ILLINOIS REGULATORY ATTACHMENT

As set forth in Sections 9.5 and 9.15 of the Agreement, the Parties agree to abide by the terms of the Agreement, and also agree to abide by the additional requirements applicable to the provision of services to Covered Persons enrolled in commercial (e.g., not Medicare Advantage) managed care plans in Illinois are set forth in this Exhibit.

This Exhibit 3 amends the Agreement to comply with legislative and regulatory requirements of the State of Illinois (e.g. 215 Illinois Compiled Statutes ("ILCS") 125/2-S(b) (the "HMO Act") and Title 50, Part 4521 of the Illinois Administrative Code) regarding provider contracts with providers rendering health care services in the State of Illinois. Provider acknowledges that the Director of the Illinois Department of Insurance ("DOI") must disapprove any provider agreement as provided for in 50 Ill. Admin. Code § 452 l.50(b).

To the extent that such laws and regulations are applicable but not preempted by applicable federal law, the provisions of this Exhibit shall apply and, to the extent of a conflict with a provision in the Agreement and this Exhibit, this Exhibit shall control. For purposes of this Exhibit, the term "Covered Person" means an individual who is eligible under a plan insured and/or administered by Plan, and the term "Covered Services" means services that are covered under any such plan. References to Provider herein means the provider listed on the signature page of the Agreement to which this Exhibit relates.

1. To the extent that Covered Services are rendered by Provider to Covered Persons enrolled in a health maintenance organization ("HMO") plan, the following provisions are hereby added to the Agreement to the extent required by law applicable to Provider:

    a. Provider attests that it and all nurses and other ancillary and paramedic personnel are licensed, certified, or registered, as required by Illinois Laws, to perform their duties. [77 Ill. Admin. Code Section 240.40]. Provider shall also provide Plan written notice of:

        i. The hours each Provider site is open;
        ii. The hours each physician is routinely available at the provider site;
        iii. The extent to which twenty-four (24) hour a day, seven (7) day a week coverage is provided through the provider site;
        iv. The number of Covered Persons the provider site serves as well as the total number of patients served by the provider site; and
        v. All admitting or staff privileges in at least one hospital within the Plan service area. [77 Ill. Admin. Code Section 240.80].

    b. Further, Provider shall provide all of the following, where applicable, to Covered Persons upon request: (1) information related to the Provider's educational background, experience, training, specialty, and board certification, if applicable; (2) the names of licensed facilities on the Provider panel where Provider presently has privileges for the treatment, illness, or procedure that is the subject of the request; and (3) information regarding Provider's participation in continuing education programs and compliance with any licensure, certification, or registration requirements, if applicable. [215 ILCS 134/15(c)]

    c. Provider shall maintain an active record for each Covered Person who receives health care services. The record shall be kept current, complete, legible and available to the medical and administrative staff of the Plan and to DOI representatives. [77 Ill. Admin. Code Section 240.90]. The medical records system shall be organized to facilitate retrieval and compilation of medical records information necessary to provide continuity of care among various providers who are

directly involved in the care of the Covered Person. Provider shall also have a policy regarding the confidentiality, security and release of Covered Persons' medical records, and the retention and retirement of Covered Persons' medical records. [77 Ill. Admin. Code Section 240.50].

d. Provider shall ensure that each entry be indelibly added to the Covered Person's record, dated and signed or initialed by the person making the entry. Provider shall ensure they have a means of identifying the name and professional title of the individual who makes each such entry. The medical record for each Covered Person who has had a routine, scheduled appointment with a Provider primary care physician shall include, at a minimum, the following information:

i. identification;
ii. patient history;
iii. known past surgical procedures;
iv. known past and current diagnoses and problems; and
v. known allergies and untoward reactions to drugs.

Further, the medical records for each Covered Person who receives Covered Services contain the following information regarding each episode of care:

i. reason for the encounter;
ii. evidence of the Provider's assessment of the Covered Person's health problems;
iii. current diagnosis of the Covered Person, including the results of any diagnostic tests;
iv. plan of treatment, including any therapies and health education; and
v. if the basic information above is not available, any medical history relevant to the current episode of care.
vi. Provider shall document that all outcomes of ancillary reports, such as laboratory tests and x-rays have been reviewed by the Provider who ordered the reports and to document that follow up actions have been taken regarding report results that are deemed significant by the provider who ordered the report.

[77 Ill. Admin. Code Section 240.90].

e. Plan's quality assessment program shall include physician participation, and all medical decisions shall be made by the medical director or the HMO's peer review body. [77 Ill. Admin. Code Section 240.60]. Further, Provider or its subcontractors shall provide, arrange for, or participate in the quality assurance programs mandated by the HMO Act, unless the Illinois Department of Public Health certifies that such programs will be fully implemented without any participation or action from such contracting provider. [50 Ill. Admin Code § 4521.50(a)(4))].

f. Plan shall not require Provider to prescribe any particular drug product to any Covered Person unless the Covered Person is a hospital in-patient where such drug product may be permitted pursuant to written guidelines or procedures previously established by a pharmaceutical or therapeutics committee of a hospital, approved by the medical staff of such hospital and specifically approved, in writing, by the prescribing physician for his or her patients in such hospital, and unless it is compounded, dispensed or sold by a pharmacy located in a hospital, as defined in Section 3 of the Hospital Licensing Act. [215 ILCS 125/2-3.1(b)].

g. If the Director of the DOI promulgates rules requiring that provider contracts contain provisions concerning reasonable notices to be given between the parties and for Plan to provide reasonable notice to its Covered Persons and to the Director, such notice shall be given for such events as, but

not limited to, termination of insurance protection, quality assurance or availability of medical care. [25 ILCS 125/2-8(c)].

h. Provide shall allow the DOI to make any examination concerning the quality of services as often as the DOI deems it necessary for the protection of the interest of the people of Illinois, but not less frequently than every three (3) years. [215 ILCS § 125/5-4].

i. Plan shall provide Provider at least sixty (60) days' notice of nonrenewal or termination. The notice shall include a name and address to which Provider may direct comments and concerns regarding the nonrenewal or termination. However, immediate written notice may be provided without sixty (60) days' notice when Provider's license has been disciplined by a state licensing board and Plan may terminate the Agreement immediately for cause. [215 ILCS 134/20; 50 Ill. Admin. Code§ 452 l.50(b).].

j. Provider shall give Plan at least (sixty) 60 days' notice for termination with cause, as defined in the Agreement, and at least ninety (90) days' notice for termination without cause. The Plan must inform the DOI of any known or intended termination, with or without cause, of Provider. [50 Ill. Admin. Code§ 452 l.50(a), 4521.50 (a)(5)].

k. Provider must maintain and provide evidence of insurance coverage for professional liability and malpractice insurance effective as of the date of the Agreement. Provider must notify Plan within fifteen (15) days of receiving notice of any reduction or cancellation of such insurance. [50 Ill. Admin. Code§ 4521.50(a)(7).]

l. Plan will not penalize or reduce or limit the reimbursement of Provider or provide incentives (monetary or otherwise) to Provider to induce Provider to provide care in a manner inconsistent with [215 ILCS 125/4-6.1].

m. Plan will require Provider, as a condition of participation with Plan, to purchase ophthalmic goods or services, including but not limited to eyeglass frames, in a quantity or dollar amount in excess of the quantity or dollar amount a Covered Person purchases under the terms of the applicable Benefit Plan. [215 ILCS 125/4-19].

n. Provider shall provide services without discrimination based on source of payment. [77 Ill Admin. Code§ 240.50(d)(4)].

o. Provider agrees that in no event, including but not limited to nonpayment by Plan of amounts due the Provider under this Agreement, insolvency of Plan , or any breach of this Agreement by Plan, shall the Provider or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the Covered Person, persons acting on the Covered Person's behalf (other than Plan), the employer or group contract holder for services provided pursuant to this Agreement except for the payment of applicable co-payments or deductibles for Covered Services or fees for Non-Covered Services. The requirements of this clause shall survive any termination of this Agreement for services rendered prior to such termination, regardless of the cause of such termination. Covered Persons, the persons acting on the Covered Person's behalf (other than Plan) and the employer or group contract holder shall be third party beneficiaries of this clause. This clause supersedes any oral or written agreement now existing or hereafter entered into between the provider and the Covered Person, persons acting on

the Covered Person's behalf (other than Plan) and the employer or group contract holder. [25 ILCS 125/2-8(a), 50 Ill. Admin Code Section 4521.50, and 215 ILC 130/2008]. Nothing herein shall preclude Provider from charging reasonable administrative fees, such as service fees for checks returned for non-sufficient funds and missed appointments. [25 ILCS 125/4-20(a).]

If Provider is Capitated, Provider shall:

a. Provider acknowledges that in the event of Plan's insolvency, Provider is secondarily liable as the ultimate risk bearer for unpaid health care services rendered to Covered Persons. [50 Ill. Admin. Code Section 4521.50(d)].

b. Submit, to Plan, copies of its quarterly financial statements, which shall include Provider's balance sheet and statements of income and cash flow within forty-five (45) days after the end of each fiscal period. In addition, Provider shall submit, within ninety (90) days after the end of Provider's fiscal year, copies of Provider's audited annual financial statements prepared in accordance with generally accepted accounting principles if available. Provider agrees to fully cooperate with, and disclose all relevant information requested by, Plan's actuaries for the preparation of such actuaries' opinion in accordance with the Actuarial Standards Board Actuarial Standards of Practice No. 16. [50 Ill. Admin. Code Section 4521.50(d)].

c. Provider agrees that in no event, including but not limited to nonpayment by Plan of amounts due Provider under this contract, insolvency of Plan or any breach of this contract by Plan, shall Provider or its assignees or subcontractors have a right to or seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, Covered Persons, persons acting on a Covered Person's behalf (other than Plan), the employer or group contract holder for services provided pursuant to this contract; except for the payment of applicable co-payments or deductibles for services covered by the organization or fees for services not covered by Plan. The requirements of this clause shall survive any termination of the Agreement for services rendered prior to such termination, regardless of the cause of such termination. Plan's Covered Persons, persons acting on a Covered Person's behalf (other than Plan), and the employer or group contract holder shall be third party beneficiaries of this clause. This clause supersedes any oral or written agreement now existing or hereafter entered into between Provider and a Covered Person, persons acting on a Covered Person's behalf (other than Plan) and the employer or group contract holder. [50 Ill. Admin. Code Section 4521.50(e)].