INDEPENDENT PRACTICE ASSOCIATION AGREEMENT

This Agreement is entered into by and between [redacted] and ____________________

1. PARTIES

A. [redacted] is an independent not-for-profit health services benefits organization incorporated under [redacted] is certified under Article [redacted] of the [redacted] Public Health Law to operate a health maintenance organization ("HMO") under the names set forth on the Article [redacted] Certificate of Authority issued to [redacted] and any amendments hereto. For purposes of this Agreement, [redacted] shall include [redacted] its subsidiaries, affiliates and parent.

B. [redacted] also operates under a license with the [redacted] that permits [redacted] to use the [redacted] in a portion of [redacted] State and other regions contiguous to [redacted] service area.

C.____________________ is an approved independent practice association ("IPA") organized under the laws of the State [redacted] IPA has entered into contracts with physicians and other Providers ("IPA Providers"), who will provide or arrange for provision of health care services to Members of [redacted] HMO, HMO-based Point of Service (HMO-based POS), and HCFA approved Medicare at Risk (hereafter referred to as [redacted]") benefit plans (hereafter collectively referred to as "Network Products").

2. RELATIONSHIP BETWEEN EMPIRE AND IPA

A. Independent Contractors [redacted] and IPA are independent legal entities. Nothing in this Agreement shall be deemed to create between [redacted] and IPA, or [redacted] and any IPA Provider who has contracted with the IPA, any relationship of employer and employee, joint venture or of principal and agent. In performing services under this Agreement, IPA is and will act at all times and in all respects as an independent contractor.

B. Agreement Solely between [redacted] and the IPA. This Agreement is entered into solely between [redacted] and the IPA. [redacted] has not entered into this Agreement as the agent of the Association. No person, entity, or organization other

than ▇▇▇ is accountable or liable to the IPA for any of ▇▇▇ representations or obligations to the IPA created under the Agreement. This paragraph does not create additional obligations upon ▇▇▇

C. Non-Exclusivity The parties' relationship is not exclusive. Either party may enter into similar arrangements with other entities provided that such arrangements do not prevent such party from fulfilling its obligations hereunder.

D. Network Participation In the event ▇▇▇ introduces any new HMO networks or products during the term hereof, ▇▇▇ reserves the right to determine which of its HMO networks the IPA shall participate in, and does not guarantee IPA's or any IPA Providers participation in any such new networks or additional products that may be introduced. In the event of IPA's participation in additional networks or products, ▇▇▇ shall furnish IPA with an addendum to this Agreement setting forth the terms of such participation. In addition, ▇▇▇ reserves the right to identify IPA Providers who shall participate in its Network Products.

3. DEFINITIONS

A. "Claim" A request to ▇▇▇ submitted by an IPA Provider electronically or in another form approved by ▇▇▇ and containing all required information, for compensation for performing medically necessary, appropriate and, when required, authorized, Covered Services pursuant to a Member's Network Product Certificate.

B. "Covered Services" The professional health care and related services provided pursuant to the Member's Network Product Certificate.

C. "In-Network" Covered Services Services provided by Providers participating in the network for a Network Product, according to the definition of "In-Network" services that appears in the Member's Network Product Certificate.

D. "IPA Fee Schedule" **(Develop a definition of the Fee Schedule)**

E. "IPA Provider" A Primary Care Physician, Referral Specialist physician or other provider who has entered into an IPA Provider contract with the IPA and is approved by Empire where appropriate to participate in its Network Products, hereafter referred to as "IPA Physician" or "IPA Provider". Psychiatrists and other mental health and/or substance abuse treatment Providers are not considered IPA Providers with respect to ▇▇▇ HMO or HMO-based Point of Service benefit plans. Hospitals are not IPA Providers with respect to any aspect of this Agreement, except as specifically set forth herein. ▇▇▇

F. "IPA Service Area" means the IPA's catchment area described to in Exhibit A annexed. The IPA is clinically responsible for this designated area. The Service Area may be changed only upon written agreement of both parties. This designation does not indicate exclusivity.

G. "Member" Any individual covered by an HMO, HMO-based POS or Senior Plan for medical and hospital services, and who has selected a Primary Care Physician who is an IPA Provider.

H. "Network Product" HMO, HMO-based POS, or "Senior Plan". HMO plans require members to choose a primary care physician (PCP) who coordinates care. HMO-based POS is a point of service product which has in-and out-of-network benefits. The "Senior is the plan developed by to provide persons enrolled in the Federal Medicare Program with HMO coverage, pursuant to a risk agreement entered into between and the Health Care Financing Administration (HCFA).

I. "Network Product Certificate" A contract, certificate, or other evidence of coverage issued to each Member enrolled in a Network Product.

J. "Non-Member Insured" A Person enrolled in a Network Product who has not selected an IPA Physician as a Primary Care Physician.

K. "Out-of-Network Services" Services that are rendered by Providers that do not participate in Network Products.

L. "Physician SourceBook" means a reference manual for participating physicians containing information on products and services and related administrative policies.

M. "Out-of Network POS Benefits" Services that are rendered to Members that are not authorized or provided by the PCP.

N. "Premium Equivalent" The portion of the premium attributed to each Member enrolled in some Network Products, based upon age and gender of each Member. Premium Equivalents apply to some Network Products, are subject to change periodically and shall be effective upon notice by

O. "Prestige and Select Networks" The two HMO networks comprised of Hospitals and Providers with whom has contracted to provide services to certain of its HMO members.

P. "Primary Care Physician" ("PCP") A licensed Family Practitioner, Pediatrician, or Internist Physician who has agreed under a contract with IPA, to be primarily responsible for the provision of health care services and for the general coordination of the health care needs of each Member who selects him or her as his or her Primary Care Physician and who has satisfied [redacted] credentialing requirements.

Q. "Referral Specialist" means any specialty Physician who has entered into a contract with IPA to provide certain medical specialist services to the Members upon referral by a Primary Care Physician pursuant to the terms of the governing Network Product Certificate and this Agreement.

4. OBLIGATIONS OF EMPIRE

A. [redacted] shall perform all administrative, credentialing, quality assurance, marketing, enrollment, financial, accounting, claims processing and payment, information management, and other functions reasonably necessary and appropriate for the proper administration of this Agreement.

B. [redacted] shall maintain an information management system and shall conduct utilization review, peer review and quality assurance programs, and to review the financial status of the IPA. [redacted] shall provide necessary related data and periodic reports to IPA.

C. [redacted] shall administer a grievance review system for Members.

D. [redacted] shall make available to Members a list of all IPA Providers, identifying their office address(es), telephone numbers, and specialties.

E. On a monthly basis, [redacted] shall prepare and make available to the IPA Providers a list identifying each Member according to the IPA Physician selected.

5. OBLIGATIONS OF THE IPA

A. Provision of Services IPA, as a duly authorized agent of each IPA Provider, agrees to require each IPA Provider to provide to Members the full continuum of Covered Services for the governing Network Products that are within the scope of

the IPA Provider's license and practice, and for which IPA Provider has been credentialed by [redacted] Such Covered Services shall be provided in accordance with the terms of the Agreement, the Network Product Certificates, the Physicians SourceBook, and all other policies and procedures of [redacted] communicated to IPA during the term of this Agreement. The IPA Providers shall be solely responsible for the creation and maintenance of physician/patient relationship with Members and for all decisions regarding Member's health care. Claim and utilization review decisions made by [redacted] will be made for the purposes of determining whether services are Covered Services. IPA shall assure that IPA PCPs shall assume primary responsibility for managing the overall health care (including coordinating admissions to hospitals and referrals to Referral Specialists or other providers) of Members who select that IPA PCP. IPA shall assure that IPA Physicians enrolled as Referral Specialists provide specialist services to Members. IPA shall cooperate with [redacted] to provide or arrange for the provision of unusual or infrequently administered Covered Services that require a specialist not represented in the IPA. IPA shall require that IPA Providers also agrees to provide Covered Services, upon referral, to Non-Member Insureds: such services shall be reimbursed at the IPA new fee schedule.

B. Non-Discrimination IPA shall assure that each Member shall be allowed to select an appropriate IPA Physician as a Primary Care Physician. IPA shall assure that IPA Providers render Covered Services to Members in the same manner, in accordance with the same standards, and with the same priority as all other patients. IPA shall assure that Providers accept Members as patients without regard to an individual patient's health history or current health status, race, national origin, color, religion, age, gender or sexual preference and in compliance with all relevant federal, state and local laws and regulations.

C. Adherence to Quality Assurance Program IPA shall, and shall assure that IPA Providers, adhere to [redacted] Quality Assurance Program and administrative requirements in accordance with Sections 8 and 9 of this Agreement, for both hospital- and office-based care, including recredentialing and referral procedures. IPA shall undertake necessary and appropriate actions to correct any deficiencies in the quality of the delivery of Covered Services consistent with [redacted] Quality Assurance Programs.

D. Adherence to Utilization Management Programs IPA shall, and shall assure that IPA providers, adhere to [redacted] Utilization Management policies, procedures, and administrative requirements in accordance with Sections 8 an 9 of this Agreement. The Utilization Management program includes referral management,

precertification review, admission and continued stay review, case management maternity management, and retrospective review. The Utilization Management program, in partnership with providers, designed to ensure that medically necessary, quality services are rendered to members in cost-effective settings by network providers.

D. Hospital Affiliations and Admissions IPA shall assure that each of its physicians who participates in [redacted] Network Products maintains an affiliation with at least one hospital in each network in which IPA participates, as identified in Exhibit B annexed. Except in cases of medical emergency, IPA Physicians shall admit Members only to hospitals in the Network appropriate to the coverage.

E. Medical Records Subject to [redacted] approval and in accordance with applicable state and federal law and regulation,, IPA shall establish standards and procedures for maintenance of medical, financial and administrative records by IPA Providers, and shall assure that IPA Providers retain such records for six (6) years after the date of service (in the case of minors, until six (6) years after the age of majority). IPA shall assure that all IPA Provider medical records are available to [redacted] its designee, or appropriate governmental authorities, including the [redacted] State Department of Health, for inspection, duplication, or audit for purposes of quality assurance and oversight, and that IPA Providers permit [redacted] or its designee access to Providers' offices for site visits. Any inspection, audit, or site visit will be held during regular business hours and upon reasonable notice. Subject to applicable confidentiality requirements, IPA shall facilitate sharing of records, equipment, and professional, technical, and administrative staff by IPA Providers. Under the terms of the Network Product Certificates, [redacted] is authorized to obtain, at no cost to [redacted] a Member's medical records from IPA Providers without a prior written release from the Member. This provision E shall survive termination of this Agreement.

F. Regulatory Compliance IPA shall, and shall require IPA Providers to comply with all local, state and federal laws and regulations relating to the delivery of Covered Services and provision of services under this Agreement including, but not limited to, those laws or regulations prohibiting or limiting referrals to a Provider or facility in which IPA Provider or a relative has a financial interest.

G. Network Compliance IPA shall, and shall require IPA Providers to comply with [redacted] administrative policies and procedures relating to the delivery of

Covered Services. IPA shall assure that IPA Providers cooperate to coordinate the care of Members in order to assure continuity of care; forward Member medical records and clinical information in a timely manner to or referral providers treating a Covered Person; participate in informational meetings concerning policies applicable to the Network Products; and cooperate in coordination of benefits and similar programs to assure that payment is obtained from other health benefit plans, workers' compensation or no-fault auto insurance when such payments are available. Any and all funds collected through coordination of benefits efforts of the parties hereto shall become the property of

H. Out-of-Network Reimbursement In the event that a Member receives care from an IPA Provider for POS services, the IPA Provider will be paid according to the applicable IPA Fee Schedule. These POS services are subject to a deductible and/or coinsurance as reflected in the Network Product Certificate. Reimbursement is subject to the provisions of Section 5.L.11 of this Agreement.

I. IPA Providers' Qualifications IPA shall assure that all IPA Providers have training and experience acceptable to in the field in which they provide services for IPA. IPA shall assure that all IPA Providers comply with credentialing and recredentialing procedures. With the assistance of IPA shall establish policies pertaining to continuing medical education and shall require IPA Physicians to comply therewith.

J. IPA Membership IPA shall provide with a list of all IPA Providers on a quarterly basis, which list shall be subject to the approval of IPA shall provide such data in a format required by Initial and continued participation in any Network Product by any IPA Provider shall be subject to the approval of Written notice of attrition or termination must be provided to on the first business day following notification to IPA by IPA Provider.

K. IPA Coverage The IPA shall obtain, with a sufficient number and distribution of IPA Providers, written contracts obligating IPA Providers to assure Member access in the IPA Service Area to all Covered Services, including, without limitation medically necessary emergency services, on a twenty-four (24) hours a day, 365-day-per-year basis, including periods after normal business hours, on weekends, or when an IPA Provider is otherwise unavailable. For those Network Products which mandate that Members use participating Providers, IPA Providers shall be required to make such arrangements only with such Providers except in cases of

medical emergency. [redacted] and IPA jointly shall determine the requirements of sufficient number and distribution.

L. IPA Provider Contracts The form of contract between IPA and IPA Providers ("IPA Provider Contract") shall obligate IPA Providers to comply with the following:

1. IPA Providers must be licensed to practice their healthcare profession in their respective jurisdictions, and remain in good professional standing at all times.

2. IPA Providers must submit to IPA along with the IPA Provider contract evidence of licensing, and make such evidence available to [redacted] upon request.

3. IPA Physicians who have narcotics licenses issued by the Federal Drug Enforcement Administration must keep copies of their license numbers on file with the IPA.

4. IPA Providers immediately shall notify IPA and [redacted] in writing in the event of any disciplinary action brought or taken against them by licensing authorities or any hospital.

5. When appropriate, IPA Physicians must meet all qualifications and standards for membership on the medical staff of at least one hospital that participates in each [redacted] network in which IPA participates, as identified in Exhibit B, and must maintain staff membership and full admission privileges, in accordance with the rules and regulations of such hospital. IPA Physicians shall notify IPA and [redacted] in writing of the loss of admitting and/or medical staff privileges at any such hospital within one (1) business day of notification by hospital.

6. All Covered Services shall be rendered subject to the terms and conditions of this Agreement, the Member's Network Product Certificate, the Physician SourceBook and [redacted] administrative policies and procedures as relayed to IPA during the term of this Agreement. The quality of Covered Services provided to Members will be in conformity with accepted hospital, medical and surgical practices in the general medical community.

7. IPA Providers shall cooperate with [redacted] administrative policies and procedures relating to the delivery of Covered Services, and shall comply with all applicable state and federal laws and regulations. IPA Providers must comply with [redacted] credentialing and recredentialing procedures.

8. IPA Providers shall be solely responsible for the creation and maintenance of provider/patient relationships with Members, and for all medical advice, medical decisions and treatment of Members rendered pursuant to the IPA Provider Contract.

9. IPA Providers must make necessary back-up arrangements with other appropriate IPA Providers to assure the availability of Covered Services to Members on a 24-hour-per-day, 365-days-per-year basis, including periods after normal business hours, on weekends, or when an IPA Provider is otherwise unavailable.

10. IPA Providers must maintain adequate medical and administrative records for Members. Such records shall include documentation regarding whether a patient has executed an advance directive, in accordance with applicable state and federal law. Subject to all applicable federal and state laws and regulations pertaining to the confidentiality of such records, the records shall be made available to IPA Providers and Referral Specialists treating any Member, and shall be available upon request by IPA, [redacted] or the [redacted] State Department of Health in order to determine that the content of such medical record and the quality of care rendered are acceptable, as well as for purposes related to peer review or grievance review procedures.

11. IPA Providers shall look solely to IPA for compensation for Covered Services rendered to Members pursuant to this Agreement. In no event, including but not limited to [redacted] insolvency or breach of this Agreement by [redacted] shall IPA or any IPA Provider bill, charge, seek compensation or reimbursement from, or have any recourse against a Member, or others acting on a Member's behalf, compensation for Covered Services provided pursuant to this Agreement. This provision shall not prohibit the collection of copayments, coinsurance or deductibles made in accordance with the Network Product Certificates. IPA Providers shall be prohibited from balance billing any Member for the difference between an IPA Provider's customary charge for a Covered Service rendered and the compensation payable hereunder for such Covered Services. This provision shall supersede any contrary oral or written agreement now existing or hereafter entered into between IPA or IPA Provider and a Member or any person acting on such Member's behalf, and shall survive the termination of this Agreement and/or the IPA Provider Contract. [redacted]

12. [redacted] shall have the right to terminate an IPA Provider's participation under this Agreement for the purposes of delivering services to Members consistent with [redacted] Network Physician Termination and Appeals Policy, or other termination and appeals policies as may be established and amended by [redacted] from time to time, as they pertain to non-physician IPA

Providers. IPA Providers shall be required to cooperate with [redacted] procedures as they pertain to cessation of provision of Covered Services to Members..

13. IPA shall require IPA Providers to provide [redacted] with written notification at least ninety (90) days in advance of the closing of an IPA Provider's practice to new members do to capacity limitations. [redacted]

14. IPA Providers who perform in-office laboratory services must document adherence to Federal CLIA standards.

15. IPA Provider shall cooperate with [redacted] procedures for hearing and responding to grievances of Members.

16. IPA Providers shall permit the use of their names, addresses, telephone numbers, and practice areas in [redacted] directories of Participating Providers, and in advertising and other materials.

17. IPA Providers shall maintain professional liability insurance pursuant to the applicable terms of section 11(A) hereof.

18. IPA Providers shall provide to members the full continuum of Covered Services for the governing Network Products that are within the scope of the IPA Provider's license an practice, and for which IPA Provider has been credentialled by [redacted]

19. IPA Provider shall have a fully executed contract with the IPA that is signed and dated by both parties. This contract must clearly state reimbursement for services rendered and describe any incentive arrangements.

20. IPA Provider must agree to the review by the utilization management and quality assurance committee/staff of services rendered to Members.

6. PHYSICIAN MANAGEMENT COMMITTEE

A. A Physician Management Committee (PMC) shall be established and shall consist of not less than five (5) IPA Physicians designated by the IPA which will include a PCP, General Surgeon, OB/GYN, Cardiologist and ENT. The PMC may

establish and operate subcommittees as needed.

B. Responsibilities of the PMC.

1. The PMC shall establish special procedures, protocols, and requirements regarding the provision of specific medical and surgical services by IPA Physicians, including but not limited to, medical and surgical procedures requiring prior approval. The development and application of their guidelines must comply with QA and UM policies and Members EOC. PMC protocols regarding provision of specific medical and surgical services by IPA Physicians are subject to prior written approval.

2. In the event the PMC determines, upon receipt of notice from or otherwise, that an IPA Provider has failed to comply with above mentioned special procedures, protocols, or requirements established by the PMC or otherwise applicable under this Agreement, the PMC may recommend to IPA and termination or temporary suspension of the IPA Provider's right to treat Members.

3. The PMC shall establish an appeals process for any IPA Provider appealing such disciplinary sanction, probation, suspension, or termination in accordance with Network Physician Termination and Appeals Policy and Procedure.

4. Nothing herein shall be deemed to limit IPA's right to terminate the IPA Provider's contract as otherwise may be stated in this Agreement or right to terminate an IPA Provider's participation under a Network Product.

7. COMPENSATION

A. General

1. will compensate IPA Providers for Covered Services provided to Members in accordance with the terms of this Section 7 and is the sole party responsible for payment of such compensation to IPA Providers. Accordingly, IPA agrees that IPA and the IPA Providers shall look solely to

for compensation for Covered Services rendered pursuant to this Agreement. Except as set forth in Sections 7 (F) and (G) below, in no event, including but not limited to [redacted] insolvency or breach of this Agreement, shall any IPA Provider bill Members, or attempt to collect compensation for Covered Services from Members, or others acting on a Member's behalf. This provision shall not prohibit the collection of copayments, coinsurance or deductibles made in accordance with paragraph H. This provision shall supersede any contrary oral or written agreement now existing or hereafter entered into between IPA or IPA Provider and a Member or any person acting on such Member's behalf, and shall survive the termination of the IPA Provider Contract.

2. For each Network Product, [redacted] shall establish and administer a Physicians Fund, Shared Risk Fund, Pharmacy Fund, and Contingency Fund, as budgets for Covered Services rendered to Members. Distributions to the risk funds shall be made according to a percentage of Premium Equivalent determined by [redacted] as set forth in Schedule 1, annexed hereto. With respect to HMO or HMO-based Point of Service benefit plans, except for Senior Plan, such distributions shall be subject to upward or downward retroactive adjustments, not to exceed 90 days, consistent with changes in membership or premium. With respect to Senior Plan, such distributions shall be subject to upward or downward retroactive adjustments, consistent with changes in membership or premium, within one month of notice to [redacted] of a Member's termination of coverage, or within one month of the effective date of a change in HCFA's payment to [redacted] Payment of Claims for Covered Services shall be attributable to the various funds based upon the type of service, as described in the financial responsibility matrix attached hereto as Exhibit C.

3. Surpluses or deficits in the Physicians Fund(s) shall be reconciled and allocated on a monthly basis. Surplus or deficits to other risk funds shall be reconciled semi-annually within ninety (90) days after the end of each six (6) month calendar period. [redacted] shall calculate the difference between the amount of Premium Equivalent allocated to each risk fund for the period and the actual charges made to that Fund. For the Shared Risk and Pharmacy Funds, this calculation shall include actual charges as well as an adequate reserve, to be determined by [redacted] for unpaid and incurred but not reported claims (IBNR). Accruals to IBNR reserves will be reviewed monthly by [redacted] and adjusted to reflect Claims history. The first distribution of any surplus in the Shared Risk or Pharmacy Funds shall be made within ninety (90) days after the end of the first 6 month calendar period of this Agreement. Distributions shall be made within ninety (90) days for each subsequent six (6) month period.

4. Prior to distribution of surplus in any Network Product risk fund, [redacted] shall use such surplus to satisfy any deficit in other risk funds for that Network Product in the following order of priority: Physicians Fund(s), Shared Risk Fund(s), Pharmacy Fund(s), Contingency Fund.

5. Surpluses remaining in the risk funds shall be shall be distributed as follows:

Physicians Funds	100% IPA
Shared Risk Fund	50% IPA/50% [redacted]

6. Deficits shall be attributed as follows:

Physicians Funds	100% IPA
Shared Risk Fund	50% IPA/50% [redacted]

[redacted] and the IPA will agree to the allocation of surpluses and deficits in the funds where the risk is shared.

7. [redacted] will make payment only for Covered Services provided to Members in accordance with the terms of this Agreement, the applicable Network Product Certificate and as properly documented in medical records.

B. Physicians Funds

1. Submission and Payment of Claims for Covered Services Paid from the Physicians Fund(s)

a. Claims for covered services rendered to members pursuant to this Agreement shall be submitted in accordance with policies and procedures outlined in the Physician SourceBook.

b. IPA Providers shall submit all Claims for Covered Services within sixty (60) days from date of service. Claims submitted after the sixty day limit shall not be paid. Incomplete claims will be returned to the IPA Provider for completion, and in order to be paid, must be resubmitted no later than the billing cycle following the one in which services were denied.

c. [redacted] shall make payments to IPA Provider for clean Claims for Covered Services payable from the Physicians Fund(s) based upon the IPA Fee Schedule, less any applicable

copayments._ A Claim shall be deemed to be a clean Claim when it is complete and does not require any further investigation prior to adjudication. [redacted] shall use best efforts to make Claim payments-to the IPA Provider within thirty (30) days after the date of adjudication.

d. Claims for Covered Services rendered by PCPs shall be paid at 110% of the IPA Fee Schedule, and claims for Covered Services rendered by Referral Specialists shall be paid at 100% of the IPA Fee Schedule. IPA Physicians who are both PCPs and specialists shall be paid specialty rates only for Covered Services rendered to patients appropriately referred to the IPA Provider for specialty services, either by another IPA PCP, Network Participating PCP or by [redacted]

e. IPA Providers who provide services upon referral to Non-Member Insured's shall be paid at 125% of IPA Fee Schedule, subject to any cost sharing and other limitations described in the Non-Member Insured's Network Product Certificate. Such Claim payments shall not be attributed to the Physicians Fund(s).

f. Services not covered, not medically necessary, or not authorized, shall not be paid by [redacted] nor shall the Member be billed for these services, except as provided in paragraph I, below. IPA Provider may seek redetermination of a denial of payment as described in Section 9 (D) below.

2. Approved laboratory tests performed in the IPA Physician's office in accordance with Exhibit C shall be paid out of the Physicians Fund(s). IPA Physicians who do not provide routine laboratory services in their offices shall refer all laboratory services to a Network laboratory.

3. Referrals of Members to specialists who are not IPA Physicians shall be paid out of the Physicians Fund(s). If that Referral Specialist has an agreement with [redacted] the specialist will be paid according to the agreement with [redacted] If that Referral Specialist has no agreement with [redacted] payment will be made according to the terms of the Member's Network Product Certificate, or as agreed upon between [redacted] and the Physician. Such amounts shall be charged to the Physician Fund.

4. Physician Fund Settlement

a. Claims will be paid to the IPA Provider based upon the IPA Fee Schedule for Covered Services rendered each month pursuant

to each Network Product and designated in Exhibit C as payable from the Physician's Fund(s). On a monthly basis, the claims and encounter data will be provided to IPA and reviewed by IPA and [redacted] at which time the status of the fund balance and the claims trends will be evaluated.

b. On a quarterly basis, a detailed review of the Physician's Fund will be performed by IPA and [redacted]. This review will include the establishment of an IBNR reserve to determine if the fund is in deficit or surplus. If the fund(s) balance is approaching a deficit, [redacted] and IPA shall agree to adjust the fee schedule to ensure that deficits are covered.

c. On an annual basis (90 days after the end of a calendar year), a final settlement of the Physician's Fund shall be performed. If the Fund is in deficit, a withhold from claim payments otherwise due to IPA Providers for Covered Services rendered hereunder shall be established and administered by [redacted] to cover the deficit, and a reserve shall be established for the current year. If the Fund is in surplus, an amount to be determined jointly by the IPA and [redacted] shall be retained in the Fund as a reserve and the remaining balance should be returned to IPA.

C. Shared Risk Funds

1. Claims for covered hospital services rendered to Members, as described Exhibit D, shall be charged to the applicable Shared Risk Fund, whether the Covered Services are provided within or outside of [redacted] service area or contracted facilities.

2. Shared Risk Fund(s) Settlement

On a monthly basis, the Shared Risk Fund shall be reviewed and evaluated by IPA and [redacted]. If the fund is approaching deficit, further education will be provided to the IPA by [redacted]. On an annual basis (90 days after the end of the calendar year), a final settlement of the Physician's Fund(s) shall be performed by [redacted]. If the Fund is in deficit, the Contingency Fund shall be applied based on the provisions in paragraph E below. If the fund is in surplus, an amount shall be retained in the Fund as an additional contingency for future years, with the remaining surpluses being distributed.

2. [redacted] and IPA shall mutually determine the method of allocating Shared Risk Fund(s) surplus and deficit to IPA Physicians.

3. In the event that this Agreement is terminated by either party prior to expiration of its term, no surplus will be distributed to IPA Providers. In the event that a IPA Provider terminates his or her contract with IPA or [redacted] or the IPA Provider's contract is terminated by IPA, prior to the termination of this Agreement, IPA Provider will forfeit any interest in the Shared Risk Fund(s) surplus or deficit. In the event of the termination of this Agreement for any reason by [redacted] or IPA, IPA shall be entitled to its share of any surplus and shall be responsible for the payment to [redacted] of any deficit(s) for which it is responsible hereunder, which exist in the Shared Risk Fund(s) with respect to all Claims for Covered Hospital Services which arise on or prior to the date on which written notice of termination is provided to the non-terminating party pursuant to Section 10 hereof.

D. Pharmacy Funds

1. Payments for all formulary or otherwise authorized non-injectable outpatient prescription drugs and Insulin (all types) which are Covered Services shall be made from the Pharmacy Funds.

2. Pharmacy expenses will be calculated monthly and payments will be made by [redacted] to its third party pharmacy vendors. Covered Pharmacy Service expenses shall include the following:

a. Ingredient costs of all formulary or otherwise authorized non-injectable outpatient prescription drugs and Insulin;

b. Pharmacy claims processing expense; and

c. Authorized drugs for eligible Members for covered urgent or out of area emergencies.

3. [redacted] will be at risk for this Fund in its entirety. The IPA shall have no responsibility for or right to any deficit or surplus in the Pharmacy Fund.

E. Contingency Fund

1. In the event that Claims for Covered Hospital Services exceed the Shared Risk Fund(s), [redacted] shall pay the difference from the Contingency Fund. If the Contingency Fund is insufficient to pay all Covered Hospital Service Claims, [redacted] may advance funds to the Shared Risk Fund(s) and

later recoup those advances from either the Contingency Fund or the Shared Risk Fund(s); provided that such advances shall not limit IPA's responsibility as described in paragraph C above.

2. In addition, the Contingency Fund shall be used to pay:

a. Excess incurred but not reported claims;

b. Claims outstanding against any Fund upon dissolution of the HMO, HMO-based POS or Plan; and

c. Increased Claims incurred as the result of a natural disaster.

F. Stop-Loss Fund

will withhold $2.50 per Member per month to protect each Physicians Fund(s) from any Member incurring more than seven thousand five hundred dollars ($7,500) in Claims paid from the Fund during any calendar year. also will withhold $2.50 per Member per month to protect each Shared Risk Fund from any Member incurring more than seventy-five thousand dollars ($75,000) in Shared Risk Fund(s) claims paid during any calendar year. Any surplus or deficit in the Stop Loss Fund shall be the responsibility of

G. Quality Fund

1. One percent (1%) of the monthly Premium Equivalent received by shall be held in a Quality Fund administered by for payment of incentives to IPA Physicians' for compliance with Quality Assurance Program.

2. Compliance with Quality Assurance Program shall be evaluated by annually, based upon objective, measurable criteria that will be made available to the IPA by Distribution to the IPA of the earned portion of the Quality Fund shall be made by on an annual basis.

3. Any surplus remaining in this Fund after incentive payments are made shall be maintained in the Fund, and made available for distribution in the following calendar year.

H. Member Copayments

IPA Provider shall collect from Members applicable deductibles and coinsurance, and retain any applicable copayments for each encounter at the Physicians' office, all according to the Members' Network Product Certificate.

I. Member's Liability for Non-Covered Services. If a Member requests services despite having been informed by [redacted] or the IPA Provider that the services are not medically necessary or are not covered, the Member shall be solely liable for payment. Prior to rendering services, IPA Provider shall obtain written confirmation from the Member of the Member's responsibility for payment. [redacted]

8. QUALITY MANAGEMENT PROGRAM

A. Quality and utilization management decisions made by [redacted] shall not influence any IPA Provider's obligation to render independent professional judgment in providing health services to Members. Nothing contained in this Section or Section 9 hereof shall be construed to require IPA Providers to render care in a manner inconsistent with sound professional judgment and practice.

B. IPA Compliance- The IPA agrees, and agrees to require IPA Providers to cooperate with all [redacted] Quality Management Programs for both hospital-based and office-based care, including but not limited to office and hospital review, and case specific review as such programs are set forth in [redacted] Physician SourceBook or are otherwise communicated to IPA during the term of this Agreement. IPA and all IPA Providers shall cooperate with [redacted] and the IPA's Quality Management processes, and with any inquiries investigations or complaints by regulatory agencies, and shall respond fully thereto within fourteen (14) calendar days to inquiries by such entities regarding Quality Management issues. Failure to comply may result in termination of this Agreement by [redacted]

C. Quality Management is a non-delegated function of [redacted] however, the IPA shall be responsible for ensuring that regularly scheduled quality management meetings are held at quarterly intervals to initiate and coordinate quality management activities, including monitoring and instituting corrective action as to programs, systems and Providers and to assure adherence to [redacted] quality management policies, procedures and standards of care. The IPA Quality Management Committee shall include at minimum an [redacted] Quality Management specialist and three IPA Physicians designated by IPA.

D. [redacted] reserves the right to conduct periodic audits and/or site surveys for the purpose of evaluating IPA Providers' compliance with [redacted] Quality Management standards. The IPA shall assure that IPA Providers respond appropriately to all quality issues identified by the Quality Management Committee

within the requested time frames not to exceed fourteen (14) days of receipt of a written request.

9. UTILIZATION MANAGEMENT - POLICIES AND PROCEDURES

A. Prior Approval IPA shall require IPA Providers to obtain prior approval in accordance with the Member's Network Product Certificate and [redacted] administrative procedures before rendering any service requiring prior approval. IPA Providers shall not bill or otherwise attempt to collect from Members the amount of any benefit denied or reduced due to [redacted] or IPA's utilization management activities.

C. Referral for Specialty Services IPA Physicians who are Referral Specialists must obtain a written, or electronic if applicable, referral from a PCP for all non-urgent specialty services. A PCP's approval of an in-hospital consultation by a Referral Specialist also includes approval for a maximum of two(2) follow-up visits with that Referral Specialist following discharge if such visits are medically necessary.

[redacted]

D. IPA Providers' Rights to Redetermination and Appeal

Need to include Medicare language.

1. Upon denial of prior approval or payment, an IPA Provider may file with the IPA PMC, a written request for redetermination. The request may be accompanied by any supporting information the IPA Provider deems relevant. The request may be submitted by facsimile transmission and if a decision is required within one (1) business day, the request should be marked "URGENT".

2. In the event the IPA Provider does not agree with the redetermination, the IPA Provider may file an appeal with [redacted] Chief Medical Executive whose decision will be final.

3. None of the IPA Providers' rights to Redetermination or Appeal shall limit the rights of Members under review processes set forth in their respective Network Product Certificates.

4. In the event that any dispute arising hereunder is resolved through an arbitration process, the Commissioner of the [redacted] State Department of Health shall not be bound by any arbitration decision which

may be rendered. The Commissioner shall be provided with all issues submitted to arbitration and copies of any decision rendered.

E. Second Opinions A second opinion may be obtained at the discretion either of [redacted] or the PMC when it is required to assist in determining whether to grant prior authorization, or at the discretion of an IPA Provider or a Member under IPA Provider's care or the PMC whenever it is required to assist in determining whether to grant prior approval the need for a surgical procedure. The Second Opinion shall be provided by an independent physician mutually acceptable to [redacted] and IPA. Second Opinions shall be paid for from the Physicians Funds.

10. TERM AND TERMINATION

A. Effective Date This Agreement shall become effective on the latest day of signature and shall remain in effect until it is terminated by either party pursuant to the terms of this Section 10.

B. Termination Without Cause Either party may terminate this Agreement without cause at any time by providing at least one hundred eighty (180) days prior written notice to the other.

C. Termination for Breach Either party may terminate this Agreement upon thirty (30) days prior written notice in the event of a material breach of the Agreement by the other party, unless such breach is cured to the reasonable satisfaction of the non-breaching party within the thirty (30) day notice period.

D. Immediate Termination Either party may terminate this Agreement immediately and without notice in the following circumstances:

1. Failure by either party to maintain regulatory licenses or approvals necessary to provide services under this Agreement.

2. Upon the institution of bankruptcy reorganization or liquidation proceedings by or against either party.

3. Failure by IPA to maintain adequate insurance under Section II of this Agreement.

4. Revocation or termination of IPA's authority to function as an IPA and to bind IPA Providers pursuant to the terms of this agreement.

5. Disciplinary action by a governmental authority impairs IPA's ability to function as an IPA.

6. Fraudulent or intentional abuse by IPA of [redacted] referral or billing system

E. Statutory Bases for Termination This Agreement may be terminated by either party upon not less than ten (10) days prior written notice to the other in the event of the enactment of any federal or state law, the adoption of any federal or state regulation, or the written interpretation of any law or regulation which materially affects the method of reimbursement or other material provision of this Agreement.

F. In the event this Agreement is terminated, or in the event of [redacted] insolvency, IPA and IPA Providers shall:

1. continue to treat Members until the earliest of the conclusion of the course of treatment, the effective date of termination, or the effective date of the orderly transfer of Members, and

2. shall provide complete copies of Member's medical records to other Providers as directed by [redacted] and/or the Member.

[redacted]

11. MISCELLANEOUS

A. <u>Insurance</u>

1. IPA shall procure and maintain professional, and directors and officers liability insurance in amounts of $1 million per occurrence and <u>$3</u> million in the aggregate.

2. In addition, IPA shall assure that each IPA Provider who is a physician procures and maintains professional liability insurance in amounts of at least $1 million per occurrence and $3 million in the aggregate, or in greater amounts if deemed necessary by [redacted] to insure against any claim, demand or expense for damages alleged to have arisen directly or indirectly from performance or omission by IPA Physician or IPA Physician's employees, agents and representatives of any act relating to this Agreement.

3. IPA also shall assure that each IPA Provider who is not a physician procures and maintains professional liability insurance in amounts deemed

acceptable to [redacted] to insure against any claim, demand or expense for damages alleged to have arisen directly or indirectly from performance or omission by Provider or Provider's employees, agents and representatives of any act relating to this Agreement.

4. Upon request, IPA and IPA Providers shall demonstrate to [redacted] that such insurance is in force. IPA Providers shall notify [redacted] of claim payments made under the policy.

B. <u>Assignment</u> This Agreement may not be assigned by IPA without [redacted] prior written consent, and any such assignment shall be void. [redacted] shall be entitled to assign this Agreement, in whole or in part to a parent, affiliate or subsidiary corporation or to a transferee of all or substantially all of [redacted] assets. Any such assignment shall be effective immediately upon written notice to IPA. [redacted] shall provide the Commissioner of [redacted] State Department of Health with notification of any assignment of this Agreement.

C. <u>Authorization to Use Name</u> IPA agrees to permit the use of its name, and the names of IPA Providers names, addresses, telephone numbers and practice areas in [redacted] advertising and other materials that list Providers participating in its managed care network.

D. <u>Non-Severability</u> If any provision of this Agreement shall be or become invalid or unenforceable under any provision of federal, state or local law or regulation, or by a court of competent jurisdiction, the validity or enforceability of other provisions shall not be affected.

E. <u>Confidential Information</u> Insurer and IPA shall each keep confidential and not disclose to any third party without the prior written consent of the other party any "Confidential Information" as defined herein, during the term of this agreement and thereafter. The term "Confidential Information" shall mean the following information provided by a party to the other party in contemplation of or in connection with this Agreement which is reasonably considered to be proprietary or confidential: information relating to business, financial condition, reimbursement methodology, and quality assurance and utilization review activities. Confidential Information shall not include information which: was, is or becomes known from a third party through no fault of a party; is learned from a third party legally entitled to disclose such information; or is required to be disclosed to a third party under applicable law.

F. Prior Agreements This Agreement and all schedules and attachments hereto supersede any prior or interim agreements or letters of intent between IPA or its Providers and [redacted] to provide health care services in accordance with [redacted] Network Products.

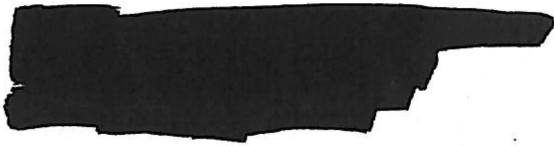
G. Choice of Law and Venue The laws of the State of [redacted] shall govern all matters relating to the validity, performance and interpretation of this Agreement and that any action arising from this Agreement shall be brought and tried in a court of competent jurisdiction in the State and County of [redacted]

H. Regulatory Approval The appropriate party will use its best efforts to obtain approval of this Agreement and material amendments thereto from regulatory authorities. In the event such approval is conditioned upon amendment(s) of this Agreement, [redacted] will revise the document(s) as required.

I. Other Individuals Covered [redacted] may enter into agreements with other [redacted] or their affiliates or subsidiaries ("Other Plans") regarding services to Other Plans' HMO, POS or Preferred Provider program members; or members of Other Plan' programs may, on an occasional basis, need medical care while traveling in the [redacted] service area. IPA Providers shall be compensated for services covered by the Other Plan's subscriber contracts on a fee-for-service basis, based upon the provisions and limitations set forth in the applicable subscriber contract. With the exception of compensation provisions, all other provisions of this Agreement shall apply to such individuals, and IPA shall assure that Providers accept and treat those individuals on the same basis as Members.

J. Amendments This Agreement and all attachments and amendments hereto are executed subject to the approval of all required government authorities and may be amended by [redacted] upon forty-five (45)days prior written notice to IPA. For purposes of this subsection J, the addition or deletion of Network Products covered hereunder hereto shall not be treated as an amendment to this Agreement. Any material amendment to this Agreement and any attachments hereto shall be subject to the approval of [redacted] State Department of Health.

IN WITNESS HEREOF, the parties have caused their duly authorized representatives to execute this Agreement, effective on the latest date set forth below.



By ______________________________

Contracting & Network Development

Date:____________________

IPA Name
IPA Address

By ______________________________

Name
Title

Date:____________________