PREFERRED NETWORK ACCESS, INC.
PREFERRED PROVIDER AGREEMENT

THIS PREFERRED NETWORK ACCESS, INC. PREFERRED PROVIDER AGREEMENT made and entered into as of the date set forth on Exhibit A attached hereto by and between PREFERRED NETWORK ACCESS, INC., an Illinois Corporation (the "Network") and the physician or physician group identified on Exhibit A attached hereto (the "Provider").

RECITALS:

A. The Network is an Illinois Corporation formed to organize a network of various health care providers and to represent various payors (the "Payors"), in establishing cost-saving relationships with health care providers and assisting the Payors with health care cost management. From time to time, the Network intends to execute agreements with Payors which offer health care programs or benefits to beneficiaries (the "Beneficiaries"), which programs or benefits include selective contracting with health care providers.

B. Provider is a physician or physician group (or a partnership or corporation composed of such persons) duly licensed by the state in which the Provider provides services.

C. Provider desires to make Provider's professional services available to Beneficiaries of Payors with which the Network contracts, in consideration of the payments described in Article 2.

D. Provider and the Network represent to one another that one of the purposes of this Agreement is to establish a health care delivery system committed to the advancement of quality health care services in an efficient and cost effective manner.

AGREEMENT

NOW THEREFORE, in consideration of the recitals and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1. Services and Duties of Provider

1.1 Provider agrees to provide Health Care Services to Beneficiaries in consideration of the payments described in Article 2.

1.2 Provider agrees to provide and maintain a standard of quality medical care consistent with the ethical principles and standards of the American Medical Association and each State Medical Association where Provider practices, in providing efficient, cost-effective delivery of Health Care Services to Beneficiaries.

1.3 Provider shall provide Health Care Services which are Medically Necessary to Beneficiaries provided that such services are consistent with the scope of Provider's license and with the standards of practice for quality care generally recognized within the medical community of Provider's subspecialty. Health Care Services which are not medically necessary are not eligible for payment under this Agreement.

1.4 Provider shall provide Health Care Services to Beneficiaries in the same manner and quality as are provided to Provider's other patients.

1.5 Provider shall maintain a medical license in the state(s) where Provider practices medicine, and shall have a current Federal DEA narcotics number. Provider shall maintain appropriate medical staff privileges with at least one (1) hospital which is a participating Hospital pursuant to a Network Preferred Hospital Agreement. Evidence of compliance with these requirements shall be submitted to the Network upon request. Provider agrees to notify the Network within five (5) business days, in writing, should Provider receive notice of any threatened or pending (i) loss of license, narcotics number or hospital privileges, (ii) sanction/disciplinary action by any professional organization or hospital, (iii) criminal indictment of any nature, or (iv) the filing of a malpractice action against Provider by any Beneficiary. Provider shall cooperate with the Network's periodic recredentialling process which shall include, but not be limited to, Provider's giving consent to the release of information from each hospital at which Provider has medical staff privileges.

1.6 Provider shall comply with relevant Federal, State and local laws, statutes, ordinances, orders and regulations which are applicable to the terms and conditions of this Agreement as reasonably determined by Provider.

1.7 Provider agrees to provide Health Care Services to those Beneficiaries who select Provider or are referred to Provider, as Provider's case load or schedule policy permits on an equal basis. In the event that Provider is unable to provide Health Care Services to any Beneficiary, Provider shall notify the Network.

1.8 Where circumstances warrant, Provider will refer Beneficiaries to other Participating Providers (defined as a person or entity who or which has signed a Network Preferred Hospital Agreement and/or Preferred Provider Agreement) unless medically contraindicated. In the event that Provider refers a Beneficiary to a physician or hospital other than a Participating Provider, Provider shall so inform Beneficiary prior to said referral.

1.9 Provider shall not discriminate against Beneficiaries on the basis of race, sex, color, marital status, sexual orientation, age, religion, national origin, or source of payment.

1.10 Provider authorizes the Network to identify Provider as a Preferred Provider and to publish Provider's name and other pertinent information in the marketing materials prepared by the Network.

1.11 To the extent permitted by law, Provider will cooperate with Payor's coordination of benefits efforts, providing such information as Provider may obtain from other payors, either primary or secondary, for a particular Beneficiary. Payments made to Provider by Payors and/or Beneficiaries pursuant to this Agreement shall be based upon the Reimbursement Rates set forth in Exhibit A regardless of whether such Payor is the primary or secondary payor of a Beneficiary.

1.12 Provider agrees to maintain a high standard of quality medical care consistent with the ethical principles and standards of the American Medical Association and State Medical Association. The Network reserves the right to monitor the care provided by Provider in order to assess practice patterns and standards.

2. Payment to Providers

2.1 Provider agrees to accept as payment in full for Health Care Services rendered to Beneficiaries (excluding services not covered under a Beneficiary's Payor's benefit plan, and any applicable co-payments, co-insurance or deductibles) Provider's customary charges, as discounted in accordance with Exhibit A (the "Reimbursement Amount"). Provider shall bill the appropriate Payor its usual and customary charges for Health Care Services. Provider's usual and customary charges for services will be communicated from time to time by Provider to the Network, and will not exceed the charges of Provider customarily assessed by Provider to patients with commercial insurance or to patients who are beneficiaries of Payors which are members of other preferred health care networks.

2.2 Coordination of Benefits. Provider acknowledges that where a Payor is primary under applicable coordination of benefit rules, Payor shall pay the Reimbursement Amount. Provider further acknowledges that where a Payor is other than primary under applicable coordination of benefit rules, Payor shall pay only those amounts, which, when added to amounts owed to Provider from other sources, pursuant to the applicable coordination of benefit rules, equals one hundred percent (100%) of the Reimbursement Amount.

2.3 Provider shall bill the relevant Payor for Health Care Services rendered to a Beneficiary, and the Payor shall be liable for the Reimbursement Amount.

2.4 Provider shall also be entitled to receive directly from the Beneficiary any co-payment, co-insurance or deductible for which the Beneficiary is responsible pursuant to the Payor's program or plan. Provider shall also be entitled to recover directly from the Beneficiary an amount equal to Provider's usual and customary charges for services which are not covered by a Payor's program or plan.

2.5 Provider shall furnish to the Payor, a HCFA 1500 Form or its future equivalent and/or other financial documentation reasonably required by the Payor to verify and substantiate the provisions of and charges for Health Care Services to a Beneficiary.

3. Duties and Obligations of the Payor

3.1 Each Payor agrees to expeditiously process a properly completed claims payment form for Health Care Services rendered to a Beneficiary.

3.2 Each Payor agrees to promptly pay the Reimbursement Amount to Provider following its receipt of properly completed claims payment form from Provider, for all Health Care Services rendered to Beneficiaries which are covered by the Payor's program or plan, within thirty (30) days of the Payor's receipt of a properly completed claims payment form (subject to Section 2.2) (Coordination of Benefits).

3.3 Each Payor agrees to verify for Provider the eligibility of any person who claims he/she is covered by a Payor program or plan.

4. Advertising and Publication

4.1 Provider agrees that the Network shall have the right to identify Provider as a Preferred Provider and to publish Provider's name and other pertinent information in the various marketing materials and Preferred Provider Directories prepared from time to time by the Network. Provider agrees to provide relevant information and documentation to the Network to enable the Network to accomplish the objectives set forth above.

4.2 Notwithstanding anything herein to the contrary, the Network, Provider and each of the Payors each reserves the right to and the control of the use of its name, symbols, trademarks and service marks presently existing or later established or developed. In addition, except as set forth above, neither the Network, Provider nor the Payors shall use any other party's name, symbols, trademarks or service marks in any advertising or promotional materials or otherwise without the prior written consent of that party.

5. Audit of Medical and Billing Records

5.1 Provider shall prepare and maintain medical, financial and other records or data with respect to Beneficiaries that Provider typically prepares and maintains on behalf of Provider's patients. Such records shall be maintained in accordance with prudent record-keeping procedures as required by applicable Federal and State law. Provider shall secure from Beneficiaries to whom it provides services an appropriate authorization to release all patient records to the Network and Payor for purposes of utilization review, quality assurance and /or claims payment determination.

5.2 The Network and Provider shall have the mutual right, upon request, to inspect and copy, upon reasonable advance notice and during normal business hours or at such other times as may be agreed upon, relevant accounting and administrative books and records, as they pertain to this Agreement. Such information shall be provided to each party pursuant to procedures designed to protect the confidentiality of patient medical records in accordance with applicable legal requirements and recognized standards of professional practice.

6. Utilization Review and Quality Control

6.1 Provider agrees to participate fully and on a regular basis in any Utilization Review and Quality Control procedures established from time to time in the reasonable discretion of the Network.

6.2 Notwithstanding the foregoing, any Utilization Review and Quality Control procedures established by the Network subsequent to the effective date of this Agreement shall be subject to the approval of Provider, which approval shall not be unreasonably withheld.

7. Insurance Requirements; Indemnification

7.1 Provider shall carry professional liability insurance or an equivalent program of self insurance (reasonably acceptable to the Network) in minimum amounts as specified below. Provider shall, where possible, name the Network as an additional insured on any such insurance policy. Provider shall notify the Network of cancellation or material modification of the coverage under such professional liability insurance at least thirty (30) days prior to any cancellation or modification. Certificates of insurance indicating Provider's professional liability insurance shall be provided to the Network no later than thirty (30) days following execution of this Agreement.

7.2 (a) Provider shall carry professional liability insurance or equivalent program of self-insurance (reasonably acceptable to the Network) in minimum amounts of one million dollars ($1,000,000) for any one incident, and three million dollars ($3,000,000) for annual aggregate.

(b) Provider shall also maintain a policy or program of comprehensive general liability insurance, with minimum coverage of not less than three hundred thousand dollars ($300,000) for Provider's property, three hundred thousand dollars ($300,000) per claim for bodily injury, together with a combined single limit bodily injury and/or property damage insurance coverage of not less than one million dollars ($1,000,000).

(c) In the case of a Physician Group, Provider shall carry the amounts in 7.2(a) and 7.2(b), above, for each physician providing medical services on behalf of the Physician Group.

7.3 In the case of a Physician Group, the terms and provisions of the Agreement to accept credentialing responsibility set forth in Exhibit C attached hereto are incorporated herein.

7.4 Provider acknowledges that it and its employees and agents are solely responsible for providing Health Care Services to Beneficiaries. Accordingly, Provider agrees to indemnify and hold the Network and Payors harmless from and against any and all losses, costs and expenses (including reasonable attorneys' fees) resulting from any breach of duty or negligent or intentional act or omission of Provider, its officers, directors, agents or employees, in the care or treatment of (or failure to care for or treat) any Beneficiary.

8. Representations and Warranties of Provider

8.1 Provider represents and warrants that Provider is currently, and for the duration of this Agreement, shall remain licensed to practice medicine in accordance with any and all applicable Federal, State and local statutes and regulations in the state in which Provider provides services.

8.2 Provider represents and warrants that Provider has, and for the duration of this Agreement, shall maintain all licenses required by law. Provider agrees to submit to the Network evidence and documentation of Provider's compliance with this section upon request by the Network

9. Confidentiality and Nondisclosure

9.1 Provider and the Network agree that neither this Agreement nor the fees Provider has received or will receive as a result of Health Care Services rendered to Beneficiaries will be disclosed to any person, firm or entity, without the prior written consent of Provider and the Network, or in the absence of a court order requiring disclosure.

10. Term and Termination of Agreement

10.1 This Agreement shall become effective as of the date specified in Exhibit A and shall continue in effect for a term of twelve (12) months from such date and shall be automatically renewed on the anniversary date thereafter for twelve (12) month periods, unless sooner terminated pursuant to this Section 10.

10.2 This Agreement may be terminated if there is any material default in the performance of the terms and conditions of this Agreement which default has not been cured within thirty (30) days following written notice of such default. Nothing in this Agreement shall be construed to limit either party's lawful remedies in the event of a material default in this Agreement.

10.3 This Agreement shall terminate automatically and without notice with respect to Provider who has Provider's license to practice medicine in any state revoked or suspended; Provider's Drug Enforcement Agency number revoked or suspended; Provider's general and professional liability insurance required by this Agreement canceled or upon Provider's indictment , arrest or conviction for (i) any felony or (ii) any criminal charges relating to the practice of medicine or financial misconduct including, but not limited to, offering or soliciting remuneration for referrals or billing for services that were not provided as claimed. Such an automatic termination shall be effective as of the date such suspension/revocation/cancellation or indictment/arrest/conviction occurs.

10.4 In the event of the expiration or termination of this Agreement, Provider shall continue to provide, and be compensated for Covered Services to Beneficiaries according to the terms and conditions of this Agreement until such Beneficiaries can be safely transferred to another Participating Provider.

10.5 Provider agrees to notify the Network immediately upon the occurrence of any circumstances, including those set forth above, which would render this Agreement terminable by the Network.

10.6 Termination of this Agreement shall not affect any rights or obligations hereunder which shall have previously accrued, or shall thereafter arise with respect to any occurrence prior to termination.

10.7 Notwithstanding anything herein to the contrary, Provider may terminate this Agreement by giving the Network party ninety (90) days prior written notice: provided, however, that Provider may not terminate this Agreement except for cause during the first twelve (12) months.

10.8 Provider agrees that if this Agreement is terminated, Provider shall exercise Provider's best efforts to notify all Beneficiaries who are under Provider's care or seek services from Provider that Provider is no longer a Network Preferred Provider. For those Beneficiaries under Provider's care who so desire, Provider shall transfer the Beneficiaries to other appropriate Network Provider(s).

10.9 Following termination of this Agreement, the Network shall notify Beneficiaries of such termination through the regular periodic updating of Network Provider listings for Beneficiaries.

11. Relationship of the Parties

11.1 Nothing contained in this Agreement shall be construed as creating the relationship of partners, joint venturers or agents between the Network (or any Payor) and Provider. Neither party, nor any of its officers, directors, agents or employees, shall hold itself out as an agent or affiliate of the other party. The Network and Payors shall not be responsible for any act, obligation, or default of Provider, Provider's officers, directors, agents or employees.

12. Notices

12.1 Any notice required or permitted with respect to this Agreement shall be in writing and either (i) personally served, (ii) served by Certified Mail - Return Receipt Requested, or (iii) by Federal Express, on or to a party at the following addresses:

To the Network: Preferred Network Access, Inc.
1510 West 75th Street, Suite 250
Darien, Illinois 60561
Attention: Joseph M. Zerega, President

Provider: See Exhibit A.

or to such other addressees or addresses as the Network or Provider, respectively, may designate by notice given in like manner.

13. Miscellaneous Provisions

13.1 This Agreement constitutes the entire agreement between Provider and the Network, and contains all of the agreements between the parties with respect to the subject matter hereof. This Agreement supersedes any and all other agreements, either oral or written, between the parties hereto with respect to the subject matter hereof.

13.2 No change or modification of this Agreement shall be valid unless the same shall be in writing and signed by both parties.

13.3 No waiver of any term or provision of this Agreement shall be valid unless in writing and signed by Provider and the Network.

13.4 If any portion or portions of this Agreement shall be, for any reason, invalid or unenforceable, the remaining portion or portions shall nevertheless be valid, enforceable and carried into effect.

13.5 This Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original, but together shall constitute one and the same agreement, which agreement shall, for all purposes be sufficiently evidenced by any such executed counterpart(s).

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

13.7 The provisions herein contained shall inure to the benefit of and be binding upon the parties hereto, their successors, subsidiaries, assigns and legal representatives. This Agreement shall also inure to the benefit of each of the Beneficiaries of a Payor which is a member of the Network.

13.8 In the event that either party institutes or responds to litigation with respect to the enforcement or interpretation of the provisions of this Agreement, the prevailing party shall be entitled to recover from the other party its costs, including reasonable attorney's fees, incurred in such litigation.

14. Additional Terms and Provisions

14.1 Exhibit B contains terms and provisions in addition to or in substitution for the terms and provisions set forth above.

IN WITNESS WHEREOF, the Provider and the Network have executed this Agreement on the date set forth below, effective as of the date set forth in Exhibit A.

PREFERRED NETWORK ACCESS, INC., an Illinois Corporation:	CHILDREN'S COMMUNITY PHYSICIANS ASSOCIATION, an IPA:
Signature: Joseph M. Zerega	Signature: Maureen Murphy
Name: Joseph M. Zerega	Name: MAUREEN MURPHY
Title: President	Title: EXECUTIVE DIRECTOR
Date: Mar. 17, 2000	Date: 3/21/00

EXHIBIT A

IPA:	Children's Community Physicians Association
PROVIDER TAX ID#:	Varies (each physician practice has its own tax ID)
EFFECTIVE DATE OF AGREEMENT:	April 1, 2000
ADDRESS OF PROVIDER:	Varies
TELEPHONE NUMBER:	Varies
CONTRACT OFFICER:	Maureen Murphy Executive Director
ADMINISTRATIVE ADDRESS:	2300 Children's Plaza, no. 49 Chicago, IL 60614-3394
TELEPHONE NUMBER:	(773) 975-8824
TELECOPY NUMBER:	(773) 975-8742

DESCRIPTION OF REIMBURSEMENT AMOUNTS:

Laboratory/Pathology - The Reimbursement Amount for Laboratory/Pathology (CPT codes 80049-89399), is one hundred fifty percent (150%) of the 1999 or current Resource Based Relative Value Scale (RBRVS). Total reimbursement shall be the lesser of the Reimbursement Amount or Provider's usual billed charges less fifteen percent (15%), less Beneficiary's applicable deductible, copayment and/or coinsurance.

Evaluation and Management (E/M) Services - The Reimbursement Amount for Evaluation and Management Services (E/M CPT codes 99201-99499) is one hundred fifty percent (150%) of the 1999 or current Resource Based Relative Value Scale (RBRVS). Total reimbursement shall be the lesser of the Reimbursement Amount or Provider's usual billed charges less fifteen percent (15%), less Beneficiary's applicable deductible, copayment and/or coinsurance.

Immunizations - The Reimbursement Amount for Immunizations (CPT codes 90281-90799) is Provider's usual billed charges less fifteen percent (15%), less Beneficiary's applicable deductible, copayment and/or coinsurance.

Specialty Care Physician Services (all other codes) - The Reimbursement Amount for all Other Services is one hundred seventy-five percent (175%) of the 1999 or current Resource Based Relative Value Scale. Total reimbursement shall be the lesser of the Reimbursement Amount or billed charges less twenty percent (20%), less Beneficiary's applicable deductible, copayment and/or coinsurance.

EXHIBIT B
ADDITIONAL TERMS AND PROVISIONS
TO THE PROVIDER AGREEMENT
BETWEEN
PREFERRED NETWORK ACCESS, INC.
AND
CHILDREN'S COMMUNITY PHYSICIANS ASSOCIATION

Amend the Title of the Agreement by replacing "The Preferred Provider Agreement" with "The Preferred IPA Agreement..."

AMENDMENT TO THE PREAMBLE:
Amend by deleting the entire paragraph and replacing it with the following: "THIS PREFERRED NETWORK ACCESS, INC. PREFERRED IPA AGREEMENT made and entered into as of the date set forth on Exhibit A attached hereto by and between PREFERRED NETWORK ACCESS, INC., an Illinois Corporation (the "Network") and the CHILDREN'S COMMUNITY PHYSICIANS ASSOCIATION (the "IPA") identified on Exhibit A attached hereto, consisting of physicians or physician groups (the "Provider")."

AMENDMENT TO THE RECITALS:
Amend Recital B by adding the following to the end of the paragraph: "The IPA is an independent physician association, authorized to represent its Participating Providers."

Amend Recital C by adding "IPA and" to the beginning of the sentence.

Amend Recital D by adding "IPA," to the beginning of the sentence.

Amend by adding the following Section to the Agreement following the Section titled, "RECITALS:"

"DEFINITIONS:

"Beneficiary or Beneficiaries" shall mean a person (persons) who is (are) entitled to receive Covered Services pursuant to the relevant Payor's Program or Plan.

"Clean Claim" and/or "Properly Completed Claim" shall mean an electronic or manual claim in the HCFA 1500 format or its future equivalent and/or other financial documentation reasonably required by the Payor to verify and substantiate the provisions of and charges for Health Care Services to a Beneficiary.

"Covered Services" and "Covered Health Care Services" shall mean health care, medical services or benefits provided to a Beneficiary for which a Payor is required to pay in accordance with the Payor's Program or Plan.

"Medically Necessary" shall mean, with respect to each Beneficiary, services or supplies which, under the terms and conditions of this Agreement are determined 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 Covered Health Care Services, means that care as an inpatient is necessary due to the type 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.

"Participating Provider" and/or "Provider" shall mean the individual physicians, licensed by the laws of the state of Illinois, who have entered into a contractual agreement with IPA which allows Provider to enter into this Preferred IPA Agreement on their behalf.

"Payor" shall mean an employer, insurance carrier, health care service plan, trust, nonprofit hospital service plan, any governmental unit or any other entity which has an obligation to provide Covered Services to a Beneficiary in accordance with the Payor's Program or Plan.

"Payor Agreement" shall mean a contract between a Payor and Network which provides for Network Providers, including Provider pursuant to this Agreement, to render Covered Services at Reimbursement Amounts determined and established by Network and such Payor.

"Physician Group" shall mean physicians formed and represented as a group for contracting and administrative purposes including, but not limited to, independent practice associations, physician hospital organizations and medical groups.

"Preferred Provider," "Network Preferred Provider" and "Network Provider" shall mean a health care provider including, but not limited to, hospital, physician or other ancillary provider who has entered into a contractual agreement with Network to provide Covered Services to Beneficiaries.

"Program or Plan" shall mean a health care benefit product or plan issued by Network or Payor which identifies to Beneficiaries Covered Services to which they are entitled.

Amend all references to "program or plan" by replacing with, "Program or Plan."

AMENDMENT TO SECTION 1; Services and Duties of Provider:
Amend Subsection 1.2 by deleting "Provider agrees to" in the beginning of the sentence and replacing it with "IPA agrees to require Provider to..."

Amend Subsection 1.3 by deleting "Provider shall provide" in the beginning of the sentence and replacing it with "IPA shall require that Provider provides..."

Amend Subsection 1.4 by deleting "Provider shall" and replacing it with "IPA shall require Provider to..."

Amend Subsection 1.5 by deleting "Provider shall" in the first and second sentences and replacing it with "IPA shall require Provider to..." Further amend by deleting "Provider" in the beginning of the fourth sentence and replacing it with "IPA..." Also in the fourth sentence after the words, "in writing," add "from the time Provider becomes aware,..." In the fifth/last sentence, add "IPA and" to the beginning of the sentence.

Amend Subsection 1.6 by deleting "Provider shall comply" and replacing it with "IPA shall comply and require Provider to comply..."

Amend Subsection 1.7 by deleting "Provider agrees to" and replacing it with "IPA agrees to require Provider to..."

Amend Subsection 1.8 by adding "or IPA" after the third/last time the word "Provider" appears in the last sentence.

Amend Subsection 1.10 by adding "IPA and" to the beginning of the sentence.

Amend Subsection 1.11 by deleting "Provider will" in the first sentence and replacing it with "IPA shall require Provider to..."

Amend Subsection 1.12 by deleting "Provider agrees to" and replacing it with "IPA agrees to require Provider to..."

AMENDMENT TO SECTION 2; Payment to Providers:
Amend Subsection 2.1 by deleting "Provider agrees to" in the beginning of the first sentence and replacing it with "IPA agrees that Provider shall..." Further amend by adding in the third/last sentence after the words "from time to time by" the words "IPA or..."

Amend Subsection 2.2 by deleting "Provider acknowledges" in the second sentence and replacing it with "IPA agrees that Provider shall acknowledge..."

Amend Subsection 2.3 by adding after "...bill the relevant Payor" the following: "within sixty (60) days..."

Amend Subsection 2.5 by deleting "Provider shall" and replacing it with "IPA shall require Provider to..."

AMENDMENT TO SECTION 3; Duties and Obligations of the Payor:
Amend the title by adding, "and Network" to the end of the section's title.

Amend Subsection 3.1 by adding the following to the end of the paragraph: "Network and Payor agrees to follow St. Anthony's and Medicare's coding and payment guidelines."

Amend Subsection 3.2 by adding the following to the beginning of the first sentence: "To obtain the benefit of the negotiated rates listed in Exhibit A,..." Further amend by adding the following to the end of the paragraph: "Properly completed claims not reimbursed as described in this Section, shall be paid at the Provider's usual and customary charges without discount in accordance with Payor's Program or Plan."

Amend by adding the following Subsection 3.4: "Network may not sell discounts made available under this Agreement to other Networks or affiliates. If IPA or Participating Provider suspects such action may have occurred, IPA shall immediately notify Network with details of the suspected default in accordance with Section 10.2, Term and Termination of Agreement."

Amend by adding the following Subsection 3.5: "The Network agrees to periodically provide IPA with updates or an up-to-date listing of all Payors who have executed Payor Agreements with the Network."

Amend by adding the following Subsection 3.6: "Network agrees to furnish IPA with all relevant information that is reasonably within Network's control including, but not limited to: (a) Network's policies and procedures; (b) the identity of each Payor; (c) summary description of each Payor's Program or Plan and Beneficiary identification cards; (d) Network's complete listing of Participating Providers."

Amend by adding the following Subsection 3.7: "Network also agrees to work in good faith with IPA, Provider and Payor should the need for dispute resolution become necessary."

Amend by adding the following Subsection 3.8: "Network agrees that it will put forth its best efforts to enforce the terms of this Agreement and actively monitor Payors, or any agents of Payor, for compliance with the terms of this Agreement."

Amend by adding the following Subsection 3.9: "Network shall notify IPA as soon as possible, but within fifteen (15) working days, of any legal, financial or government action, or other problem or situation which may impair the ability of the Network or Payors, or any aspect of Payor, to carry out its obligation and duties under this Agreement including, but not limited to: (a) changes in ownership or equity partnerships; (b) changes in licensure, NCQA or similar accreditation, or HCFA or similar certification; (c) new product development from Network or Payors."

Amend by adding the following Subsection 3.10: Network agrees to notify its Payors, Beneficiaries and Network Preferred Providers of this Agreement and about the services of Provider. Nothing in this Agreement shall be construed as interfering with the freedom of choice of eligible Beneficiaries."

Amend by adding the following Subsection 3.11: "Network represents and warrants that it is authorized to execute this Agreement on behalf of each Payor, and each Payor hereby agrees to the terms of this Agreement."

Amend by adding the following Subsection 3.12:"Network shall require all Payors to maintain defined, acceptable financial incentives to encourage Beneficiaries to use Preferred Providers when healthcare services are required. Acceptable financial incentives are defined as a minimum of a 10% differential in coinsurance between in-network and out-of-network benefits. Such financial incentives shall be clearly outlined to Beneficiaries in their Program or Plan description. In the event that a Beneficiary is covered under a Program or Plan which does not provide for such minimum benefit differential, then the negotiated rates listed in Exhibit A shall not apply and Network or Payor shall reimburse Participating Provider one hundred percent (100%) of Participating Provider's usual billed charges in accordance with Payor's Program or Plan."

Amend by adding the following Subsection 3.13: "Any Payor who has not agreed to include acceptable financial incentives, as described in Subsection 3.12, shall be clearly identified to IPA in writing. IPA may reject participation of any Payor whose Program or Plan does not include acceptable financial incentives by notifying Network in writing within ten (10) days of receiving such notification. If IPA fails to respond within ten (10) days, it will be deemed acceptance of the new Payor's participation."

Amend by adding the following Subsection 3.14: "Network shall require all Payors to provide each Beneficiary with an identification card to be presented to Provider at the time of service or as soon as feasible in the case of an emergency. The identification card shall clearly identify: (a) the Network, Payor and employer; (b) a telephone number for verification of eligibility and benefits; (c) a telephone number to determine and comply with pre-certification, pre-authorization or other utilization management requirements and; (d) a telephone number and address for claims submission and billing inquiries."

AMENDMENT TO SECTION 4; Advertising and Publication:
Amend Subsection 4.1 by adding "IPA and" to the beginning of both the first and second sentences.

Amend Subsection 4.2 by adding "IPA," after the word "Network," in both the first and second sentences.

AMENDMENT TO SECTION 5; Audit of Medical and Billing Records:
Amend Subsection 5.1 by deleting "Provider shall" in the beginning of the first sentence and replacing it with "IPA shall require Provider to..."

Amend Subsection 5.2 by adding "IPA," after the word "Network" and "written" after the word, "upon" in the first sentence. Further amend by adding the following to the end of the paragraph: "Network, Payor, IPA or Provider shall compensate the requesting party a reasonable amount to cover the cost of copying such records."

Amend by adding the following Subsection 5.3: "Participating Provider and Network agrees that refunds will be requested in writing on an individual account basis with the same time limitations as the Network or Payor allows the Provider to submit a claim; sixty (60) days as stated in Subsection 2.3 (i.e., 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 from the date of payment). The Payor shall not be allowed to process an offset against any subsequent payments due to the Provider."

Amend by adding the following Subsection 5.4: "Network and/or Payor agree that audit of medical and billing records will not delay payment on the individual accounts selected for such audit."

AMENDMENT TO SECTION 6; Utilization Review and Quality Control:
Amend Subsection 6.1 by adding "IPA and" to the beginning of the sentence.

Amend Subsection 6.2 by deleting the word "Provider" and replacing it with "IPA..."

AMENDMENT TO SECTION 7; Insurance Requirements; Indemnification:
Amend Subsection 7.1 by deleting the words "Provider shall" and replacing with "IPA shall require Provider to..." Delete the word "Provider" in the third sentence and replace with "IPA..." Delete the fourth/last sentence in its entirety.

Amend Subsection 7.2(a) by adding the following to the beginning of the sentence: "For Providers practicing in the State of Illinois, IPA ensures that each..." Further amend by adding the following paragraph: "For Providers practicing in the State of Indiana, IPA ensures that each Provider shall carry and maintain professional liability coverage as shall be necessary to insure Provider against claims or damages arising in connection with the performance of services as shall be necessary to qualify Provider as a "provider" under the Indiana Medical Malpractice Act. Evidence of such coverage and qualification shall be provided upon request."

Amend Subsection 7.2(b) by adding the following to the beginning of the sentence: "IPA shall make its best efforts to require that each..."

Amend Subsection 7.2(c) by deleting the paragraph and replacing it with the following: "In the case of a Physician Group, IPA shall require and ensure that each physician providing medical services on behalf of the Physician Group shall carry the amounts in 7.2(a), above, and its best efforts in 7.2(b), above.

Amend Subsection 7.3 by deleting the words "a Physician Group" and replacing with "an IPA..."

Amend Subsection 7.4 by deleting "Accordingly, Provider agrees" in the second sentence and replacing it with "Accordingly, IPA agrees on behalf of it Participating Providers..." Also amend by adding the following to the end of the paragraph: "Further, Network agrees to indemnify and hold the IPA harmless from and against any and all losses, costs and expenses (including reasonable attorneys' fees) resulting from any breach of duty or negligent or intentional act or omission of the Network, its officers, directors, agents or employees."

AMENDMENT TO SECTION 8; Representations and Warranties of Provider:
Amend Subsection 8.1 by deleting the word "Provider" in the beginning of the sentence and replacing it with "IPA..."

Amend Subsection 8.2 by deleting the word "Provider" in the beginning of the sentence and replacing it with "IPA..." Further amend by adding "IPA and/or..." to the beginning of the second sentence.

Amend by adding the following Subsection 8.3: "IPA represents and warrants that it is authorized to execute this Agreement on behalf of the Participating Providers and hereby agrees to the terms of this Agreement."

AMENDMENT TO SUBSECTION 9.1; Confidentiality and Nondisclosure:
Amend this Subsection by adding "IPA," to the beginning of the sentence.

AMENDMENT TO SECTION 10; Term and Termination of Agreement:
Amend Subsection 10.1 by deleting it and replacing it with the following: "This Agreement shall become effective as of the date specified in Exhibit A and shall continue in effect for an initial term through December 31, 2001 from such date and shall be automatically renewed thereafter for consecutive twelve (12) month periods, unless sooner terminated pursuant to this Section 10."

Amend Subsection 10.4 by adding the following to the end of the sentence: ", but not later than sixty (60) days from the expiration or termination date. IPA, Provider and Network shall work together to arrange for other Preferred Providers to furnish Covered Healthcare Services to such Beneficiary. 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 sixty-first (61st) day after expiration or termination, whichever occurs first. If a Beneficiary is receiving ongoing ambulatory treatment, IPA will require Participating Provider to promptly notify Beneficiary that this Agreement has expired or been terminated. Reimbursement for Covered Services rendered to Beneficiaries following sixty (60) days after the termination of this Agreement will be at one-hundred percent (100%) of Participating Provider's usual billed charges. Participating Providers will not be required to accept Beneficiaries after termination of this Agreement except as previously stated."

Amend Subsection 10.5 by deleting the word "Provider" and replacing it with "IPA..."

Amend Subsection 10.7 by deleting the word "Provider" and replacing it with "IPA" both times it appears in the paragraph. Further amend by adding the words, "or Network" after the first time the word, "IPA" appears in the sentence.

Amend Subsection 10.8 by deleting the entire paragraph and replacing it with the following: "IPA agrees that if this Agreement is terminated, IPA, Provider and Network shall exercise their best efforts to notify all Beneficiaries who are under Provider's care or seek services from Provider that Provider is no longer a Network Preferred Provider. For those Beneficiaries under Provider's care who so desire, Provider shall transfer the Beneficiaries to other appropriate Network Provider(s) in accordance with Subsection 10.4."

AMENDMENT TO SUBSECTION 11.1; Relationship of the Parties:
Amend this Subsection by deleting the word "Provider" at the end of the first sentence and both times it appears in the third sentence and replacing it with "IPA..."

AMENDMENT TO SUBSECTION 12.1; Notices:
Amend by deleting the words, "See Exhibit A." and replacing it with the following:

"Maureen Murphy
Executive Director
Children's Community Physicians Association
Children's Memorial Hospital
2300 Children's Plaza, Mailbox #49
Chicago, Illinois 60614-3394"

Further amend this Subsection by deleting the word "Provider" and replacing it with "IPA..."

AMENDMENT TO SECTION 13; Miscellaneous Provisions:
Amend Subsection 13.1 by deleting the word "Provider" and replacing it with "IPA..."

Amend Subsection 13.3 by deleting the word "Provider" and replacing it with "IPA..."

Amend Subsection 13.6 by adding the following to the beginning of the paragraph: "Network is duly licensed by the Illinois Department of Insurance and/or by other appropriate regulatory or governmental agencies, covering the provision of medical and health care services."

Amend Subsection 13.7 by deleting it in its entirety and replacing it with the following: "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."

Amend by adding the following Subsection 13.9: "In the event that Network or Payor is regulated under the Employee Retirement Income Security Act of 1974 ("ERISA") or state legislation of a similar nature, Network and/or Payor and not IPA shall be responsible for complying with all requirements of ERISA and/or such state legislation. IPA shall reasonably cooperate with Network and/or Payor by furnishing such material or information as it has access to and control of to aid Network and/or Payor in meeting statutory and regulatory reporting requirements. For the purposes of ERISA and any applicable state legislation of a similar nature, IPA shall not be designated or deemed to be an administrator or named fiduciary of the Program or Plan offered by Network or Payor."

Amend the closing paragraph before the signature section by deleting the word "Provider" and replacing it with "IPA..."

AMENDMENT TO EXHIBIT C; Agreement to Accept Credentialing Responsibility:
Amend the Preamble and the entire Exhibit C by deleting the word "Group" and replacing it with "IPA..." Further amend by deleting all reference to "Provider Agreement" and replacing it with "IPA Agreement..."

Amend Item 1.a by deleting the word "practice" after the word "state" and replacing it with "medical..."

EXHIBIT C

AGREEMENT TO ACCEPT CREDENTIALING RESPONSIBILITY

Children's Community Physicians Association (hereinafter "Group") is separately entering into a Provider Agreement with Preferred Network Access, Inc. (the "Network"). As an alternative to participating in the Network's usual physician credentialing process, Group has agreed to accept full and complete responsibility for credentialing all physicians in the group who will participate as providers under the Provider Agreement, including, but not limited to, confirming licensure, board certification, hospital admitting privileges, presence of adequate professional liability insurance as defined in the Network Preferred Provider Agreement, and absence of adverse disciplinary actions. Group assumes responsibility for establishing and adhering to a physician credentialing process which shall meet the following minimum criteria:

1. Written policies and procedures for physician credentialing which:

   a. require the physician to have a valid state practice license, a valid DEA license, adequate professional liability insurance coverage as defined in the Network Preferred Provider Agreement, and to provide a statement regarding board certification(s) and hospital privilege(s), with such information verified from a primary source;

   b. require a statement by the physician revealing any professional disciplinary action taken by local, state or national organizations including all information from the National Practitioner Data Bank;

   c. require a statement by the physician regarding any physical or mental conditions which could interfere with the provision of care or pose a health risk to patient;

   d. require disclosure of all malpractice actions brought against the physician;

2. Written policies and procedures for provider recredentialing such that the credentialing:

   a. is performed at a minimum of every two years for each physician;

   b. incorporates items (1.a) through (1.d) of the credentialing process;

3. Written policies and procedures for responding to complaints about physicians and

4. Written policies and procedures for the suspension or termination of physician contract.

Group further agrees to indemnify, defend and hold harmless the Network and its directors, officers, employees and agents from any and all liability, claims and damages, including costs of defense and attorneys' fees, arising out of the alleged failure of the Network or Group to properly credential any physician in Group.

Group further agrees to permit the Network's representatives, upon seventy-two (72) hours advance notice and during normal business hours or at such other times as may be agreed upon, to inspect and review a random sample of physician applications and credential files selected at time of audit to ascertain compliance with Group's stated credentialing process.

Group further agrees that if their credentialing policies and procedures are revised, such new policies and procedures shall be communicated to the Network at least thirty (30) days prior to the effective date of the revision. If the Network, upon review, finds that the revised policies and procedures result in the failure of the credentialing procedures of Group to meet the minimum credentialing criteria as previously established, the Network shall have the right to immediately terminate this "Agreement to Accept Credentialing Responsibility."

PREFERRED NETWORK ACCESS, INC., an Illinois Corporation:	CHILDREN'S COMMUNITY PHYSICIANS ASSOCIATION, an IPA:
Signature: Joseph M. Zerega	Signature: Maureen Murphy
Name: Joseph M. Zerega	Name: MAUREEN MURPHY
Title: President	Title: EXECUTIVE DIRECTOR
Date: March 17, 2000	Date: 3/21/00

PNA

AMENDMENT I TO THE PREFERRED PROVIDER AGREEMENT
BETWEEN
PREFERRED NETWORK ACCESS, INC.
AND
CHILDREN'S COMMUNITY PHYSICIANS ASSOCIATION

This Amendment to the Preferred Provider Agreement of April 1, 2000 (the "Effective Date") by and between Preferred Network Access, Inc. (the "Network") and Children's Community Physicians Association (the "Provider") is made effective this First (1st) day of ~~February~~ March, 2004.

RECITALS:

A. WHEREAS, Preferred Network Access, Inc. and Children's Community Physicians Association entered into the Agreement, pursuant to which Children's Community Physicians Association agreed to provide certain health care services pursuant to said Agreement at agreed upon rates.

B. WHEREAS, Preferred Network Access, Inc. and Children's Community Physicians Association now desire to amend Exhibits A and B of the Agreement and Amendments thereto, if any, in certain respects.

NOW, THEREFORE, incorporating the above Recitals and in consideration of the mutual covenants herein contained, the parties hereto agree to amend the Agreement as follows:

Amend Exhibit A, Description of Reimbursement Amounts, by replacing it with the following:

DESCRIPTION OF REIMBURSEMENT AMOUNTS

Laboratory/Pathology - The Reimbursement Amount for Laboratory/Pathology (CPT codes 80048-89399), is one hundred fifty percent (150%) of the 2003 or current Resource Based Relative Value Scale (RBRVS). Total reimbursement shall be the lesser of the Reimbursement Amount or Provider's usual billed charges, less Beneficiary's applicable deductible, copayment and/or coinsurance.

Evaluation and Management (E/M) Services - The Reimbursement Amount for Evaluation and Management Services (E/M CPT codes 99201-99499) is one hundred fifty-five percent (155%) of the 2003 or current Resource Based Relative Value Scale (RBRVS). Total reimbursement shall be the lesser of the Reimbursement Amount or Provider's usual billed charges, less Beneficiary's applicable deductible, copayment and/or coinsurance.

Immunizations - The Reimbursement Amount for Immunizations (CPT codes 90281-90799) is Provider's usual billed charges less fifteen percent (15%), less Beneficiary's applicable deductible, copayment and/or coinsurance.

Specialty Care Physician Services (all other codes) - The Reimbursement Amount for all Other Services is one hundred seventy-five percent (175%) of the 2003 or current Resource Based Relative Value Scale. Total reimbursement shall be the lesser of the Reimbursement Amount or Provider's usual billed charges, less Beneficiary's applicable deductible, copayment and/or coinsurance.

Amend Exhibit B, Additional Terms And Provisions To The Physician Agreement, by adding the following:

AMENDMENT TO SECTION 13; Miscellaneous Provisions:
Amend by adding the following Subsection 13.9: "It is agreed that if Network and Provider are determined to be "business associates" under the provisions of the Health Insurance Portability and Accountability Act ("HIPAA") that Network and Provider hereby agrees that it will comply with all applicable requirements of HIPAA and will permit the timely amendment of this contract to be made to satisfy the applicable requirements of HIPAA."

All other terms and conditions of the Agreement not inconsistent with these amendments shall remain in full force and effect.

In WITNESS WHEREOF, the parties hereto have executed and delivered this Amendment as of the date set forth below, effective as of the date specified in the first paragraph of this Amendment.

PREFERRED NETWORK ACCESS, INC.,
an Illinois Corporation:

Signature: Joseph M. Zerega

Name: Joseph M. Zerega

Title: President

Date: Jan. 20, 2004

CHILDREN'S COMMUNITY
PHYSICIANS ASSOCIATION,
an Illinois Corporation:

Signature: Teresa Chan

Name: TERESA CHAN

Title: Executive Director

Date: February 18, 2004