Physician will render health care services in a manner in keeping with his/her best professional judgment irrespective of a Payor's coverage decision.

Section 5.16 **Silent PPO Arrangement.** PLAN represents and warrants to CCPA that neither PLAN, nor any claims paying organization with which it is affiliated by ownership or contract, nor any Payor (or agent of any Payor) shall use the provider rates or fee schedules established for Participating Providers under this Agreement to process or re-price claims for services of Participating Providers other than claims for Covered Services under Benefit Plans and Payor Agreements which are within the scope of this Agreement and which have been disclosed to CCPA. PLAN shall hold CCPA and Participating Providers financially harmless from any unauthorized re-pricing of claims by PLAN, any Payor or the agent of PLAN or any Payor. Further, CCPA may, upon notice to PLAN, refuse to continue the negotiated rates under this Agreement to any Payor if CCPA becomes aware that such Payor is accessing networks other than PLAN and utilizing the best rate available among all such networks.

Section 5.17 **Confidentiality of Charges and Rates.** PLAN and CCPA agree that they shall not disclose the negotiated rate and or the compensation payable to Participating Providers pursuant to the terms of this Agreement except to the extent required by applicable laws or as may be required to carry out the terms of this Agreement. CCPA warrants that it will require Participating Providers to comply with this Section. PLAN warrants that it will require all Payors to comply with this Section and to maintain the confidentiality of all Participating Provider fees and charges.

Section 5.18 **Responsibilities of PLAN.** On or before the effective date of this Agreement and throughout the Term thereof, PLAN shall furnish CCPA with all relevant information that is reasonably within PLAN's control and which is required by CCPA and/or Participating Providers to discharge its/their duties and responsibilities under this Agreement, including (but not limited to) information regarding:

(a) PLAN's policies and procedures;

(b) The identity of each Payor;

(c) The Covered Services, Benefit Plans and Beneficiary Identification Card from each Payor;

(d) The applicable policies and procedures of each Payor;

(e) PLAN's complete listing of Participating Providers;

(f) Enrollment projections for each Payor;

(g) Benefit plans for each Payor and/or employer, including steerage mechanisms; and

(h) The provisions of any PLAN or Payor Agreement which create the provisions of any PLAN or Payor Agreement which create any obligations for CCPA or any

Participating Provider that is subsequently different from the obligations under other Payor Agreements maintained by PLAN or substantially at variance with industry standards and practices.

Plan shall also require Payors to respond within thirty (30) days to any reasonable request by CCPA for similar information concerning such Payor's policies, procedures and performance under this Agreement.

Section 5.19 Changes in Status of PLAN.

(a) PLAN warrants to CCPA that it will vigorously enforce the terms of this Agreement and PLAN agrees to actively monitor Payors (or any agents of Payor) for compliance with the terms of this Agreement.

(b) PLAN shall notify CCPA 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 PLAN or Payors (or any aspect of Payor) to carry out its obligation and duties under this Agreement, including but not limited to:

- Changes in ownership or equity partnerships,
- Changes or notification of possible changes in licensure, NCQA or similar accreditation, or HCFA or similar certification;
- Financial solvency of PLAN or Payors or of the individual products offered by PLAN or Payors;
- New product development from PLAN or Payors; and
- Employee strikes or walkouts or damage to the physical plant resulting in any interruption of PLAN's service.

Article 6
Compensation and Billing

Section 6.1 **Participating Provider Compensation.** It is acknowledged and agreed by the parties that Participating Providers under this Agreement have committed unilaterally to accept the rates of payment set forth in Exhibit D, which rates were determined and offered unilaterally by PLAN and without negotiation by or through CCPA. CCPA agrees that the listing of any Participating Provider on Exhibit A is contingent upon that Participating Provider having accepted PLAN's compensation rates (including, as applicable, such rates as the Participating Provider and PLAN may negotiate independently).

Section 6.2 **Modification of Rates.** PLAN agrees that, notwithstanding the Renewal Terms in Section 2.2 of this Agreement, changes in the rates of compensation accepted by any Participating Provider constitute an amendment to this Agreement and shall not be effective except upon written notice to CCPA and written acceptance by such Participating Provider, as per CCPA's Participating Provider Agreements for this Product.

Section 6.3 **Calculation of Payment for Covered Services.** CCPA and Participating Providers calculate payments for Covered Services as the rates of payment for such services (as set forth in Exhibit D), reduced by any copayments, deductibles or coinsurance applicable to the service rendered (whether or not the Participating Provider has attempted to collect or has received payment of any such copayments, deductibles or coinsurance).

CCPA Participating Providers shall accept the rates of payment as set forth in Exhibit D as payment in full for Covered Services and shall not bill or collect any additional amounts from Beneficiaries for Covered Services. Notwithstanding the preceding sentence, CCPA and Participating Providers shall have the right to bill Beneficiaries directly and collect:

(a) Copayments, deductibles and/or coinsurance;

(b) Payment for any Covered Services delivered to Beneficiary after the expiration of that Beneficiary Benefit Plan Benefits;

(c) Amount owing by other payors after application of a Coordination Of Benefits provision;

(d) Non-Covered Services; and

(e) Services for which the Beneficiary otherwise has agreed to be financially responsible.

Section 6.4 **Billing.**

(a) Participating Providers will submit all claims to PLAN or Payor for medically necessary Covered Services on billing forms HCFA 1500 or such other forms as may be approved by CCPA.

PLAN agrees that there are no requirements, on the part of Participating Providers, for standard additional attachments to the claim form such as emergency room reports, discharge summaries, etc. PLAN agrees to make a special request to Participating Provider for any additional attachments to the claim by PLAN or Payor. If additional information is requested claims payment will not exceed the thirty- (30) day time frame from PLAN or Payor's receipt of claim or the penalty for late payment will apply.

(b) Participating Physicians shall use best efforts to submit clean claims within forty-five (45) days after the provision of such services. Participating Providers are allowed to submit interim claims (30 day intervals) for extended length of stays, which means that claims may be submitted for services provided regardless of whether the Beneficiary is still being treated by Participating Provider.

(c) Payor (or any agent of Payor) will make payment to individual Participating Providers, in accordance with terms in this Product Description, within thirty (30) days of receipt of clean claims by the Payor. Payor (or any agent of Payor) agrees to reimburse Participating Provider at 100% of Participating Provider's total billed charges, if a clean claim is not paid within thirty (30) days of receipt.

A listing of claims on which payments were received late will be submitted to the PLAN or Payor within six (6) months of payment. No additional support is required in an electronic claims environment to substantiate claim receipt. However, in the current environment, certified mail/returned receipt provides the necessary claim receipt documentation to validate and collect late payment penalties.

(d) PLAN or Payor (or any agent of Payor) may not be responsible for payment of claims submitted more than one hundred-eighty (180) days after the date of service, except when such claims submission is not reasonably possible within such time period. PLAN or Payor (or any agent of Payor) shall deem this obligation satisfied if claims submission is made within this 180 day time period, even if the claim is subsequently returned because of inaccuracy or incongruities, provided that Participating Provider resubmits a corrected claim.

(e) PLAN or Payor (or any agent of Payor) agrees to furnish to CCPA (or its designated vendor) an Explanation Of Benefits (EOB) for each claim, regardless of whether a payment is due or made to CCPA or a Participating Provider. The EOB must clearly identify the following: the contract name and product under which the Beneficiary is covered, the billed amount (total charges), the discount amount, the date of service, benefit payment and the amount to be paid by the Beneficiary (co-insurance and deductible responsibilities).

Identification of the Beneficiary name (first and last) is essential. Many Beneficiaries who are dependents of the insured bear a different last name than the insured member and the EOB's only reflect the last name of the subscriber. It is recommended PLAN and Payors include the provider's unique patient account number to insure appropriate patient identification.

The EOB should clearly state the reason for pending account and claim denials. PLAN and Payor agree to make available to the Participating Provider a written guideline for proper EOB interpretation.

Section 6.5 **Repricing Offices for PPO Contracts.** PLAN agrees that if more than one re-pricing office is used under a single contract, and the provider has evidence of inconsistent re-pricing among multiple offices, the provider should be able to request a single re-pricing office through which all provider claims will be handles.

Section 6.6 **Referral Forms.** PLAN agrees to make every attempt to eliminate unnecessary referral documents requirements within the network hospitals and physician groups. As long as the primary care provider is ordering the services, referral forms should not be required.

Section 6.7 **Future Reimbursement.** CCPA agrees that any current or future financial arrangements between CCPA and Participating Providers are not covered by this Agreement and shall be handled by direct arrangements between such parties.

Section 6.8 **Automatic Down Coding.** PLAN or Payor (or any agent of Payor) agrees not to automatically or retroactively down code any code submitted by CCPA provider without express permission from CCPA or Participating Provider.

Article 7
Additional Provisions

Section 7.1 **Confidentiality.** PLAN and CCPA agree that this Agreement contains confidential information and the particular terms of this Agreement shall be kept confidential and not disclosed to any third party. PLAN and CCPA further agree that the performance shall be kept confidential and not disclosed to any third party. PLAN and CCPA further agree that the performance of this Agreement may require the disclosure to each other of confidential and proprietary information, which may include information regarding costs, prices, customer lists, and methods of doing business, and that such information likewise shall be kept confidential and not disclosed to any third party. The foregoing prohibitions on disclosure shall not apply to any disclosures (1) which are necessary to perform this Agreement, (2) required to comply with applicable state, federal or local law; or (3) which concern information that is or becomes generally known to third parties other than by reason of a violation of this Section 7.1. PLAN warrants that, to the extent it discloses such information to Payors (or any agent of Payor) for purposes of performing this Agreement, it shall require Payors (or agent of Payor) to comply with this Section 7.1. This Section 7.1 shall survive the termination of this Agreement for any reason for the mutual benefit of the parties.

Section 7.2 **Advertising References.**

(a) CCPA agrees that PLAN and Payors may use CCPA's and each Participating Provider's name, address(es), telephone number(s), a description of specialty area, and hospital or health facility affiliations in any roster of Participating Providers published by PLAN and/or any Payor in the advertisement of the Payor's Benefit Plan. The roster may be inspected by and is intended for the use of prospective and existing Payors and their respective employees and participants as well as for advertising purposes.

(b) CCPA also agrees that any materials authorized or produced by CCPA or Participating Providers which contain references to PLAN, this Agreement, PLAN clients, or Beneficiaries will be forwarded to PLAN for advance review and written approval, except to the extent such materials contain or reproduce information furnished to CCPA by PLAN. After receiving such written approval, PLAN shall forward, or cause to be forwarded, to CCPA ten (10) copies of any materials at time of or in advance of publication of such materials.

(d) PLAN and CCPA agrees that the use of name, symbols, trademarks, or service marks for any purpose other than the roster of Participating Providers, shall require written consent in advance to parties.

(e) Participating Provider agrees to afford PLAN or Payor the same opportunity to display brochures, signs or advertisements in Participating Provider office(s) as Participating Provider affords any PLAN or Payor not contracting with CCPA. CCPA shall arrange with PLAN or Payor to permit Participating Provider to use each PLAN or Payor's name in connection with Participating Provider's own marketing activities designated to promote provider as a Participating Provider in the appropriate Product(s).

(f) Upon termination of this Agreement or any Product Description, CCPA and its Participating Providers shall not engage in further marketing activity which implies a continuing relationship between CCPA, PLAN or Payor with respect to any Product in which participation has been terminated. In such instances, CCPA shall arrange for PLAN or Payors to cease any activity that implies a continuing relationship between Participating Providers, PLAN or Payor as to such Product(s).

Section 7.3 **Acknowledgments by CCPA.** CCPA hereby expressly acknowledges that:

(a) Each Payor that is a party to a Payor Agreement has the full and final responsibility for payment of any Health Care Services rendered by Participating Providers and that CCPA shall not be liable, under any circumstances, for the payment thereof;

(b) PLAN may not be an insurer, guarantor or underwriter of the liability of any Payor to provide benefits to Payor's Beneficiaries or pay the cost thereof and any final claim decisions will be the responsibility of the Payor; and

(c) PLAN or Payor does not warrant or guarantee that a Beneficiary or any number of Beneficiaries will utilize Participating Providers.

Section 7.4 **Amendment.** This agreement may be amended only in written amendment executed by the parties and found in Exhibit "E". The parties agree to comply with any and all provisions in Exhibit "E" and that in the event of any conflict between the provisions in Exhibit "E" and any provisions elsewhere in this Agreement, the provisions in Exhibit "E" shall take precedence.

Section 7.5 **Successors and Assigns.** Neither party may assign any or all of its rights and obligations hereunder without the prior written consent of the non-assigning party. Any attempted assignment in violation of this provision shall be void and considered grounds for immediate termination.

Section 7.6 **Severability.** In the event any term or provision of this Agreement is rendered invalid or unenforceable by the enactment of any law or governmental regulation or the ruling of any court of competent jurisdiction, the remainder of the provision hereof shall remain in force and given effect to the extent possible without the invalid or unenforceable term or provision.

Section 7.7 **Entire Agreement.** This Agreement together with all attachments contains the entire agreement between the parties concerning the subject matter hereof. Any prior agreements, promises, negotiations, or representations concerning this subject matter hereof, either oral or written, are hereby superseded by the terms of this Agreement.

Section 7.8 **Notices.** A notice required or permitted by this Agreement shall be in writing and shall be deemed to be properly given (i) when delivered personally or (ii) on the seventh (7^{th}) business day after it is sent postage prepaid by certified or registered mail, return receipt requested, or (iii) facsimile confirmed with overnight delivery, and sent to the addresses indicated below:

If to CCPA:

Maureen Murphy
Executive Director
Children's Community Physicians Association
Children's Memorial Hospital
2300 Children's Plaza, Mailbox #49
Chicago, Illinois 60614

If to PLAN:

Jay Tress
Network Operations
Managed Care Strategies™ Inc.
1 East Uwchalan Avenue, Suite 401
Exton, PA 19341

Section 7.9 **Choice of Law.** It being acknowledged that the delivery of all services pursuant to this Agreement shall occur in Illinois, this Agreement shall be governed and enforced in accordance with the laws of the State of Illinois.

Section 7.10 **Headings.** The headings contained in this Agreement have been inserted for the convenience of reference only and shall in no way restrict or modify any of the terms or provisions hereof.

Section 7.11 **Waiver of Breach.** Waiver by a party of a breach of any term or provision of this Agreement shall not be deemed a waiver of any other breach of the same or a different provision. A failure to exercise any right hereunder shall not operate as a waiver of such right. All rights and remedies provided for herein are cumulative.

Section 7.13 **Dispute Resolution.**

(a) CCPA, Payor and PLAN agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement. The matter shall be submitted within five (5) days to a committee of two representatives from each party.

(b) If such committee concludes that it is unable to resolve the matter, the committee may, at its discretion, decide to (i) terminate this Agreement within thirty (30) days thereafter; or (ii) arbitrate such problem or dispute.

(c) Any arbitration shall be conducted pursuant to the rules of the American Arbitration Association. CCPA, Payor and PLAN agree that the arbitration results shall be binding on both parties in any subsequent litigation or other dispute.

Section 7.14 **Effective Date.** The Effective Date of this Agreement is October 1, 1999 with an initial term through December 31, 2000.

IN WITNESS WHEREOF, the undersigned have executed this Agreement in two counterparts, each of which shall be deemed an original.

CCPA

By: _____
Maureen A. Murphy

Its: Executive Director, Children's Community Physicians Association

Date: 8/27/99

PLAN

By: _____
VINCENT FORCHETTI

Its: President

Date: 9/2/99

Exhibit A
CCPA Participating Providers

Data from CCPA to be provided in an electronic file (excel compatible) and e-mailed to Jtress@mcs-ppo.com

Exhibit B
CCPA Credentialing, Re-Credentialing and Membership Criteria

Materials previously provided to MCS

Exhibit C
Utilization Review Program

(to be attached by MCS)

Exhibit D
Fee Schedule
CCPA Compensation for Participating Providers

Reimbursement to Participating Providers will be at 85% of Provider's billed charges.

Exhibit E
Future Amendments
(to be attached as required)

Amendment to the Contract between
Children's Community Physician Association (CCPA)
And
MCS Patient Centered National Healthcare Network (PLAN)

CCPA agrees to accept 90% of Provider's billed charges as reimbursement to Participating Providers. Accordingly, Exhibit D, "Fee Schedule CCPA Compensation for Participating Providers" is amended to reflect that reimbursement to Participating Providers will be at 90% of Provider's billed charges.

This Amendment will be effective for services rendered on and after May 1, 2000.

Children's Community Physicians Association (CCPA)	**MCS Patient Centered National Healthcare Network (PLAN)**
Signature: Jo Letwaitis	Signature:
Print Name: Jo T. Letwaitis	Print Name: Vincent Forchetti
Title: Executive Director, CCPA	Title: President
Date: 5.1.00	Date: 5/8/00