PREFERRED PLAN, INC.
INDEPENDENT PHYSICIAN ASSOCIATION/INTEGRATED DELIVERY SYSTEM
PARTICIPATING AGREEMENT

This Agreement is made and entered into by and between Preferred Plan, Inc., 10600 West Higgins Road, Suite 405, Rosemont, Illinois 60018, (hereafter "PPI") and the Children's Community Physicians' Association, (hereafter "IPA").

WHEREAS, PPI represents and is authorized by various organizations and institutions, including employers, third-party administrators and other similar entities, (herein together defined as "Client(s)") who provide or administer health care insurance pursuant to a benefit plan or other programs (herein together defined as "Benefit Program(s)") for covered individuals ("Participant(s)") to establish a preferred provider relationship with IPA.

WHEREAS, IPA wants its facilities and practitioners (hereinafter "Participating Provider(s)") to provide health care services in accordance with the terms of this Agreement.

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

A. DEFINITIONS

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:

1. **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.

2. **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.

3. **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.

4. **COVERED SERVICES** means, when used with respect to a particular Payor, those Health Care Services and supplies as set forth in Exhibit G received by Beneficiaries for which a Payor is obligated to pay pursuant to the terms of a Benefit Plan as then in effect.

5. **HEALTH CARE SERVICES** means those inpatient (including ancillary), outpatient and emergency hospital services and other medical services provided by Participating Providers.

6. **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:

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

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

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

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

   (e) 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.

7. **PARTICIPATING PROVIDER** means those physicians, hospitals 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.

8. **PARTICIPATING PROVIDER AGREEMENT** means the CCPA Provider Master Agreement and the CCPA Product Description for provider services.

9. **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.

10. **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.

11. **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.

12. **PHYSICIAN PROVIDER** means a Participating Provider who is a licensed physician.

13. **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.

14. **UTILIZATION REVIEW** means a program to review the necessity, appropriateness and/or quality of Covered Services rendered to Beneficiaries pursuant to this Agreement.

15. **EMERGENCY** means PLAN or Payor agrees that an emergency condition, as applicable to Beneficiaries enrolled in HMOs through Title XVIII of the Social Security Act (Medicare), shall be defined as an injury or sudden illness, which if not immediately treated, would result in risk of permanent damage to the Beneficiary's health and which occurs at a time or location which reasonably precluded obtaining care from a Participating Provider

B. RESPONSIBILITIES OF PPI

1. **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.

2. **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.

3. **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.

4. **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 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.

5. **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 10 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.

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

6. **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 notify CCPA and its Participating Providers of any changes to Payor listing or material changes in Payor's Benefit Plan quarterly 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 are not applied. Any services without the required benefit differentials shall be reimbursed at 100% of Participating Provider's billed charges.

7. **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 phone 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 phone 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; and

   PLAN agrees to make best efforts 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 (regardless of benefit plan type HMO/PPO/POS/EPO) 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 PLAN, Payor and Beneficiary shall reimburse Participating Provider for 100% of billed charges. In addition, PLAN or Payor shall emphasize to the Beneficiary the importance of contacting the primary care physicians for authorization of applicable services.

   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.

8. **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) business 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.

9. **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.

   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.

10. **Utilization Review.** PLAN or Payor (or the agent of Payor) conducting Utilization Review:

    PLAN agrees use best efforts to provide all applicable and written UR programs and Provider Manuals (both physician and hospital) 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 and if not available then the next business day. PLAN agrees that the notification time frame 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 precertification/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 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.

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, unless PPI, Payor and CCPA agree that services were not necessary.

When PLAN 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, PLAN 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.

Should Participating Provider or the Beneficiary's attending physician disagree with PLAN'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 PLAN's determination to the PLAN PPO Medical Director or his or her designee. Such an appeal must be made no later than ten (10) working days following notification by PLAN of its determination. The decision of the PPO Medical Director, or designee, shall be binding on PLAN.

When the PLAN PPO Medical Director's, or designee's, decision upholds PLAN's initial determination, Participating Provider or the Beneficiary's attending physician may request that the matter be reviewed by a PLAN physician consultant. Such request must be made no later than ten (10) working days following PPO Medical Director's, or designee's decision. PLAN 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 PLAN physician consultant. The decision of PLAN physician consultant shall be binding upon PLAN, Participating Provider, Physician, and the Beneficiary with respect to PLAN's financial liability for initial or continued inpatient hospitalization, outpatient diagnostic or treatment procedure, or that a more appropriate setting is available.

11. **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.

12. 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:

(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 Payors or of the individual products offered by PLAN or Payors;

(4) New product development from PLAN or Payors; and

(5) Employee strikes or walkouts or damage to the physical plant resulting in any interruption of PLAN's service.

12. **Notification.** PPI shall use its best efforts to keep its clients informed of the availability of and the financial benefits of utilizing IPA services. PPI shall notify its participating clients of this agreement and shall distribute material to its clients about the services of Participating Providers. Nothing in this agreement shall be construed as interfering with the freedom of choice of eligible participants.

13. **Limitations.** PPI acts exclusively as a consultant to its Clients and its duties are limited to assisting its Clients in negotiating contracts with Participating Provider(s). PPI does not determine benefits, eligibility or benefit availability for persons covered by a Client's Benefit Plan. The parties agree that PPI specifically does not exercise any discretion or control as to Client's Benefit Plan assets or with respect to policy, payment, interpretation, practices or procedures. PPI will use its best effort in supporting contracted payment terms as expressed in this agreement.

14. **Eligibility and Identification of Participants.** PPI shall cooperate to assure that its clients provide to Participating Providers a means of identifying eligible individuals for covered services.

15. **Payor List.** PPI shall provide IPA with a listing of its Clients who shall receive services under this Agreement on a quarterly basis.

16. PPI or PPI Payor designee agrees to follow all CPT-4 and Medicare coding.

C. RESPONSIBILITIES OF THE PROVIDER

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.

2. **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 each of the minimum participation criteria set forth in Exhibit B. CCPA agrees to furnish PLAN with the results thereof together with the data to be furnished to the PLAN by CCPA ~~(see Section 4.9).~~

3. **Coverage verification and Recoveries from Third Parties.** 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.

   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, PLAN or Payor shall be liable for such fee(s) rather than Beneficiary or Participating Provider.

4. **Provision of Health Care Services.** IPA shall assure the provision of hospital services in the form of usual and customary inpatient, outpatient and emergency services available at the hospital provider; and shall obtain the provision of medical services through appropriately licensed practitioners including, but not limited to, diagnostic, therapeutic, evaluation and preventative services which are prescribed, directed, ordered, or authorized by a licensed practitioner for a participant, and subject to the IPA Participating Provider agreements, including any clinical decisions regarding the admission, treatment, or discharge of a Participant under Participating Provider's care, provided pursuant to this agreement. Such services shall be provided to Participants in accordance with the standards and procedures similar to services provided to other patients and without discrimination to sex, race, color, religion, marital status, sexual orientation, age, ancestry, national origin or this Agreement.

5. **IPA Data.** The IPA will provide PPI upon reasonable request with the following documents:
   (a) The IPA Articles of Incorporation
   (b) The IPA Federal Identification Number
   (c) The IPA Provider Credentialing Criteria
   (d) A List of the IPA's Participating Providers, showing:

   -Name
   -Office Address(es)
   -Office Telephone Number(s)
   -Specialty(ies)
   -Federal Tax Identification Number
   -Board certification or current Board eligibility status.

Changes to the above shall be provided in a timely manner, but not more than thirty (30) days after any changes.

6. **Authorization.** IPA represents that it is authorized to execute this Agreement on behalf of each Participating Provider shown on the list (which may be amended from time to time) mentioned in C.5., and each Participating Provider hereby agrees to the terms of this Agreement.

7. **Licensure and Certification.** Each Participating Provider shall comply with all laws relating to furnishing health care services to Participants and maintain in effect all permits, licenses and governmental approvals which may from time to time be necessary for that purpose. The IPA agrees to notify PPI within thirty (30) days of any change in compliance with these requirements. IPA and each Participating Provider shall comply with all laws relating to furnishing medical services to Participants and maintain in effect all permits,

licenses, and governmental approvals which may from time to time be necessary for that purpose.

8. **Referrals**. Each IPA Participating Provider shall make its best efforts to refer Participants to other Participating Providers in the IPA or to other PPI facilities or Practitioners according to patient needs, Participating Provider's expertise and Participating Providers medical judgment except where inappropriate due to a clinical emergency or due to the unavailability of other Participating Providers in the IPA or other PPI facilities or Practitioners in an appropriate Medical Specialty. PPI shall furnish to IPA a listing of other PPI facilities and practitioners for purposes of IPA's compliance with this paragraph.

9. **Utilization**. Participating Provider shall encourage reasonable use of services and shall on request provide to a Client or its designee appropriate and complete information, records and other written documentation regarding health care services provided to Participants hereunder. The Participating Provider agrees to participate in and comply with Client's or its designee's utilization program (e.g., preadmission, concurrent and retrospective reviews, managed care, etc.). No Participating Provider or participating hospital of IPA shall be required to release information from, or permit inspection or copying of, a patient's medical record unless the Participating Provider or participating hospital is first presented with a properly executed authorization, or certified copy thereof, consenting to the release of such information and records. The parties acknowledge and agree that the confidentiality of patients' medical records shall be maintained in accordance with applicable federal and state law and Participating Provider policy.

10. **Insurance**. IPA, each Participating Provider shall maintain appropriate professional and/or comprehensive general liability insurance covering its respective acts or omissions which may arise out of the services to be performed hereunder in such minimum amounts as required by law or, in the absence of statutory requirements, no less than the amount shown on Appendix A. When the form of insurance is claims made, each respective party shall be required to purchase appropriate tail coverage for claims, demands or actions made in future years for acts or omissions during the term of this agreement. Upon request, each respective party shall send the other a copy of the certificate evidencing such insurance coverage. Each party agrees to notify the other in writing within thirty (30) days of any cancellation, non-renewal or material changes in such coverage.

12. **Representations.** Each Participating Provider shall meet the IPA's credentialing requirements as shown in C.6., which equals or exceeds PPI's credentialing criteria as shown in Appendix B. Each Participating Provider agrees to notify PPI within fifteen (15) business days of any change in, specifically including, but not limited to, the occurrence of any of the following:

(a) The revocation, restriction, termination, or voluntary relinquishment of any required licenses, certifications, or accreditations; or

(b) Any final adverse disposition or settlement of any legal action against IPA and/or Participating Provider for professional negligence; or

(c) Any conviction for a felony

(d) Any lapse, termination, or material change in the liability insurance coverage required by this Agreement; or

(e) Any restriction, suspension, revocation, or voluntary relinquishment of medical staff membership or clinical privileges at any health care facility; or

(f) Subject to a requirement of reasonable accommodation, any chronic or recurring illness, communicable disease, physical or emotional disability, or alcoholism or narcotic addiction which would affect or impair Participating Provider's ability to provide medical services.

13. **Payment.** Participating Provider shall submit claims to Clients for all services rendered to Participants on standard commercial billing forms. To obtain the benefit of the payment schedule, Clients must make payment to Participating Provider to the extent of their liability, within thirty (30) business days from the date of receipt of the clean bill. Participating Provider shall furnish on request, all information reasonably required by Client to verify and substantiate Participating Provider's health care services and the charges for such services. PPI shall not be liable for the payment of service under Clients' Benefit Programs. PPI is not the administrator, insurer, guarantor or underwriter of benefits of Clients' Benefit Programs. There shall be no retroactive denials of claims on the basis of medical necessity for services that have been approved under Client's utilization review program.

14. **Adjustments to Clients' Payments.** Clients' payments due under this Agreement shall be reduced by any deductibles, copayments or amounts billed for non-covered medical services as required by Clients' Benefit Programs.

15. **Coordination of Benefits.** Participating Provider agrees to assist Clients for purposes of coordinating benefits. Clients, when primary payor, shall make payments according to the amounts established in Appendix C. When Clients are other than primary, their payments will not exceed an amount which, when added to amounts payable or paid by other payors, equals the amount established in Appendix C less any deductibles, copayments or non-covered services as required by Clients' Benefit Programs.

16. **Participant Billings.** Participating Provider agrees to bill the Participant only for the amount of the difference between the Clients' and other payors' payments and the amount due based on Appendix C. Participant will be financially liable for non-covered services.

D. COMPENSATION AND BILLING

1. **Modification of Rates.** PLAN agrees that, notwithstanding the Renewal Terms 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.

2. **Calculation of Payment for Covered Services.** CCPA and Participating Providers calculate payments for Covered Services as the lesser of Participating Provider's charge for the service or the rates of payment for such services (as set forth in Appendix C), 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 Appendix C 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;

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

(f) Except with respect to any PLAN or Payor that is a health maintenance organization, amounts due from any PLAN or Payor that has become insolvent or otherwise has failed to make payment to Participating Providers for Covered Services as required by this Agreement or the Payor Agreement in effect at the time such Services were rendered, whether or not this Agreement or the Payor Agreement subsequently has been terminated by Payor or PLAN; and

3. Billing.

(a) 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) PLAN or Payor (or any agent of Payor) will make Payment to CCPA (and not individual Participating Providers), in accordance with terms in this Product Description, within thirty (30) days of receipt of clean claims. PLAN or Payor (or any agent of Payor) agrees to reimburse CCPA at 100% of Participating Provider's total billed charges, if a clean claim is not paid within thirty (30) days of receipt. If payment has not been made on clean claims within thirty (30) days of receipt of bill, the participating Provider reserves the right to bill the Beneficiary at full charges.

(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 EOBs 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.

4. Refund Requests. Participating Provider and PLAN agrees that refunds will be requested in writing on an individual account basis with the same time limitations as the PLAN or Payor allows the provider to submit a claim. In other words, if the provider has sixty (60) days from the date of service to submit a claim, the Payor may only request a refund within sixty (60) days of the date of payment. The Payor shall not be allowed to process an offset against any subsequent payments due to the provider.

Refunds will only be issued directly to the Payor and not to outside agencies acting on behalf of the Payor.

5. 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.

E. TERM AND TERMINATION

1. Term and Termination. This Agreement shall be effective for two (2) years from the effective date and thereafter shall automatically renew from year to year. Either party may terminate this Agreement with our without cause at anytime by giving the other party no less than sixty (60) days advance written notice. Either party may terminate this Agreement for cause due to a material breach by giving sixty (60) days advance written notice during which the breach may be corrected. The notice of termination for cause will not be

effective if the breaching party cures the breach to the reasonable satisfaction of the other party within the sixty (60) day notice period.

2. **Charges after Termination.** If any Participant remains an inpatient on the termination date or if confinement has been approved by Participating Provider and Client or where Participant is receiving outpatient treatment, Client shall pay to the extent of its liability as if the Agreement had not been terminated until such Participant is discharged or transferred. When a patient is receiving ambulatory treatment, the Participating Provider must promptly notify the Patient that this contract has been terminated. If the patient chooses to continue treatment after the termination date, Client shall only be obligated to pay to the extent of its liability under the Benefit Plan.

3. **Early Termination.** The parties agree that 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.

4. **Effect of Termination.** Upon the expiration or termination of this Agreement for any reason, Participating Providers shall, at PLAN'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 PLAN is able to arrange for another Participating Provider to furnish Covered Services to such Beneficiary. PLAN 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.

F. MISCELLANEOUS

1. **Indemnification.** The parties hereto mutually agree to indemnify and to hold each other (including officers, agents and employees) harmless against any and all claims, demands, damages, liabilities and costs incurred by the other party, including a reasonable attorneys' fees, arising out of or in connection with, either directly or indirectly, the performance of any service, or any other act or omission by or under the direction of the indemnifying party or its employees or agents. Neither party hereto nor any of their respective agents or employees shall be liable to third parties for any act or omission of the other party, their respective agents or employees. Each party shall be solely responsible for its own acts or omissions which results in injury or damage to persons or property pursuant to this agreement.

2. **Waiver/Governing Law.** The waiver by either party of any breach of any provision of this Agreement shall not be construed as a waiver of any subsequent breach of the same or any other provision. This failure to exercise any right hereunder shall not operate as a waiver of such right. All rights and remedies provided for herein are cumulative. This Agreement shall be governed in all respects by the laws of the state shown in Appendix A. When any provision hereof is held to be invalid or unenforceable, the remaining provisions shall nevertheless continue in full force and effect, unless the provision held invalid or unenforceable shall substantially impair the benefits of the remaining portions of this Agreement.

3. **Confidentiality of Patient Data.** PPI, IPA and each Participating Provider understand and agree that the right to information and records of participants is governed by state and federal law regarding the confidentiality of patient medical records. Each party shall comply with all such laws and regulations in the performance of its respective obligations under this Agreement.

4. **Confidentiality of Rate Data.** PPI, IPA and Participating Provider agree that they will not disclose the discounted rates and/or the compensation payable to Participating Provider pursuant to the terms of this Agreement, except to the extent required by applicable laws or as may be required in order to carry out the terms of this Agreement.

5. **Cooperation.** PPI, IPA and Participating Provider agree that, to the extent compatible with the separate and independent management of each, they shall maintain an effective liaison and close cooperation.

6. **Modification.** This Agreement constitutes the entire understanding of the parties hereto and no changes, amendments or alterations shall be effective unless signed by both parties.

7. **Assignment.** This Agreement may not be assigned by either party without the written approval of both parties.

8. **Relationship of Parties.** It is understood and agreed that each party, together with its agents, servants and employees, is at all times acting as an independent contractor and that neither has any expressed or implied authority to assume or create any obligation or responsibility on behalf of or in the name of the other party.

9. **Appendices.** Any attached appendices are an integral part of this Agreement.

10. **Third-Party Beneficiary.** Participating Provider hereby designates PPI Clients as third-party beneficiaries of this Agreement.

11. **Roster.** The IPA or its Participating Providers agree that PPI and/or Clients may use the names, addresses, telephone numbers and type of services or facilities associated with the IPA.

12. **ERISA Requirements.** In the event a client is regulated under the Employee Retirement Insurance Security Act of 1974 (ERISA) or state legislation of a similar nature, client and not IPA shall be responsible for complying with all requirements of ERISA or pursuant to such state legislation. IPA will reasonably cooperate with client by furnishing such material or information as it has access to and control of to aid client in meeting statutory or regulatory reporting requirements. For the purposes of ERISA and any applicable state legislation of a similar nature, neither IPA nor any of its Participating Providers shall be designated or deemed to be an administrator or named fiduciary of the benefit programs offered by a PPI client.

13. **Force Majeure.** Neither party shall be liable nor deemed to be in default of any delay or failure to perform under this agreement deemed to result, directly or indirectly, from any cause beyond the reasonable control of either party, including without limitation, acts of God, civil or military authority, acts of public enemy, fires, floods, strikes or regulatory delay or restraint.

14. **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.

15. **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) 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.

(c) 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).

(d) 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).

16. **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.

17. **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.

18. **Dispute Resolution.**

(a) CCPA 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 and PLAN agree that the arbitration results shall be binding on both parties in any subsequent litigation or other dispute.

19. **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 (7th) 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 Preferred Plan, Inc.
Robert J. Curry
President
Preferred Plan, Inc.
10600 W. Higgins Road, Ste. 405
Rosemont, IL 60018

IN WITNESS WHEREOF, the parties have executed this Agreement.

Effective Date: December 1, 1998 Through December 31, 2000

IPA: CCPA

By: [signature]

Name: MAUREEN MURPHY

Title: EXECUTIVE DIRECTOR

Address: 2300 CHILDREN'S PLAZA
MAILBOX #49
CHICAGO, IL 60614

Date: 12/1/98

PREFERRED PLAN, INC.

By: [signature]

Robert J. Curry

President

10600 W. Higgins Road, Ste. 405

Rosemont, IL 60018

Date: 12/8/98

APPENDIX A

Licensure and Certification.

The IPA Hospital Facility is licensed in the State in which the IPA is located and is accredited by.

__X__ JCAHO: Accreditation ends __/__/__

__X__ Medicare Participating Facility; approval ends ___/___/___.

_____ Other (specify) _____; ends ___/___/___.

Professional Liability Insurance.

IPA Participating Providers shall maintain professional liability insurance in the amounts of no less than $1,000,000 per occurrence and $3,000,000 per annual aggregate. The carrier is _____.

Governing Law.

This Agreement shall be governed by and construed in accordance with the laws of the State in which the IPA is located.

Notices.

Notices are to be sent to the addresses below.

IPA: CCPA	PREFERRED PLAN, INC.
By: Maureen Murphy	By: Robert J. Curry
Name: MAUREEN MURPHY	Robert J. Curry
Title: EXECUTIVE DIRECTOR	President
Address: 2300 CHILDREN'S PLAZA MAILBOX #49 CHICAGO, IL 60614	10600 W. Higgins Road, Ste. 405 Rosemont, IL 60018
Date: 12/1/98	Date: 12/8/98
Federal Tax I.D. #: 36-4071049	

APPENDIX C

CHILDREN'S COMMUNITY PHYSICIANS' ASSOCIATION

To assist PREFERRED PLAN, INC., in their efforts, the IPA and it's Physicians will agree to accept as payment in full a negotiated fee of fifteen percent (15%) below the lesser of billed charges or Preferred Plan Inc's usual and customary rate (70th percentile of MDR). Payment will be made within 30 business days of receipt of claim. If payor fails to make payment in accordance with this Agreement, Payor will forfeit said discount.

AMENDMENT 1 TO THE PREFERRED PLAN CONTRACT WITH CHILDREN'S MEMORIAL HOSPITAL OF ILLINOIS

IDENTIFICATION: The following list of National PPO Affiliations, exclusive with the Preferred Plan, Inc., shall be entitled to the Preferred Plan discount as long as their ID and/or Preferred Plan's identification is shown at point of registration (inpatient and outpatient). Lack of proper identification will result in forfeiture of the discount.

USA Managed Care Organization (formerly USA HealthNetwork)
Pro America Managed Care
Provider Networks of America (PRO NET)
Medical Control
Ethix Mid-Rivers

By: _____ Date: 12/1/98
(A duly authorized representative of Children's Memorial Hospital)

By: _____ Date: 12/8/98
Robert J. Curry, President of Preferred Plan, Inc.

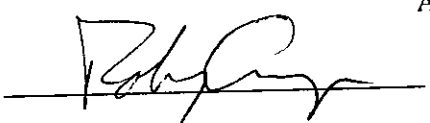
Amendment to the Contract between Children's Community Physicians' Association and Preferred Plan, Inc.

To assist PREFERRED PLAN, INC., in their efforts, Children's Community Physicians' Association and its Physicians will agree to accept as payment in full a negotiated fee of 88% of billed charges.

Payment will be made within 30 business days of receipt of a fully documented clean claim for the services performed. If Payor fails to make payment in accordance with this Agreement, Payor will forfeit said discount and be responsible for the non-discounted fee as determined above.

This Amendment will be effective for services rendered on and after June 1, 2003.

PREFERRED PLAN, INC.

Signature: 

Print Name: Robert J. Curry

Title: President

Date: 4/29/03

CHILDREN'S COMMUNITY PHYSICIANS' ASSOCIATION

Signature: Teresa Chan

Print Name: TERESA CHAN

Title: Executive Director

Date: April 25, 2003