AMENDMENT OF
PARTICIPATING PROVIDER AGREEMENT

THIS AMENDMENT, effective October 1, 2004, is entered by and between **MultiPlan, Inc.**, (or "MPI") 115 Fifth Avenue, New York, New York 10003-1004, and Children's Community Physicians Association (Provider), with principal offices located at 2300 Children's Plaza, Box 113, Chicago, Illinois 60614-3394.

WHEREAS, Provider previously has entered into one or more agreements ("Provider Agreement(s)") with BCE Emergis Corporation and/or its subsidiary or subsidiaries ("BCE Emergis"), under which Provider agreed to accept negotiated reimbursement rates ("Contract Rates") as reimbursement in full for health care services rendered to the individuals covered ("Covered Persons" or "Participants"), under health benefit plans ("Benefit Programs") issued or administered by Emergis customers ("Payors" or "Clients"); and

WHEREAS, effective March 4, 2004, BCE Emergis has been acquired by MultiPlan, Inc.;

WHEREAS, as part of that acquisition, all agreements entered into by Emergis were assigned to MultiPlan, Inc., and MultiPlan, Inc. has assumed all rights and obligations of Emergis under such agreements;

WHEREAS, the parties desire to amend the Provider Agreement(s) to incorporate reference to the acquisition described above;

THEREFORE, the Provider Agreement(s) are amended as follows:

I. All references to BCE Emergis or any of its subsidiaries in the Provider Agreement(s) shall be deemed to read "MultiPlan, Inc.", such that MultiPlan, Inc. is the party in privity of contract with Provider.

II. Provider agrees to recognize and accept the name and logo of MultiPlan, Inc. on identification cards and Explanation of Benefits forms (EOBs) issued by Payors/Clients as evidence of their respective rights, as a consequence of a contractual relationship with MultiPlan, Inc. or one of its subsidiaries, to access Provider as participating provider and to reimburse provider at Contract Rates for health care services rendered to Covered Persons/Participants. The rates below are not applicable to clients with discount card programs, auto liability programs and their members.

III. The Contract Rates set forth in the Agreement(s) as reimbursement rates are hereby deleted and replaced with the following:

MultiPlan – S99 Illinois 606	
Surgery Codes 10040-69999	153% of Current Medicare
Radiology Codes 70000-79999	153% of Current Medicare
Pathology Codes 80000-89999	153% of Current Medicare
Medicine Codes 90000-99499	153% of Current Medicare
Anesthesiology Codes	Conversion factor of $57 per 15 minute ASA Unit
HCPCS Codes	100% of Charges
Vaccines Percentile MDR Default	50th Percentile
Non-Vaccines Percentile MDR Default	90th Percentile

IV. In the event a Client repeatedly fails to pay Clean Claim within thirty (30) business days of receipt, Provider shall have the right, upon thirty (30) calendar days' written notice to Network, to exclude such Client from access under this Agreement. Notwithstanding the foregoing, Network shall have the right to attempt to resolve the matter to the reasonable satisfaction of Provider within the notice period, such that the Client will not be excluded.

V. In the event of a conflict between this Amendment and any provision of the Agreement(s), this Amendment shall prevail. No further modification is made to the Agreement(s) hereby.

IN WITNESS HEREOF, the undersigned duly authorized representatives of the parties have executed this Amendment.

MultiPlan, Inc.
115 Fifth Avenue

Children's Community Physicians Association
2300 Children's Plaza, Box 113

New York, New York 10003-1004

By: 10-20-04
Donald Rubin Date
Chairman

Chicago, Illinois 60614-3394

By: Teresa Chan Sept. 1, 2004
Signature Date
TERESA CHAN, EXECUTIVE DIRECTOR.
Print Name and Title

TIN: 36-407-1049

MultiPlan clients may use the following logos on participants' ID cards

Revised 7.21.04

AMENDMENT TO PROVIDER AGREEMENT

This Amendment ("Amendment") is entered into by **HealthNetwork ProAmerica Midwest, Inc.** ("HN") and **Children's Community Physicians Association** ("Provider"), and is effective as of June 1, 2000.

Recital:

Wheras, HN and Provider desire to amend **Exhibit A Preferred Rate Charges** of the **Provider Agreement** between them dated January 1, 1999 ("the Agreement") on the terms set forth in this Amendment, the parties agree as follows:

Amendment

The Preferred Rate Charges for Preferred Rate Services provided to Covered Persons by Provider in a Complete Claim submitted by Provider shall be the billed charges for such services less the following percentage discount ("the Discount"):

Fifteen (15%) Percent

Ratification

Except as specifically set forth herein, The Agreement is hereby ratified and affirmed in its entirety.

CHILDREN'S COMMUNITY PHYSICIAN ASSOCIATION

By: _____

Name: Jo T. Letwaitis

Title: Executive Director

HEALTHNETWORK PROAMERICA MIDWEST, INC.

By: _____

Lore Stanley
Vice President

WELLMARK HEALTHNETWORK, INC. PROVIDER AGREEMENT

The Provider Agreement attached to this signature page is entered into by and between the following parties as of the Effective Date set forth below:

CHILDREN'S COMMUNITY PHYSICIANS ASSOCIATION
PRINT FULL NAME OF INDIVIDUAL OR EXACT CORPORATE NAME OF THE CONTRACTING PROVIDER

2300 Children's Plaza, No. 49
(Address)

Chicago, IL 60614-3394
(City, State, Zip Code)

Phone Number: 773/975-8824

Fax Number: 773/975-8742

E-Mail Address: Mmurphy@childmmc.edu

By: _____
(Signature of Authorized Representative)

EXECUTIVE DIRECTOR
(Title)

36-4071049
(Tax Identification Number)

WELLMARK HEALTHNETWORK, INC.
1420 Kensington Road
Suite 203
Oak Brook, Illinois 60523

Phone: (630) 954-2900
Fax: (630) 472-4242

By: _____
David M. Gillies
Vice President

FOR WELLMARK HEALTHNETWORK USE ONLY:

EFFECTIVE DATE: JANUARY 1, 1999

F.S. 270
C.L. X

CHECK IF AGREEMENT:

INCLUDES APPENDIX AL – AUTOMOBILE LIABILITY ☐

PROVIDER AGREEMENT

This **PROVIDER AGREEMENT** ("Agreement") by and between **WELLMARK HEALTHNETWORK, INC.,** an Illinois corporation ("WHN") and the provider named on the signature page ("Provider") is effective as of the Effective Date set forth on the signature page ("Effective Date").

RECITALS:

A. WHN is an Illinois corporation which operates as a managed care organization, providing access to quality, cost-effective health care services of selected providers to purchasers of such services;

B. Provider is an individual health care provider, or an entity comprising individual health care providers, which desires to provide services pursuant to this Agreement; and

C. The parties desire that Provider participate in one or more WHN products on the terms of this Agreement.

AGREEMENT:

1. INCORPORATION INTO AGREEMENT. The signature page, Preamble, Recitals, Exhibits and Appendices are hereby incorporated into and made a part of this Agreement.

2. DEFINITIONS. In addition to the terms defined elsewhere in this Agreement, for purposes of this Agreement the following terms shall have the following definitions:

2.1 Covered Person is an Eligible Person and an Eligible Person's eligible dependents.

2.2 Eligible Person is an employee or member of a Payor who is represented by such Payor as entitled to receive Preferred Rate Services pursuant to a Plan.

2.3 Covered Services are, when used with respect to a particular Payor, services, supplies and products received by Eligible Person for which a Payor is obligated to pay pursuant to the terms of a Plan as the in effect.

2.4 Payor is: (a) an employer, labor union, association, insurance coalition, trust or other organization that is the administrator, payer or underwriter of any Plan benefits directly or indirectly subject to a Payor Agreement; and (b) the claim administrator or other claims processing agent of any Payor.

2.5 Payor Agreement is the agreement between WHN and a Payor by which Preferred Rate Services are made available to Covered Persons pursuant to the terms of a Plan and which contains one or more financial or other type of incentives for Covered Persons to utilize Provider.

2.6 Plan is a health benefit or automobile liability program underwritten or administered by a Payor.

2.7 Preferred Rate Charges are the rates applicable to each respective WHN product and applied to claims submitted by Provider for payment for Preferred Rate Services.

2.8 Preferred Rate Services are all Covered Services furnished by Provider to Covered Persons.

3. PROVIDER SERVICES.

3.1 Preferred Rate Services. Upon the presentation of an identification card issued to the Covered Person which includes the name or logo of WHN and states the Eligible Person's social security or other identification number ("ID Card"), Provider shall provide Preferred Rate Services to Covered Persons with respect to the WHN preferred provider product and each WHN product set forth in any **APPENDIX** attached hereto, in accordance with professional standards prevailing in the community and the terms of this Agreement, and without discriminating in the acceptance or treatment of Covered Persons on the basis of race, color, religion, national origin, sexual orientation, age, disability or type or availability of health care coverage. Provider may rely on a Payor's telephonic verification of a Covered Person's eligibility. Any patient who fails to present an I.D. card or who presents an I.D. card without the name or logo of WHN, or who presents an I.D. card with more than one name or logo of a managed care provider will not be eligible for the rates negotiated in this Agreement.

3.2 Assignment of Benefits; Release of Records; Referrals. Provider shall secure an assignment of benefits from each Covered Person for whom treatment is provided so that Provider may receive payments directly from the Payor. Provider shall obtain a valid written authorization for the release of medical records of each Covered Person to WHN or its authorized agent in connection with WHN's performance of its duties and obligations under this Agreement. If a referral to another provider or a hospital admission is indicated, Provider shall refer and admit Covered Persons to other WHN providers whenever clinically appropriate and consistent with Provider's professional judgment.

3.3 Credentialling. As an alternative to participating in WHN's usual physician credentialling protocols, Provider shall verify credentials of physicians who will participate as providers under this Agreement pursuant to WHN's credentialling/recredentialling provisions, attached as **APPENDIX CR**, and otherwise required by Illinois law, including, but not limited to, confirming licensure, board certification, hospital admitting privileges, presence of adequate professional liability insurance or required by each hospital, and absence of adverse disciplinary action.

In consideration for WHN delegating this responsibility to Provider, Provider shall indemnify and hold WHN harmless from and against any claims or damages, including attorneys' fees and expert witness' fees, which may be sought from WHN as a result of the negligence of Provider in performing credentialling as set forth in this Section 3.3.

4. PROVIDER COMPENSATION.

4.1 Claim Submission. Provider shall submit all bills and required authorizations to WHN or its designee at the address set forth on the ID Card within sixty (60) days of the date of service. In the event additional information is necessary for each bill to be considered a Complete Claim, it will be submitted within thirty (30) days of WHN's request.

4.2 Complete Claim. A claim shall be considered a "Complete Claim" if it: (a) is submitted on a HCFA 1500 form or its successors and contains all information necessary for adjudication, including: Provider's Unique or National Provider Identification Number, or other recognized identifier; a Federal Tax Identification Number registered with WHN; all necessary authorization forms and numbers; social security number of the Eligible Person; patient's name, date of birth and date of service; amount of payment collected from or on behalf of the patient at the time service was rendered; name and payor group or other identification number of the Payor or plan sponsor; ICD-9 code or its successors, revenue codes, and the most appropriate, comprehensive current CPT code or HCPC that describes the services actually provided; and name, address and authorized signature of Provider; and (b) is entered, audited, and adjudicated with no manual intervention by a processor within thirty (30) days of receipt (without an edit or suspend code that holds the claim in the system until manually reviewed and adjudicated).

4.3 Repricing. Provider's Complete Claims shall be repriced by WHN or its designee pursuant to the terms of this Agreement and forwarded to the Payor within five (5) business days of receipt. Provider hereby acknowledges and agrees that such repricing may include the application of coding criteria for medical, surgical and ancillary services, based on the AMA CPT-4 manual or its successors, HCFA data or other common industry sources, to identify unbundling, multiple surgical procedures, fragmentation, upcoding, use of mutually exclusive procedures, duplicate, obsolete and invalid codes and other similar processes. WHN agrees not to automatically down code any code submitted by Provider without express permission from Provider.

4.4 Claim Payment.

(a) Provider shall accept the lesser of Provider's billed charges or the Preferred Rate Charge set forth in Exhibit A as full payment collectively from the responsible Payor and the Covered Person for Preferred Rate Services rendered to each Covered Person, regardless of what federal tax identification number appears on the bill and regardless of the location at which services are rendered.

(b) Provider shall not request any deposit or other pre-payment or bill Covered Persons for Preferred Rate Services, except: (i) any Plan co-payments; or (ii) following receipt of an Explanation of Benefits from the Payor, any Plan co-insurance or deductibles.

(c) Payors shall pay their portion of repriced Complete Claims directly to Provider within [redacted] days of the later of receipt of the repriced Complete Claim, or the conclusion of any coordination of benefits, subrogation, workers' compensation or other adjudication. Late payments shall be made at

Provider's billed charges. Provider shall not contest any discounts included in any Preferred Rate Charges received from any Payor more than ninety (90) days after receipt of such payment.

(d) Each Payor shall furnish Provider and each Eligible Person with an Explanation of Benefits for each payment of Preferred Rate Charges, which shall include the following: (i) the name of the patient; (ii) the Eligible Person's social security or other identification number; (iii) that the patient is a Covered Person; (iv) the name of the Payor; (v) the group number of the employer, union, association or other plan sponsor; (vi) the dates of service; (vii) the co-payment and/or co-insurance amount, if any; (viii) the deductible amount, if any; (ix) the amount due Provider, if any; (x) the Preferred Rate Charges; (xi) the billed charges; and (xii) the amount paid by the Payor.

4.5 Coordination of Benefits. If a Covered Person is eligible for reimbursement for any Preferred Rate Services pursuant to any other contractual or legal entitlements, Provider shall be responsible for the billing and collection of such reimbursements, and shall authorize and assist each Payor coordinating benefits with other carriers or benefit plans. If, under National Association of Insurance Commissioners ("NAIC") criteria, the Payor is the primary payer, Provider's compensation shall be as specified in this Agreement. If, under NAIC criteria, the Payor is other than the primary payer, any further reimbursement to Provider from such Payor shall not exceed the lesser of the Preferred Rate Charge or an amount which, when added to the amount paid by the primary payer, equals the Preferred Rate Charge.

4.6 Amendment of Preferred Rate Charges. The Preferred Rate Charges may be revised by WHN upon notice to Provider at least sixty (60) days prior to the end of the then current initial or renewal term, effective as of the following renewal term. If Provider rejects the revised rates and new rates are not renegotiated by the anniversary of the effective date, the Agreement terminates as of the anniversary of the effective date and subject to Section 9.4.

4.7 Liability for Claim Decisions and Payments. All claims decisions and payments shall be the responsibility of the Payor or Covered Persons as described in the applicable Plan. WHN shall not be responsible or liable for any claims decisions or claims payments and shall not be an insurer, guarantor or underwriter of the responsibility or liability of any Payor to provide benefits pursuant to any Plan.

5. MARKETING AND PROMOTION. WHN, with Provider's cooperation, shall market, advertise and actively promote the services, goals and purposes of WHN and the affiliation of Provider with WHN. WHN may use the name, address, telephone number, specialties, hospital affiliations and medical practice affiliations of Provider for such purposes by distribution of the WHN provider directory and as otherwise reasonably determined by WHN. Likewise, Provider may promote its affiliation with WHN.

6. GENERAL OBLIGATIONS OF THE PARTIES.

6.1 Of WHN. WHN shall comply with the terms and conditions of this Agreement and shall:

(a) make best efforts to enter into Payor Agreements in which Covered Persons have access to Provider;

(b) provide WHN provider directories upon the reasonable request of Provider;

(c) provide Plan Sponsor listing on a quarterly basis;

(d) provide protocols for and, when applicable to Covered Persons, administer the WHN Utilization Management/Quality Assurance Program ("UM/QA Program");

(e) administer the Grievance Procedure and the Payment and Billing Dispute Procedure, attached as Exhibit B; and

(f) make best efforts to have Payors apply the terms and conditions of Payor Agreements only to Eligible Persons and, when notified by Provider, investigate any alleged misapplication and, to the extent such misapplication is verified by WHN, assist Provider in obtaining reimbursement of any improper discounts and, at the election of Provider, terminate access to Provider for such Payor's Covered Persons, subject to Section 9.4.

6.2 Of Provider. Provider shall comply with the terms and conditions of this Agreement and shall:

(a) hold and continue to maintain an unrestricted license, certificate or other governmental authorization to provide services in each state in which Provider provides Preferred Rate Services;

(b) continue to be a member in good standing of the professional staff of each WHN hospital of which Provider shall be a member at any time during the term of this Agreement, subject to the credentialling requirements of WHN;

(c) purchase and maintain policies of professional liability and other insurance, or self-insurance reasonably acceptable to WHN, in amounts necessary to insure Provider and Provider's agents and employees, acting within the scope of their duties, against any claims arising directly or indirectly out of Provider's services hereunder. Provider shall make best efforts to notify WHN prior to any cancellation or material alteration of such insurance, and shall obtain replacement coverage prior to such cancellation or material alteration, and provide WHN with the new certificate of insurance. If any such insurance is maintained in a claims-made form, Provider shall insure the tail period for not less than two (2) years after the expiration of the policy, subject to applicable law;

(d) provide WHN with access to the patient records and information of all Covered Persons as may be reasonably requested by WHN;

(e) cooperate in the resolution of matters filed pursuant to the Grievance Procedure and the Payment and Billing Dispute Procedure in effect at the time the matter is filed with WHN;

(f) notify WHN in advance of using any new or modified Federal Tax Identification Number in connection with this Agreement;

(g) permit authorized representatives of WHN to inspect the premises and equipment and review the scope of services provided to Covered Persons;

(h) maintain financial records of services provided pursuant to this Agreement for at least four (4) years from the date of termination of this Agreement, or longer as required by law, regulation or otherwise, and permit inspection by WHN or its authorized representatives, upon reasonable notice during normal business hours, of the financial records of such services;

(i) comply with the protocols of the UM/QA Program when the Covered Person's ID Card requires Provider to call the WHN toll-free number for pre-certification by WHN pursuant to Exhibit C, as amended from time to time. Provider hereby acknowledges and agrees that:

(i) notwithstanding any policy, procedure or determination of the UM/QA Program or any other similar program, Payors bear sole responsibility for all claims decisions, and in no event shall any such program or any claim determination affect Provider's professional judgment or any Provider-patient relationship. The denial of any pre-certification, certification or referral authorization pursuant to Exhibit C shall only affect Provider compensation and shall not affect Provider's professional obligations to the Covered Person; and

(ii) nothing herein shall be construed to preclude Provider from providing services outside the scope of the Covered Person's Plan upon their written agreement, subject to Section 4.4 (unless otherwise agreed to by the Covered Person); and

(j) notify WHN in writing within five (5) business days of the date that Provider becomes aware of:

(i) any termination, suspension, limitation or restriction of Provider's license, certification or other governmental authorization;

(ii) any termination, suspension, limitation or restriction of any professional staff appointment or clinical privileges at, or any disciplinary action taken by, any hospital, if applicable to Provider;

(iii) the failure to maintain any insurance as required herein;

(iv) Provider's conviction for a felony, or any other criminal charge relating to Provider's professional practice;

(v) any lawsuits, judgments or settlements relating to Provider's treatment of any Covered Person pursuant to this Agreement;

(vi) any disciplinary action taken by a state licensing board, DEA or other government agency;

(vii) Provider's suspension or exclusion from participation in the Medicare, Medicaid or any state health care program; or

(viii) any other legal, governmental or other action or event which materially impairs Provider's ability to perform its duties and obligations under this Agreement.

7. REPRESENTATIONS AND WARRANTIES.

7.1 By WHN. WHN represents and warrants to Provider that:

(a) WHN is a corporation duly organized, validly existing and in good standing under the laws of the State of Illinois with full corporate power and authority to conduct its business as currently conducted;

(b) this Agreement has been authorized by all necessary corporate action on behalf of WHN and has been duly executed and delivered by it and constitutes a legal and binding obligation of WHN;

(c) WHN now possesses, and during the term of this Agreement shall maintain, all licenses, permits, registrations, governmental and other approvals and insurance required to engage in the business of a managed care organization and to carry out its obligations hereunder and under its agreements with Payors; and

(d) WHN shall comply with all legal requirements relating to its operation and the terms of this Agreement.

7.2 By Provider. Provider represents and warrants to WHN that:

(a) the information furnished by Provider in connection with the Provider Application and all updates thereto is and shall remain true, correct and complete, with no material omissions;

(b) Provider now possesses, and during the term of this Agreement shall maintain, all licenses, permits, registrations, governmental and other approvals and all insurance required hereby;

(c) Provider shall comply with all legal requirements relating to the provision of services and the terms of this Agreement; and

(d) if Provider is a partnership, corporation, professional association, independent practice association or group of individual providers:

(i) Provider is an entity duly organized and validly existing under the laws of the state of its organization with full power and authority to conduct its practice as currently conducted;

(ii) this agreement has been authorized by all necessary action on behalf of Provider and has been duly executed and delivered by it and constitutes a legal and binding obligation of Provider;

(iii) Provider is authorized and empowered to execute this Agreement on behalf of each such provider as though they were original signatories hereto, and each such provider shall be bound by the duties and obligations of Provider hereunder; and

(iv) unless Provider furnishes notice to WHN to the contrary, all of Provider's individual providers shall be subject to the terms of this Agreement. Concurrently herewith, Provider shall provide WHN with a list of all individual providers subject to this Agreement, and shall provide notice to WHN within thirty (30) days of the addition or deletion of an individual provider from such list.

8. CONFIDENTIAL AND PROPRIETARY INFORMATION.

8.1 Non-Disclosure of Confidential Information. During the term of this Agreement, certain non-public information may be disclosed by each party to the other party, including, without limitation, Preferred Rate Charges, Payor service fees, patient finances, earnings, volume of business, methods, systems, practices, plans and all similar information of any kind or nature. Each party, its officers, directors, employees and agents shall hold such information in the strictest confidence as a fiduciary; shall not voluntarily or involuntarily sell, transfer, publish, disclose, display or otherwise make available to others any portion of such information or related materials without the express written consent of the other party; and shall use its best efforts to protect such information consistent with the manner in which it protects its most confidential business information. Neither party shall be in default for failure to supply information which such party reasonably believes cannot by law be supplied, or for supplying information which such party reasonably believes is required by law to be supplied.

8.2 Medical Records. The parties shall maintain the confidentiality of the medical records of Covered Persons. The dissemination of such information shall require the consent of such Covered Persons or as shall be otherwise permitted by law.

8.3 Trademarks, Service Marks and Copyrights. The parties reserve the right to the control and use of their names and all symbols, trademarks, or service marks presently existing or later established. Except as specifically provided in Section 5, neither party shall use the other party's name, symbols, trademarks or service marks in advertising or promotional materials or otherwise without the prior written consent of such other party.

8.4 Remedies. The parties acknowledge that irreparable injury and damage will result from any violation of this Section 8 and that remedies at law would be inadequate. Accordingly, the parties are authorized and entitled to obtain from any court of competent jurisdiction temporary, preliminary and permanent injunctive relief for the breach of any provision of this Section 8 without proving actual damages resulting from such breach. The remedies provided for in this paragraph shall be cumulative and in addition to any other rights and remedies to which a party may be entitled at law or in equity.

9. TERM AND TERMINATION.

9.1 Term. The initial term of this Agreement shall be two (2) years from the Effective Date. This Agreement shall be automatically renewed for additional two (2) year terms unless not renewed by either party upon notice at least ninety (90) days prior to the end of the then current term, or terminated by Provider within thirty (30) days of its receipt of an amendment to Exhibit B or Exhibit C, all subject to Section 9.4. If this Agreement is not renegotiated by the anniversary of the effective date, the Agreement is terminated as of the anniversary of the effective date, subject to Section 9.4. Either party may terminate this Agreement without cause upon ninety (90) days written notice.

9.2 Termination.

(a) By WHN Without Appeal. WHN may terminate this Agreement immediately, upon notice to Provider and without appeal under the WHN Provider Termination Appeal Procedure, attached as Exhibit D, upon the occurrence of any of the following:

(i) the material breach of any provision of Section 6.2 or Section 7.2 or the occurrence of any event in Section 6.2(k);

(ii) the death, disability or retirement of Provider, if an individual Provider;

(iii) the sale, exchange or other disposition of substantially all of the assets or stock of, or membership in Provider or the merger or consolidation of Provider with any other entity;

(iv) the institution of bankruptcy, receivership, insolvency, reorganization, liquidation or other similar proceedings by or against Provider not cured pursuant to Section 9.3; or

(v) the occurrence or happening of any event, or any action by Provider, which reasonably could place WHN in material breach of any agreement with any Payor or WHN provider.

(b) By Provider. Provider may terminate this Agreement immediately, upon notice to WHN, upon the occurrence of any of the following:

(i) the material breach of any provision of Section 6.1 or Section 7.1;

(ii) the sale, exchange or other disposition of substantially all of the assets or stock of, or membership in WHN or the merger or consolidation of WHN with any other entity;

(iii) the institution of bankruptcy, receivership, insolvency, reorganization, liquidation or other similar proceedings by or against WHN not cured pursuant to Section 9.3; or

(iv) the occurrence or happening of any event, or any action by WHN, which reasonably could place Provider in material breach of any agreement with any other entity.

9.3 Termination for Default of Agreement. In the event of a default of this Agreement other than the occurrence of an event specified in Section 9.2, and without limiting any other remedy available at law or in equity after termination of this Agreement, the non-defaulting party may terminate this Agreement upon thirty (30) days prior notice, unless within such thirty (30) day period the default is cured or Provider files a notice of appeal pursuant to the WHN Provider Termination Appeal Procedure.

9.4 Continuing Obligations. In the event of the non-renewal of this Agreement, or the termination of this Agreement other than pursuant to Section 9.2, Provider shall continue to provide, and each Payor shall continue to make payments for Preferred Rate Services to all Covered Persons then under the care of Provider until the appropriate discharge or transfer of such inpatient Covered Persons, and until the conclusion of treatment of such outpatient Covered Persons for a specific condition existing as of termination, but in no event longer than thirty (30) days following termination.

9.5 Termination of Payor. Provider may terminate access to Provider of all Covered Persons of any Payor upon at least ninety (90) days notice to WHN, subject to Section 9.4.

10. MISCELLANEOUS PROVISIONS.

10.1 Independent Contractor. In performing the services described in this Agreement, Provider shall at all times be an independent contractor. Nothing in this Agreement shall be deemed to create or constitute the relationship of employer and employee between WHN and Provider, or be construed as giving either party any rights as a partner in or owner of the business of the other party, or entitling either party to control in any manner the conduct of the other party's business.

10.2 Notices. All notices shall be in writing and delivered either in person, effective on the date of delivery, or by registered mail, return receipt requested, postage prepaid, effective on receipt, addressed to the parties at the address set forth on the signature page of this Agreement, or to such other address as a party may provide in accordance with this Section 10.2.

10.3 Other Documents. The parties shall execute any and all documents necessary in order to effectuate the purposes of this Agreement.

10.4 Entire Agreement. This Agreement represents the entire agreement and understanding of the parties and all prior and concurrent agreements, understandings, representations and warranties, whether written or oral, in regard to the subject matter hereof, including without limitation any provider agreement with WHN in force and effect, are superseded hereby and have been merged herein. This Agreement may be amended in writing executed by an authorized representative of each party.

10.5 Compliance with Terms. The failure of either party to insist upon strict compliance with any of the terms herein (by way of waiver or breach) shall not be deemed to be a continuous waiver in the event of any future breach or waiver of any condition hereunder.

10.6 Assignment; Rights of the Parties. No rights or obligations under this Agreement may be assigned without the written consent of the parties. Nothing in this Agreement, whether express or implied, is intended to: confer any rights or remedies under or by reason of this Agreement on any persons other than the parties and their respective successors and permitted assigns; relieve or discharge the obligation or liability of any third persons to either party; or give any third persons any right of subrogation or action over against either party.

10.7 Conflict of Laws. This Agreement shall be governed by the laws of the State of Illinois without giving effect to its conflicts of law provisions.

10.8 Attorneys' Fees and Legal Expenses. If either party shall institute any action or proceeding in court to enforce any provision hereof, for damages, or for any other judicial remedy, the prevailing party shall be entitled to receive from the losing party reasonable attorneys' fees, all expenses of litigation, and all court costs in connection with such action or proceeding.

10.9 Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same agreement.

10.10 Force Majeure. Neither party shall be liable for failure to perform any duty or obligation that such party may have under this Agreement where such failure has been caused by an act of God, fire, flood, strike, inevitable accident, war or any cause outside the reasonable control of such party.

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

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TABLE OF EXHIBITS

(PROVIDER AGREEMENT)

EXHIBIT A

PREFERRED RATE CHARGES

Complete Claims for Preferred Rate Services will be repriced to, and the Preferred Rate Charge shall be, the lesser of billed charges or the Preferred Rate Charge fee schedule, a representative sampling of which is attached to this Exhibit A and made a part hereof.

FEE SCHEDULE

270

ANESTHESIA SERVICES

$50.00 per unit
Time units are calculated on 15 minute timer intervals
Base units are determined by McGraw-Hill Base Anesthesia Values
Total units = base units + modifiers + time units
Total units x $50.00 per unit = Preferred Rate Charge

ALL OTHER SERVICES

Any procedure not included in the fee schedule or covered as anesthesia services shall be repriced to 80% of billed charges.

CPT-4 CODE 99070

CPT-4 Code 99070 will be repriced to $0.00.
An appropriate CPT-4 Level I Code or HCPCS Level II Code must be identified on claims submitted for supplies and materials provided to Covered Persons

PHARMACEUTICALS

The Preferred Rate Charge for Pharmaceuticals not uniquely Identified by a CPT-4 or HCPCS Code shall be limited to the most current AWP.

EXHIBIT A
MAXIMUM ALLOWABLE FEE SCHEDULE BASE

1997 Illinois Locale "16" Medicare Par RBRVS

Category	CPT Code Range	Multiplier
Surgery	10000-69999	2.0
	20000-29999	2.1
	30000-39999	2.2
	40000-49999	2.2
	50000-59999	2.2
Except Obstetrics	59400-59699	2.0
	60000-69999	2.0
Except Neurology	61000-64999	2.3
Radiology	70000-79999	1.7
Pathology	80000-89999	2.0
Medicine except	90000-99999	1.5
Immunizations	90700-90745	See Attached
Cardiovascular	92950-93999	1.8
except Surgery	92982-92996	2.0
	93501-93545	2.0
Evaluation & Management	99201-99215	1.6
Preventative	99381-99412	See Attached

CPT Code 99070 will be repriced to $0.00; please use the most appropriate HCPCS Level II code to identify supplies and materials.

The Preferred Rate Charge for HCPCS Level II codes shall be the 50th percentile Med Index for zip code 606 release 12/96.

ANESTHESIA SERVICES

$50.00 per unit
Time units are calculated on 15 minute timer intervals
Base units are determined by McGraw-Hill Base Anesthesia Values
Total units = base units + modifiers + time units
Total units x $50.00 per unit = Preferred Rate Charge

ALL OTHER SERVICES

Any procedure not included on the RBRVS or covered as anesthesia services shall be repriced to 80% of billed charges.

PHARMACEUTICALS

The Preferred Rate Charge shall be limited to the most current AWP.

IMMUNIZATIONS

CPT-4	Fee Max
90700	36.90
90701	30.94
90702	20.50
90703	20.50
90704	29.82
90705	35.04
90706	28.33
90707	34.67
90708	30.19
90709	31.31
90712	32.80
90713	37.28
90714	20.50
90716	65.98
90717	63.37
90718	20.87
90719	31.31
90720	51.81
90724	22.36
90725	22.36
90726	137.54
90727	26.84
90728	156.55
90730	71.20
90731	40.26
90732	23.86
90733	73.06
90735	27.21
90737	38.39
90741	23.86
90744	28.70
90745	38.39

PREVENTATIVE

CPT-4	Fee Max
99381	71.68
99382	77.20
99383	82.71
99384	88.22
99385	119.47
99386	130.50
99387	147.04
99391	58.82
99392	62.49
99393	68.01
99394	73.52
99395	99.25
99396	108.44
99397	123.15
99401	32.17
99402	64.33
99403	96.50
99404	128.66
99411	45.95
99412	91.90

EXHIBIT A
FEE SCHEDULE

CPT		DESCRIPTION	PREFERRED RATE CHARGE
10040		ACNE SURGERY	120.52
10060		DRAINAGE OF SKIN ABSCESS	129.94
10061		DRAINAGE OF SKIN ABSCESS	236.40
10120		REMOVE FOREIGN BODY	138.26
11040		SURGICAL CLEANSING, ABRASION	78.54
11050		TRIM SKIN LESION	69.34
11100		BIOPSY OF SKIN LESION	112.20
11200		REMOVAL OF SKIN TAGS	95.86
11300		SHAVE SKIN LESION	91.94
11400		REMOVAL OF SKIN LESION	118.96
11401		REMOVAL OF SKIN LESION	164.14
11402		REMOVAL OF SKIN LESION	209.40
11420		REMOVAL OF SKIN LESION	129.66
11421		REMOVAL OF SKIN LESION	185.04
11422		REMOVAL OF SKIN LESION	226.54
11600		REMOVAL OF SKIN LESION	216.32
11601		REMOVAL OF SKIN LESION	281.74
11700		SCRAPING OF 1-5 NAILS	56.42
11710		SCRAPING OF 1-5 NAILS	56.42
11730		REMOVAL OF NAIL PLATE	131.60
11750		REMOVAL OF NAIL BED	335.50
11770		REMOVAL OF PILONIDAL LESION	483.74
11900		INJECTION INTO SKIN LESIONS	64.54
11960		INSERT TISSUE EXPANDER(S)	1,469.26
12011		REPAIR SUPERFICIAL WOUND(S)	168.82
12031		LAYER CLOSURE OF WOUND(S)	233.80
12051		LAYER CLOSURE OF WOUND(S)	287.56
13150		REPAIR OF WOUND OR LESION	472.12
17200		ELECTROCAUTERY OF SKIN TAGS	86.36
17260		DESTRUCTION OF SKIN LESIONS	177.72
19000		DRAINAGE OF BREAST LESION	106.42
19100		BIOPSY OF BREAST	169.42
19160		REMOVAL OF BREAST TISSUE	909.06
19162		REMOVE BREAST TISSUE, NODES	2,041.04
19180		REMOVAL OF BREAST	1,253.54
20220		BONE BIOPSY, TROCAR/NEEDLE	194.48
20670		REMOVAL OF SUPPORT IMPLANT	218.86
20680		REMOVAL OF SUPPORT IMPLANT	633.51
22610		THORAX SPINE FUSION	3,172.47
22612		LUMBAR SPINE FUSION	3,946.68
22840		INSERT SPINE FIXATION DEVICE	1,688.84
23410		REPAIR OF TENDON(S)	2,189.25
23455		REPAIR SHOULDER CAPSULE	2,863.29
24650		TREAT RADIUS FRACTURE	411.22

EXHIBIT A
FEE SCHEDULE

CPT		DESCRIPTION	PREFERRED RATE CHARGE
25500		TREAT FRACTURE OF RADIUS	437.43
25600		TREAT FRACTURE RADIUS/ULNA	514.86
25605		TREAT FRACTURE RADIUS/ULNA	874.08
26600		TREAT METACARPAL FRACTURE	315.99
26720		TREAT FINGER FRACTURE, EACH	246.52
26750		TREAT FINGER FRACTURE, EACH	218.74
27130		TOTAL HIP REPLACEMENT	4,280.32
27235		REPAIR OF THIGH FRACTURE	2,512.50
27447		TOTAL KNEE REPLACEMENT	4,526.05
27760		TREATMENT OF ANKLE FRACTURE	511.52
27786		TREATMENT OF ANKLE FRACTURE	494.97
27814		REPAIR OF ANKLE FRACTURE	1,919.50
27880		AMPUTATION OF LOWER LEG	1,833.64
28060		PARTIAL REMOVAL FOOT FASCIA	864.51
28290		CORRECTION OF BUNION	1,008.25
28292		CORRECTION OF BUNION	1,248.87
28470		TREAT METATARSAL FRACTURE	337.26
29065		APPLICATION OF LONG ARM CAST	160.31
29075		APPLICATION OF FOREARM CAST	131.00
29125		APPLY FOREARM SPLINT	88.16
29130		APPLICATION OF FINGER SPLINT	58.72
29405		APPLY SHORT LEG CAST	157.39
29515		APPLICATION LOWER LEG SPLINT	109.98
29540		STRAPPING OF ANKLE	72.79
29870		KNEE ARTHROSCOPY, DIAGNOSTIC	850.10
29877		KNEE ARTHROSCOPY/SURGERY	1,625.69
29881		KNEE ARTHROSCOPY/SURGERY	1,707.49
30520		REPAIR OF NASAL SEPTUM	1,281.98
30620		INTRANASAL RECONSTRUCTION	1,299.43
31575		DIAGNOSTIC LARYNGOSCOPY	266.44
31622		DIAGNOSTIC BRONCHOSCOPY	518.61
32480		PARTIAL REMOVAL OF LUNG	3,501.83
33210		INSERTION OF HEART ELECTRODE	524.79
33405		REPLACEMENT OF AORTIC VALVE	6,048.59
33511		CABG, VEIN, TWO	6,040.32
33512		CABG, VEIN, THREE	6,577.91
33513		CABG, VEIN, FOUR	7,115.39
33533		CABG, ARTERIAL, SINGLE	5,669.69
35301		RECHANNELING OF ARTERY	3,268.43
36000		PLACE NEEDLE IN VEIN	36.06
36471		INJECTION THERAPY OF VEINS	170.76
36620		INSERTION CATHETER, ARTERY	148.19
42820		REMOVE TONSILS AND ADENOIDS	651.38
42821		REMOVE TONSILS AND ADENOIDS	788.04

EXHIBIT A
FEE SCHEDULE

CPT		DESCRIPTION	PREFERRED RATE CHARGE
42825		REMOVAL OF TONSILS	570.70
42830		REMOVAL OF ADENOIDS	426.16
43235		UPPER GI ENDOSCOPY, DIAGNOSI	444.49
43239		UPPER GI ENDOSCOPY, BIOPSY	499.40
44005		FREEING OF BOWEL ADHESION	2,087.29
44140		PARTIAL REMOVAL OF COLON	2,846.98
44950		APPENDECTOMY	1,302.49
45330		SIGMOIDOSCOPY, DIAGNOSTIC	178.64
45378		DIAGNOSTIC COLONOSCOPY	631.97
45378	53	DIAGNOSTIC COLONOSCOPY	178.64
46600		DIAGNOSTIC ANOSCOPY	60.70
47000		NEEDLE BIOPSY OF LIVER	259.31
47600		REMOVAL OF GALLBLADDER	1,836.82
49000		EXPLORATION OF ABDOMEN	1,769.59
49500		REPAIR INGUINAL HERNIA	977.59
49505		REPAIR INGUINAL HERNIA	1,080.11
49520		REREPAIR INGUINAL HERNIA	1,314.79
51720		TREATMENT OF BLADDER LESION	216.52
51726		COMPLEX CYSTOMETROGRAM	286.99
51726	26	COMPLEX CYSTOMETROGRAM	234.06
51726	TC	COMPLEX CYSTOMETROGRAM	52.93
52000		CYSTOSCOPY	317.61
52005		CYSTOSCOPY, URETER CATHETER	442.84
52281		CYSTOSCOPY AND TREATMENT	491.30
52332		CYSTOSCOPY AND TREATMENT	592.66
52601		PROSTATECTOMY (TURP)	2,277.42
55250		REMOVAL OF SPERM DUCT(S)	563.51
55700		BIOPSY OF PROSTATE	298.03
56300		PELVIS LAPAROSCOPY,(PERITONEOSCOPY) DIAGNOSTIC	858.95
56304		LAPAROSCOPY; LYSIS	1,065.66
56340		LAPAROSCOPIC CHOLECYSTECTOMY	1,901.53
56501		DESTRUCTION, VULVA LESION(S)	191.97
57454		VAGINA EXAMINATION, BIOPSY	258.02
57505		ENDOCERVICAL CURETTAGE	170.10
58120		DILATION AND CURETTAGE (D&C)	579.70
58150		TOTAL HYSTERECTOMY	2,405.15
58260		VAGINAL HYSTERECTOMY	2,139.19
58340		INJECT FOR UTERUS/TUBE X-RAY	140.18
59400		OBSTETRICAL CARE	3,499.88
59510		CESAREAN DELIVERY	3,963.84
59820		CARE OF MISCARRIAGE	777.70
60500		EXPLORE PARATHYROID GLANDS	2,455.86
61510		REMOVAL OF BRAIN LESION	5,766.56
61700		INNER SKULL VESSEL SURGERY	8,251.96

EXHIBIT A
FEE SCHEDULE

CPT		DESCRIPTION	PREFERRED RATE CHARGE
61712		SKULL OR SPINE MICROSURGERY	885.82
62270		SPINAL FLUID TAP, DIAGNOSTIC	149.06
62279		INJECT SPINAL ANESTHETIC	210.70
62284		INJECTION FOR MYELOGRAM	382.49
62289		INJECTION INTO SPINAL CANAL	241.50
63030		LOW BACK DISK SURGERY	2,928.68
63047		REMOVAL OF SPINAL LAMINA	3,449.91
64450		INJECTION FOR NERVE BLOCK	173.21
64721		CARPAL TUNNEL SURGERY	960.96
65420		REMOVAL OF EYE LESION	711.30
66821		AFTER CATARACT LASER SURGERY	545.00
66984		REMOVE CATARACT, INSERT LENS	1,990.26
67210		TREATMENT OF RETINAL LESION	1,583.34
67840		REMOVE EYELID LESION	269.54
69421		INCISION OF EARDRUM	245.32
69433		CREATE EARDRUM OPENING	248.18
69436		CREATE EARDRUM OPENING	361.98
90782		INJECTION (SC)/(IM)	6.18
90801		PSYCHIATRIC INTERVIEW	177.05
90847		SPECIAL FAMILY THERAPY	143.18
90862		MEDICATION MANAGEMENT	69.26
90937		HEMODIALYSIS, REPEATED EVAL.	258.90
92002		EYE EXAM, NEW PATIENT	74.39
92004		EYE EXAM, NEW PATIENT	118.97
92012		EYE EXAM ESTABLISHED PT	57.60
92014		EYE EXAM, TREATMENT	83.66
92081		VISUAL FIELD EXAMINATION(S)	35.48
92081	26	VISUAL FIELD EXAMINATION(S)	27.26
92081	TC	VISUAL FIELD EXAMINATION(S)	8.22
92083		VISUAL FIELD EXAMINATION(S)	72.24
92083	26	VISUAL FIELD EXAMINATION(S)	56.19
92083	TC	VISUAL FIELD EXAMINATION(S)	16.05
92250		EYE EXAM WITH PHOTOS	45.50
92250	26	EYE EXAM WITH PHOTOS	35.46
92250	TC	EYE EXAM WITH PHOTOS	10.02
92270		ELECTRO-OCULOGRAPHY	79.01
92270	26	ELECTRO-OCULOGRAPHY	61.16
92270	TC	ELECTRO-OCULOGRAPHY	17.85
92504		EAR MICROSCOPY EXAMINATION	24.27
92507		SPEECH/HEARING THERAPY	45.09
92552		PURE TONE AUDIOMETRY, AIR	25.83
92553		AUDIOMETRY, AIR, BONE	39.45
92557		COMPREHENSIVE HEARING TEST	71.08
92567		TYMPANOMETRY	31.62

EXHIBIT A
FEE SCHEDULE

CPT		DESCRIPTION	PREFERRED RATE CHARGE
92585		BRAINSTEM EVOKED AUDIOMETRY	223.88
92585	26	BRAINSTEM EVOKED AUDIOMETRY	115.46
92585	TC	BRAINSTEM EVOKED AUDIOMETRY	108.42
93015		CARDIOVASCULAR STRESS TEST	214.16
93224		ECG MONITOR/REPORT, 24 HRS	314.53
93307		ECHO EXAM OF HEART W/ OR W/OUT M-MODE RECORDING	391.07
93307	26	ECHO EXAM OF HEART W/ OR W/OUT M-MODE RECORDING	126.22
93307	TC	ECHO EXAM OF HEART W/ OR W/OUT M-MODE RECORDING	264.85
93320		DOPPLER ECHO EXAM, HEART, PULSED WAVE	175.81
93320	26	DOPPLER ECHO EXAM, HEART, PULSED WAVE	57.62
93320	TC	DOPPLER ECHO EXAM, HEART, PULSED WAVE	118.19
93325		DOPPLER COLOR FLOW	209.30
93325	26	DOPPLER COLOR FLOW	7.49
93325	TC	DOPPLER COLOR FLOW	201.80
93562		CARDIAC OUTPUT MEASUREMENT	67.61
93562	26	CARDIAC OUTPUT MEASUREMENT	44.51
93562	TC	CARDIAC OUTPUT MEASUREMENT	23.11
93738		ANALYZE CARDIO/DEFIBRILLATOR	116.62
93738	26	ANALYZE CARDIO/DEFIBRILLATOR	81.02
93738	TC	ANALYZE CARDIO/DEFIBRILLATOR	35.60
93880		EXTRACRANIAL STUDY	330.73
93880	26	EXTRACRANIAL STUDY	63.49
93880	TC	EXTRACRANIAL STUDY	267.25
93970		EXTREMITY STUDY	366.89
93970	26	EXTREMITY STUDY	69.59
93970	TC	EXTREMITY STUDY	297.31
94010		BREATHING CAPACITY TEST	48.93
94010	26	BREATHING CAPACITY TEST	24.89
94010	TC	BREATHING CAPACITY TEST	24.03
94060		EVALUATION OF WHEEZING	90.78
94060	26	EVALUATION OF WHEEZING	37.77
94060	TC	EVALUATION OF WHEEZING	53.01
94640		AIRWAY INHALATION TREATMENT	23.49
94760		MEASURE BLOOD OXYGEN LEVEL	15.11
95004		ALLERGY SKIN TESTS	5.64
95024		ALLERGY SKIN TESTS	8.39
95115		IMMUNOTHERAPY, ONE INJECTION	21.69
95117		IMMUNOTHERAPY INJECTIONS	27.72
95861		MUSCLE TEST, TWO LIMBS	192.95
95861	26	MUSCLE TEST, TWO LIMBS	150.35
95861	TC	MUSCLE TEST, TWO LIMBS	42.59
95869		MUSCLE TEST, LIMITED	50.28
95869	26	MUSCLE TEST, LIMITED	37.91
95869	TC	MUSCLE TEST, LIMITED	12.38

EXHIBIT A
FEE SCHEDULE

CPT		DESCRIPTION	PREFERRED RATE CHARGE
95900		MOTOR NERVE CONDUCTION TEST	57.60
95900	26	MOTOR NERVE CONDUCTION TEST	41.40
95900	TC	MOTOR NERVE CONDUCTION TEST	16.20
95904		SENSE NERVE CONDUCTION TEST	49.94
95904	26	SENSE NERVE CONDUCTION TEST	37.02
95904	TC	SENSE NERVE CONDUCTION TEST	12.92
99201		OFFICE/OUTPATIENT VISIT, NEW	50.30
99202		OFFICE/OUTPATIENT VISIT, NEW	79.25
99203		OFFICE/OUTPATIENT VISIT, NEW	109.17
99204		OFFICE/OUTPATIENT VISIT, NEW	162.43
99205		OFFICE/OUTPATIENT VISIT, NEW	203.70
99211		OFFICE/OUTPATIENT VISIT, EST	22.50
99212		OFFICE/OUTPATIENT VISIT, EST	43.17
99213		OFFICE/OUTPATIENT VISIT, EST	62.00
99214		OFFICE/OUTPATIENT VISIT, EST	93.41
99215		OFFICE/OUTPATIENT VISIT, EST	148.00
99217		OBSERVATION CARE DISCHARGE	92.58
99218		OBSERVATION CARE	102.75
99219		OBSERVATION CARE	166.31
99220		OBSERVATION CARE	211.92
99221		INITIAL HOSPITAL CARE	102.21
99222		INITIAL HOSPITAL CARE	165.75
99223		INITIAL HOSPITAL CARE	210.66
99231		SUBSEQUENT HOSPITAL CARE	53.57
99232		SUBSEQUENT HOSPITAL CARE	78.21
99233		SUBSEQUENT HOSPITAL CARE	108.68
99238		HOSPITAL DISCHARGE DAY	92.03
99241		OFFICE CONSULTATION	71.34
99242		OFFICE CONSULTATION	110.27
99243		OFFICE CONSULTATION	142.52
99244		OFFICE CONSULTATION	198.63
99245		OFFICE CONSULTATION	268.04
99251		INITIAL INPATIENT CONSULT	73.94
99252		INITIAL INPATIENT CONSULT	111.15
99253		INITIAL INPATIENT CONSULT	146.21
99254		INITIAL INPATIENT CONSULT	199.86
99255		INITIAL INPATIENT CONSULT	270.59
99261		FOLLOW-UP INPATIENT CONSULT	40.31
99262		FOLLOW-UP INPATIENT CONSULT	68.70
99263		FOLLOW-UP INPATIENT CONSULT	100.32
99271		CONFIRMATORY CONSULTATION	58.25
99272		CONFIRMATORY CONSULTATION	85.44
99273		CONFIRMATORY CONSULTATION	120.60
99274		CONFIRMATORY CONSULTATION	157.41

EXHIBIT A
FEE SCHEDULE

CPT		DESCRIPTION	PREFERRED RATE CHARGE
99275		CONFIRMATORY CONSULTATION	217.89
99281		EMERGENCY DEPT VISIT	33.66
99282		EMERGENCY DEPT VISIT	52.07
99283		EMERGENCY DEPT VISIT	94.07
99284		EMERGENCY DEPT VISIT	143.63
99285		EMERGENCY DEPT VISIT	226.17
99291		CRITICAL CARE, FIRST HOUR	277.56
99292		CRITICAL CARE, ADDL 30 MIN	133.07
99295		NEONATAL CRITICAL CARE	1,153.01
99296		NEONATAL CRITICAL CARE	571.77
99297		NEONATAL CRITICAL CARE	285.54
99354		PROLONGED SERVICE, OFFICE	138.75
99355		PROLONGED SERVICE, OFFICE	138.75
99356		PROLONGED SERVICE, INPATIENT	134.06
99357		PROLONGED SERVICE, INPATIENT	134.06
99431		INITIAL CARE, NORMAL NEWBORN	127.95
99432		NEWBORN CARE NOT IN HOSPITAL	137.75
99433		NORMAL NEWBORN CARE, HOSPITA	67.58
99440		NEWBORN RESUSCITATION	320.24

EXHIBIT B

WELLMARK HEALTHNETWORK GRIEVANCE PROCEDURE

If a Covered Person has a complaint against a WHN provider ("Provider") or a Payor concerning services provided, WHN, through its staff members, will investigate the complaint, communicate with the parties and use its best efforts to satisfactorily resolve the matter. To take advantage of this service, the Covered Person must inform WHN no later than thirty (30) days after the occurrence of the incident that is the basis for the complaint. This procedure does not cover complaints of alleged malpractice by a Provider or questions of coverage or eligibility.

If the WHN staff does not successfully resolve the complaint, then the President of WHN will endeavor to resolve the matter. If the resolution has not been accomplished to the satisfaction of the Covered Person, Provider or the Payor, the dispute is submitted to an Arbitration Panel of three persons, one of whom is selected by the Covered Person, or its designee, one of whom is selected by Provider or the Payor, as applicable, and one of whom is selected by the other two previously-selected Panel Members. Each party is responsible for the fees of its own appointee, one-half (1/2) of the fee of the shared Panel Member and one-half (1/2) of any other costs of the arbitration proceeding, exclusive of attorneys', witnesses' and experts' fees, which are the responsibility of the party incurring them.

The Arbitration Panel may meet in person or by telephone, and within thirty (30) days of their selection will arrive at a decision following the rules of the American Arbitration Association.

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WELLMARK HEALTHNETWORK PAYMENT AND BILLING DISPUTE PROCEDURE

WHN makes every effort to resolve problems and disputes between a WHN provider ("Provider") and a Payor, rapidly and effectively. If the dispute cannot be resolved by the WHN staff, the issue is reviewed by the President of WHN. Should the President be unable to resolve the dispute within ten (10) working days, documentation of the dispute is developed through a collaborative effort between WHN, the Payor and Provider. Full disclosure of each party's position is the intent of such documentation.

If the resolution has not been accomplished to the satisfaction of the Payor or Provider, the dispute shall be submitted to an Arbitration Panel of three persons, one of whom is selected by the Payor, or its designee, one of whom is selected by Provider and one of whom is selected by the other two previously-selected Panel Members. Each party is responsible for the fees of its own appointee, one-half (1/2) of the fee of the shared Panel Member and one-half (1/2) of any other costs of the arbitration proceeding, exclusive of attorneys', witnesses' and experts' fees, which are the responsibility of the party incurring them.

The Arbitration Panel may meet in person or by telephone, and within thirty (30) days of their selection will arrive at a decision following the rules of the American Arbitration Association.

EXHIBIT C

PRE-CERTIFICATION/CERTIFICATION PROCESS

1. **General.** The Pre-Certification/Certification Process consists of a review of acute inpatient or outpatient treatment for surgical, medical, pediatric, psychiatric and substance abuse cases. Pre-Certification is required five (5) days in advance for all elective hospital admissions, outpatient surgical or invasive procedures (excluding emergency first aid), and high-cost non-invasive tests such as MRIs and CT Scans, or in less than five (5) days in extenuating circumstances, as determined by WHN. For any admission that is Pre-Certified/Certified, the initial length of stay will not ordinarily be greater than three (3) days, and in conjunction with the Concurrent Review and Discharge Planning function, the final determination of the length of stay will be established and communicated by the WHN Utilization Review Department to the WHN provider ("Provider") and other affected providers.

2. **Initiation of Process Determination.** Pre-Certification/Certification is initiated by the Covered Person or other certifying provider who calls WHN's designated toll-free number. WHN Nurse Reviewers perform the Pre-Certification/Certification with the review and support of the WHN Medical Director. The Nurse Reviewer uses accepted protocols, plus relevant patient-specific information collected during the call to determine whether the proposed treatment meets the following Pre-Certification/Certification medical criteria:

a. The type, level, duration and setting of services are necessary to provide adequate care and treatment, given the symptoms and patient history, and are consistent with any related diagnosis;

b. The care is rendered in accordance with generally accepted medical practice and professionally recognized standards;

c. The care is not generally regarded as experimental or unproven by recognized medical professionals or appropriate governmental agencies, including without limitation, United States Department of Health and Human Services, the Office of Pre-Paid Health Planning, the United States Food and Drug Administration and the Public Health Services Office of Health Technology Assessment; and

d. The care is specifically permitted by all applicable licensing statutes. If the Nurse Reviewer agrees with Provider or the pre-certifying provider on the necessity, location and duration of treatment, the case is certified by the Nurse Reviewer and put into the system for Concurrent Review.

3. **Concurrent Review and Discharge Planning.** Every Pre-Certification/Certification includes a planned discharge date. On or before the Pre-Certified/Certified discharge date, the Nurse Reviewer will review for medical necessity to determine if a length of stay extension is needed. If necessary, the Nurse Reviewer will then contact Provider to aid in discharge planning.

4. **Pre-Certification/Certification Clinical Protocols.** The clinical protocols guide the Nurse Reviewers in collecting necessary patient-specific information, identifying cases appropriate for outpatient care alternatives to hospitalization, and identifying potential high-cost patients for individualized case management. Pre-admission testing is encouraged because the Pre-Certification Process is designed to authorize admission on the day of surgery, unless the particular procedure or unique needs of the patient necessitate an inpatient pre-operative day.

5. **The Appeals Process.**

a. If the treatment is not Pre-Certified/Certified and Provider or other certifying provider does not agree with the determination, the case is referred to the WHN Medical Director or other Medical Advisor selected by WHN. If the Medical Director or Advisor agrees with the treatment, it will be Pre-Certified/Certified.

b. If the Medical Director or Advisor and Provider or other certifying provider cannot reach an agreement with the WHN determination, the case is referred for final review to another medical advisor who was not involved with the initial decision. If the second medical advisor agrees with the treatment, it will be Pre-Certified/Certified. WHN follows URAC standards for all appeals.

c. If (i) Provider or other certifying provider completes the appeals process and the treatment is not pre-certified or certified, as applicable; and (ii) the Covered Person has been fully informed by Provider of the outcome of each stage of the Utilization Management, Pre-Certification/Certification and appeals process; and (iii) Provider and the Covered Person shall determine that they nonetheless wish to proceed with the treatment, then the Payor may waive the Pre-Certification/Certification requirement if the service is otherwise reimbursable under the terms of the patient's Plan.

d. For a standard appeal, a decision will be reached to uphold, modify, or reverse the denial of pre-certification/certification or continued hospital stay and written notification will be given to appropriate parties (enrollee/patient, hospital/provider facility personnel, and payor) within thirty (30) days after the receipt of the medical record. The complete medical record will be provided to the medical advisor (i) or medical advisor (ii) at the requestor's expense.

(e) For an expedited appeal, a decision will be reached within one (1) business day after the receipt of the request, to uphold, modify, or reverse the denial of pre-certification/certification or continuous hospital stay. Telephonic notification (followed by written notification) will be given to appropriate parties (enrollee/patient, hospital/provider facility personnel, and payor) within one (1) business day after the receipt of the request for an expedited appeal. The attending physician seeking the appeal must be available for discussion when needed. Upon request, the complete medical record will be provided to the WHN medical advisor at the expense of the requestor submitting the appeal.

6. **Retrospective Review.** WHN may, from time to time, conduct retrospective review or other appropriate review, including without limitation, appropriate case management. Retrospective review includes, without limitation, review of provision of health care services, utilization patterns, quality of care, and other factors relevant to professional practices, and performance of services under this Agreement. Such retrospective or other review is coordinated with the Medical Director, WHN and other appropriate persons. Retrospective review findings may be considered by WHN in connection with this Agreement, including, without limitation, in future contract negotiations with Provider. Retrospective reviews may not revoke certification for services already rendered.

EXHIBIT D

WELLMARK HEALTHNETWORK PROVIDER TERMINATION APPEAL PROCEDURE

I. RECITAL

Whether or not Wellmark HealthNetwork, Inc. ("WHN") constitutes a "health care entity" as defined by the Health Care Quality Improvement Act of 1986 ("Act"), WHN hereby adopts this Provider Termination Appeal Procedure ("Procedure") for appeals by any individual directly or indirectly subject to a Provider Agreement with WHN ("Provider") in all instances in which a hearing is required under the Act or any WHN contract and for all terminations, unless otherwise provided by contract.

II. PROCEDURE

1. **Applicability.**

a. This Procedure shall apply when any action adverse to Provider is proposed by WHN ("Adverse Recommendation") or has already been taken by WHN ("Adverse Action") which relates to with-cause termination of the Agreement for any reason other than as specifically set forth in the Provider Agreement, or which otherwise concerns the competence or professional conduct of Provider, where the competence or conduct could adversely affect the health or welfare of a patient of Provider who is a Covered Person of WHN (as defined in the Provider Agreement). Provider shall not be entitled to more than one (1) hearing with respect to the same subject matter.

b. This Procedure shall not apply to warnings, letters of reprimand, probationary periods preceding the possible termination of a Provider Agreement or denial of an application for initial participation in WHN.

2. **Notice of Adverse Recommendation or Adverse Action.** WHN shall notify Provider of the Adverse Recommendation or, if a hearing has not already been offered regarding an Adverse Recommendation relating to the same subject matter, of the Adverse Action. The notice shall include the following:

a. The reasons for the Adverse Recommendation or Adverse Action;

b. Notice that Provider has the right to request a hearing before a panel to be designated by the WHN Board of Directors and the time limit within which Provider must request a hearing, which may not be less than thirty (30) days from the date of the notice; and

c. A summary of Provider's rights regarding the hearing as set forth in Section 4 of this Procedure.

3. **Notice of Hearing.** If Provider requests a hearing, WHN shall notify Provider of the place, time and date of the hearing, which shall not be less than thirty (30) days after the date of the notice of hearing, and of any witnesses who are expected to testify at the hearing on behalf of WHN.

4. **Conduct of Hearing and Notice.**

a. The hearing panel appointed by the WHN Board shall number either 3, 5 or 7 members, as determined by the WHN Board, and shall not include any providers who are in direct economic competition with Provider. The final determination of whether a panel member is in direct economic competition with Provider shall be made by the WHN Board. The majority of the panel members shall be Providers. The Board may appoint a hearing officer, who shall not be a voting member of the panel, to preside over the hearing panel.

b. At the hearing, Provider has the right:

(i) To representation, by an attorney or other person of Provider's choosing;

(ii) To have a record made of the hearing and to have copies of the record made available to Provider upon payment of a reasonable charge related to the cost of preparation of the copy;

(iii) To call, examine and cross-examine witnesses;

(iv) To present evidence determined to be relevant by the hearing officer or, if none, by the hearing panel, even if such evidence would not be admissible in a court of law; and

(v) To submit a written statement to the hearing panel at the close of the hearing.

c. After the hearing, Provider has the right:

(i) To receive the written recommendation of the hearing panel to WHN including the basis for the recommendation; and

(ii) To receive the written decision of the WHN Board of Directors, including a statement of the basis for its decision.

d. The right to a hearing may be forfeited by Provider if, without good cause, Provider fails to appear at the time and place designated for the hearing.

5. **Provider Confirmation**. Provider shall make a written election to have a hearing in accordance with this Procedure or in accordance with any other procedures available to Provider pursuant to any contract then in effect.

6. **Costs**. WHN and Provider shall each pay one-half (1/2) of the costs of the hearing, exclusive of any attorneys', witnesses' or experts' fees, which shall be borne by the party incurring such fees.

APPENDIX CR

WELLMARK HEALTHNETWORK
CREDENTIALLING AND RECREDENTIALLING PROVISIONS

WHN has written policies and procedures for the credentialling process based upon NCQA Standards for Managed Care Organizations.

CREDENTIALLING

1. WHN has written policies and procedures for the credentialling process that include the original credentialling, recredentialling, re-certification and/or re-appointment of physicians and other licensed independent practitioners who fall under its scope of authority and action.

   a. The standards were designed for physicians; therefore, some of the standards may not be applicable to other licensed practitioners. The standard will apply to M.D.s, D.O.s, D.D.S.s, D.P.M.s, and D.C.s.

2. The Credentialling Committee reviews and approves credentialling policies and procedures.

   a. The Credentialling Committee is comprised of senior level persons representing the following departments: Quality Assurance, Provider Relations, Network Development, Administration and the Medical Director.

3. The Credentialling Committee delegates to the Contract Review Committee (CRC) the authority to recommend acceptance of credentials based upon the criteria contained in this document, with final acceptance only upon signature of the CEO or his delegate..

4. WHN identifies those practitioners who fall under its scope of authority and action.

   a. Included, at a minimum, are all physicians and other licensed practitioners listed in the managed care organization's literature for members. This includes M.D.s, D.O.s, D.D.S.s, D.P.M.s, and D.C.s.

5. The initial credentialling process is ongoing and up-to-date. At a minimum, the CRC obtains and reviews verification of the following:

   5.1 Current valid license to practice; verification by copy of the current state license.

   5.2 Clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility.

      a. Review, at a minimum of ___ "yes" answers to Preferred Physician Provider Application Form or Recredentialling Form with subsequent review of narratives by Medical Director.

      b. If recommended by the Medical Director, subsequent information shall be obtained from the facility for review by the medical Director and the CRC:

         1. Date of appointment
         2. Scope of privileges
         3. Restrictions

   5.3 A valid DEA or CDS certificate, as applicable, verified by one of the following sources:

      a. Visually inspecting the actual certificate (can be accomplished during on-site office review), or copy of current DEA.

      b. State pharmaceutical license copy, where applicable

   5.4 Board Certification, Board Eligibility or Completion of Residency:

      a. Board Certification may be verified by either of the following sources;

1. ABMS Compendium (most current edition)
2. The appropriate specialty board certificate

b. Board Eligibility/Completion of Residency may be verified by any of the following methods:

1. Copy of specialty board eligibility statement
2. Copy of documentation certifying completion of accredited residency prior to establishment of Board examinations ("Grandfathered" status)
3. Copy of document certifying completion of accredited residency within last five (5) years ("New graduate" status)

5.5 Work history

a. Documentation of work history is not required on the provider application at this time.

5.6 Current, adequate malpractice insurance according to the managed care organization's policy. Coverage can be verified through any of the following:

a. Confirmation with the carrier;
b. A copy of the Certificate of Insurance stating dates of coverage and amount of coverage; or
c. State licensing agency, if the agency conducts primary verification.

5.7 Professional liability claims history

a. All professional liability claims, past and/or pending are requested in narrative form and reviewed by the Medical Director.

6. The applicant completes an application for membership

6.1 The application includes a statement by the applicant regarding:

a. Physical and mental health status;
b. Lack of impairment due to chemical dependency/substance abuse;
c. History of loss of license and/or felony convictions; and
d. History of loss or limitation of privileges or disciplinary activity;
e. Malpractice history

6.2 There is an attestation by the applicant to the correctness and/or completeness of the application.

RE-CREDENTIALLING

7. There is a process for the periodic verification of credentials (credentialling, re-appointment or re-certification) that is ongoing and up-to-date.

7.1 There is evidence that the process is implemented at least every two years.

7.2 At a minimum, the re-credentialling, re-certification or re-appointment process includes the verification of;

a. A valid state license to practice; (see 5.1)
b. Clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility; (see 5.2)
c. A valid DE or CDS certificate, as applicable; (see 5.3)
d. Board certification, as applicable; (see 5.4)
e. Current, adequate malpractice insurance, according to the managed care organization's policy; (see 5.6) and
f. Professional liability claims history. (see 5.7)

7.3 The re-credentialling process includes a current statement by the applicant regarding:

a. Physical and mental health status; and
b. Lack of impairment due to chemical dependency/substance abuse.

8. The re-credentialling, re-certification or performance appraisal process includes review of data from:

8.1 Member complaints;

8.2 Results of quality reviews;

8.3 Utilization management; and

8.4 Member satisfaction surveys.

The above listed quality improvement sources shall be incorporated into the EPO re-credentialling process.

9. The re-credentialling process may include an on-site visit to provider offices.

9.1 The visit results in documentation of a structured review of the site and of the medical record keeping practices, to ensure conformance with the PPO's EPO standards.

9.2 The following offices should be visited:

a. All primary care providers;
b. All obstetricians/gynecologists; and
c. High volume specialists.

COMPONENTS OF CREDENTIALLING AND RE-CREDENTIALLING

Credentialling		Re-credentialling
X	Licensure	X
X	Hospital Privileges	X
X	Education	--
X	Board Certification	X
X	Malpractice	X
--	Sanctions	X
X	DEA	X
X	Health & Environment	X
--	On-site Office Review	X
--	Satisfaction Survey	X
--	Plan Profile (QA, UR, Grievance)	X