

**HEALTHCHOICE PREFERRED PROVIDER ORGANIZATION**

**PAYOR PARTICIPATION AGREEMENT**

THIS AGREEMENT is made and entered into this 1st day of June, 2005 by and between HEALTHCHOICE, INC., a Florida corporation (hereinafter referred to as PPO) and WEB-TPA (hereinafter referred to as Payor).

WITNESSETH:

WHEREAS: PPO has organized and developed a Preferred Provider Organization Program (hereinafter referred to as the Program) for the purposes of

- (i) assembling Physician Providers, Hospital Providers, Mental Health Providers, Organizational Providers and Other Providers, as hereinafter defined;
- (ii) soliciting participating payors (defined as employers, insurers, and other payors of costs of health care for employees and related groups) to enter into agreements with PPO for PPO to provide, through Physician Providers, Hospital Providers, Mental Health Providers, Organizational Providers and Other Providers, services for selected groups of beneficiaries at negotiated payment rates; and
- (iii) arranging for utilization review, credentialing, and quality control program for Physician Providers; and

WHEREAS, Payor desires to develop an agreement to establish a PPO option for certain of its Clients under the benefit plans marketed by Payor in the service area in which PPO exists.

NOW, THEREFORE, the parties hereto, in consideration of the terms and conditions set forth herein, agree as follows:

PART I. DEFINITIONS

For purposes of this Agreement, the following definitions shall apply:

- A. Beneficiary means a person for whose health care services Payor is obligated to pay according to the terms of the Plan.
- B. Client means the group customer for which Payor administers a group health insurance program.
- C. Contiguous Service Area - any counties in which Healthchoice has developed a PPO network other than Orange, Osceola, Seminole, Lake and Brevard Counties.
- D. Covered Services - means all services provided by a Physician Provider, Mental Health Provider, Organizational Provider, Hospital Provider, or Other Provider to a Beneficiary for which Payor is obligated to pay according to the terms of this Agreement and the applicable benefit plan.

- E. Hospital Provider means a hospital under contract with PPO to furnish hospital services to Beneficiaries of Payor pursuant to the terms of this Agreement.
- F. Mental Health Provider means a physician or licensed health professional under contract with PPO to furnish mental health care services to Beneficiaries of Payor pursuant to the terms of this Agreement. Licensed mental health professionals for purposes of this Agreement include psychiatrists, psychologists, masters level Social Workers and R.N.'s licensed to practice psychotherapy in the State of Florida.
- G. Organizational Provider means an organization under contract with PPO to furnish mental health services to Beneficiaries of Payor pursuant to the terms of this Agreement.
- H. Other Provider means a provider of services or supplies under contract with PPO to furnish health care services or supplies to Beneficiaries of Payor pursuant to the terms of this Agreement.
- I. Physician Provider means a physician under contract with PPO to furnish health care services to Beneficiaries of Payor pursuant to the terms of this Agreement.
- J. Plan means a group healthcare policy, a self-funded health benefit plan, or any other legally enforceable instrument administered by Payor, which specifies the term, and conditions under which Covered Services are rendered to a Beneficiary.
- K. Primary Service Area - Orange, Osceola, Seminole, Lake and Brevard Counties, Florida.
- L. Providers means Physician Providers, Hospital Providers, Mental Health Providers, Organizational Providers and Other Providers.
- M. Relative Value Study (RVS) means the schedule prepared by PPO which lists medical procedures and reflects the relative values of such procedures by designation of a unit value for each procedure.
- N. Clean Claim means a request a payment for Covered Services submitted by a Provider which is complete and is in reasonable compliance with the "Clean Claim" definition contained in Exhibit "H" to this Agreement.

## PART II. PAYOR'S RESPONSIBILITIES AND WARRANTIES

- A. Payor warrants that it administers the plan for group health benefits to employees of contracted Clients.
- B. Payor shall provide PPO with written information on all Client Plans in a manner substantially similar in form and content to the Client Plan Information Form attached hereto and incorporated herein as Exhibit "A". The form will include the name and address of each Client Plan, the Client number, the effective date of the preferred provider provisions, and the approximate number of

employees eligible to be Plan Participants, deductible/copayment amounts and the co-insurance percentages.

- C. For purposes of notification of providers, Payor shall make best efforts to provide the Client Plan Information Form as soon as possible for participation in the PPO network
- D. Payor agrees to assist PPO in marketing and promoting the Program to Beneficiaries and to implement the Program for Beneficiaries.
- E. Payor acknowledges that PPO shall have no responsibility or liability for any claims decisions or payments. Payor agrees that PPO shall not be directly or indirectly responsible for the payment from its own funds of any claims or billings from any Provider of covered or non-covered health care services to Beneficiaries. Payor acknowledges that PPO is not an insurer, guarantor, or underwriter of the responsibility or liability of Payor to provide benefits pursuant to the Program, the Plan, or any other plan or contract. All claims decisions and payment will be the responsibility of Employer.
- F. If Payor determines that any claim or billing from a Provider contains charges resulting from a Provider mistake or error, Payor shall promptly notify such Provider and PPO of such error. Such mistake or error may include, but is not limited to, duplicate billing or billing for services not rendered. PPO agrees to assist Payor in obtaining reimbursement from such Provider if payment by Payor has been made as a result of such mistake or error. Payor will work through PPO to address requirements to correct billing practices on the part of Providers.
- G. Each party agrees to indemnify the other party and its officers, agents, and employees and to hold such other party harmless from any liability, demands, damages or claims arising from any failure of the indemnifying party or its officers, agents or employees to perform its obligations under this Agreement. Neither party hereto or any of their respective agents or employees shall be liable to third parties for any act or omission of the other party, their respective agents or employees. In no event shall PPO be liable or provide indemnity for any acts of omission of any other health care provider, including, without limitation, physicians or other healthcare professionals not employed by PPO.
- H. Payor will cooperate with PPO to develop procedures for identification of Beneficiaries. Payor, at PPO's option, will place the wording "Healthchoice" or other identifying information, as may be requested by PPO, on the Beneficiary Group Health identification cards in a manner that is clearly distinguishable. Payor agrees to pay for services rendered to individuals identified by Providers as Beneficiaries under the identification procedures established by Payor and PPO. Payor will use a Customer Service phone line to confirm patients eligibility and verify coverage to Providers.
- I. Payor shall provide to PPO such reports as Payor and PPO shall mutually agree upon.
- J. Payor shall administer the payment of access fees to compensate PPO for PPO's administrative services under this Agreement in the manner set forth in Exhibit "G" attached to this Agreement.
- K. In order to examine or receive copies of medical records of Beneficiaries, Payor shall obtain and deliver to PPO written releases from Beneficiaries authorizing the release of such medical records by providers or PPO to Payor.

- L. Clean Claim means a request for payment for Covered Services submitted by a Provider which is complete and is in reasonable compliance with the "Clean Claim" definition contained in Exhibit "H" to this Agreement.

### PART III. PPO'S RESPONSIBILITIES AND WARRANTIES

- A. PPO has agreed or will agree to contracts with Providers which include terms for reimbursement or payment as set forth in more detail in Sections 5 & 6 below. Payor agrees to recognize such contractual arrangements and to pay claims of Beneficiaries for Covered Services which are delivered by a Provider and are submitted to Payor as set forth herein.
- B. PPO will provide appropriate administrative, reporting, and consulting services to Payor in connection with the promotion, implementation, and operation of the Program and the Plan. PPO will provide a Beneficiary Services Program designed to process and consider questions, complaints, and other matters, as appropriate, with respect to Beneficiaries.
- C. PPO agrees to indemnify and hold the Payor harmless from any and all loss, damage and expense, including attorneys' fees, caused by the error, omission, negligence or malfeasance of PPO, its agents and employees. PPO will not be responsible for error, omission, negligence or malfeasance by Providers. This section shall not be construed as an indemnity of Payor by PPO from liability or claims for damages arising from professional malpractice by Providers.
- D. PPO and Payor agree to develop and implement appropriate administrative procedures to facilitate claims decisions and payments pursuant to Section 6 below.
- E. **Use and Disclosure of Patient Information.** PPO acknowledges that Administrator is subject to various state and federal laws regarding the confidentiality and security of individually identifiable health information ("Protected Health Information" or "PHI"). Such state and federal laws include, but are not limited to, the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) commonly known as HIPAA as well as the rules and regulations adopted and to be adopted in connection therewith. In the course of performing its obligations under this Agreement, PPO may be provided or have access to Protected Health Information. PPO agrees that any Protected Health Information received by it shall be held strictly confidential, and shall not be used by PPO or disclosed by PPO except as specifically provided in this Agreement, as otherwise directed by Administrator in a separate writing or as required by law.

Use or disclosure of Protected Health Information must not violate 45 CFR part 160 and part 164, subparts A and E (the "Privacy Rule"). Except as otherwise limited in this Agreement, PPO may use or disclose Protected Health Information on behalf of, or to provide services to Employer/Administrator for the purposes listed below:

- (a) Treatment, payment or health care operations including, but not limited to: Case Management Services, Claims Adjudication assistance and Quality Assurance. Only those employees performing the above functions and account managers shall be permitted to have access to PHI.
- (b) Use and disclosure of PHI shall be in accordance with any current or future state or federal statutes, rules or regulations.

To comply with the Privacy Rule, PPO further agrees that it will:

- (a) Not use or further disclose PHI other than as permitted or required by the Agreement or as required by law.
- (b) Use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement.
- (c) Mitigate, to the extent practicable, any harmful effect that is known to PPO of a use or disclosure of PHI by PPO in violation of the requirements of this Agreement.
- (d) Report to Administrator any use or disclosure of the PHI not provided for by this Agreement.
- (e) Ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by PPO on behalf of Administrator agrees to the same restrictions and conditions that apply through this Agreement to PPO with respect to such information.
- (f) Provide access, at the request of Administrator, and in the time and manner designated by Administrator, to PHI in a Designated Record Set, to Administrator or, as directed by Administrator, to an Individual in order to meet the requirements under 45 CFR 164.524.
- (g) Make any amendment(s) to PHI in a Designated Record Set that the Administrator directs or agrees to pursuant to 45 CFR 164.526 at the request of Administrator or an Individual, and in the time and manner designated by Administrator.
- (h) Make internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by PPO, on behalf of Administrator, available to the Administrator, or at the request of the Administrator, in a reasonable time and manner, for purposes of determining Administrator's compliance with the Privacy Rule.
- (i) Document such disclosures of PHI and information related to such disclosures as would be required for Administrator to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.
- (j) Provide to Administrator or an individual patient, information collected in accordance with section (i) of this Agreement, to permit Administrator to respond to a request by an individual patient for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.

In complying with the foregoing, PPO will conduct such assessments and adopt such administrative procedures, physical safeguards and technical security services as may be required by Administrator or by law to safeguard the security of PHI. Furthermore, PPO agrees to comply with all applicable federal and state laws and/or regulations regarding confidentiality and security of PHI including, but not limited to, any regulations, standards or rules promulgated under the authority of the HIPAA.

Upon termination of this Agreement, for any reason, PPO shall return or destroy all PHI received from Administrator, or created or received by PPO on behalf of Administrator. This provision shall apply to PHI that is in the possession of subcontractors or agents of PPO. PPO shall retain no copies of the PHI.

If PPO determines that returning or destroying the PHI is not feasible, PPO shall provide to Administrator notification of the conditions that make return or destruction not feasible. Upon mutual agreement of the Parties that return or destruction of PHI is infeasible, PPO shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as PPO maintains such PHI.

#### PART IV. TERMS AND TERMINATION

- A. This Agreement shall have an initial term of twelve (12) months, commencing **June 1, 2005**. It is agreed between the parties that the renewal date of this contract shall be amended to the 1<sup>st</sup> day of June, commencing **June 1, 2006**, and shall continue to automatically renew for successive twelve (12) month periods until terminated at the end of any twelve (12) month period by written notice of termination delivered not less than sixty (60) days prior to the end of the then-current twelve (12) month period.
- B. Either party may terminate this Agreement upon the breach of the Agreement by the other party, provided that such breach is not corrected within thirty (30) days following written notification of breach of the breaching party. PPO or Payor may terminate this Agreement without cause at any time upon sixty (60) days prior written notice by either party to the other.
- C. Termination shall have no effect upon the rights and obligations of PPO or Payor that arise from any treatments, admissions, or other transactions occurring between Providers and Beneficiaries prior to the effective date of such termination. For Beneficiaries admitted for inpatient care prior to termination, the Provider will continue to provide treatment until patient is discharged, and Payor will pay for covered services rendered to the Beneficiary through the date of discharge at the rates set forth in this Agreement.
- D. Notwithstanding anything hereto to the contrary, upon the occurrence of any of the following events, either party hereto shall have the option to terminate this agreement upon ten (10) days prior written notice and all rights and obligations of the parties hereto, and of the Participating Providers shall cease:
  - (i) If a party shall file a petition for bankruptcy or an involuntary petition for bankruptcy shall be filed against a party.
  - (ii) If a party shall fail to obtain or shall lose any permit, license or governmental approval necessary for the lawful conduct of its business pursuant hereto.
  - (iii) Upon the sale, exchange or other disposition of substantially all of the assets of the other party.

#### PART V. RATES FOR COVERED SERVICES

- A. The rates payable by Payor for Hospital Services shall be as set forth in Exhibit "C" attached hereto.

- B. The rates payable by Payor for all other Services shall be set forth in Exhibit "D" attached hereto.
- C. The rates payable by Payor for Mental Health Organizational Providers shall be as set forth in Exhibit "E" attached hereto.

#### PART VI. PAYMENT

- A. Bills for Covered Services will be submitted to Payor by Providers either directly or through PPO, at the option of PPO.
- B. Providers will submit claims to: .
- C. Provider claims data will be submitted as follows, unless otherwise agreed to by the parties in writing:
  - (i) Physician Provider and Mental Health Provider claims will include appropriate Current Procedural Terminology (CPT-IV) coding or DSM III coding for mental health and diagnosis nomenclature.
  - (ii) Hospital Provider and Organizational Provider claims will be that information normally submitted on Form UB-92, including International Classification of Disease (ICD-9-CM) coding or diagnosis nomenclature.
  - (iii) Other Provider claims will be submitted in a statement format, listing all applicable information necessary to identify the Beneficiary and process the claim.
- D. Payor agrees that it will furnish the following to the Provider (with copies or summaries to the Beneficiary) within 14 days following the receipt by Payor of a Clean Claim:
  - (i) Payor's check in full payment for all services reflected in the bill (less applicable copayments, coinsurance or deductible), including an explanation of payment to include patient name, date of service, procedure, charge, allowed charge, copayment, coinsurance and or/ deductible amounts, at the rates set forth in Section 5 above, except those services that Payor has determined are not Covered Services. Notwithstanding any language to the contrary contained in the exhibits attached to this Agreement, such amount shall be reduced by any applicable copayment, coinsurance and/or deductible amount; and
  - (ii) As to services that Payor has determined are not Covered Services, a statement setting forth the reasons for its determination; or
  - (iii) Notice that additional time is required to process claim with final benefit determination date; however no more than 20 percent of claims for any Provider may be delayed. Best efforts will be made to process such claims within thirty (30) days of receipt of claim.
- E. PPO warrants that its contracts with Providers provide that such Providers shall accept payment at the rates set forth in Section 5 above as full payment for all Covered Services provided to Beneficiaries, less applicable copayments, coinsurance and deductibles.

- (i) Notwithstanding the foregoing, Providers shall not be prohibited, after receipt of payment from Payor, from billing a secondary insurer other than Payor for the unreimbursed balance of Provider's usual and customary charges for any Covered Services provided to a Beneficiary, as may be permitted by law, where the Beneficiary has secondary health insurance coverage, provided that the total amount of payment which Provider receives from the Beneficiary, the Payor and the secondary insurer does not exceed Provider's usual and customary charges for the Covered Services provided.
  - (ii) If the Payor is other than the primary payor, Providers will submit billed charges to the primary payor first. Payor will be considered the secondary insurer and will pay Providers, as permitted by law, for services covered under this Agreement not paid for by the primary payor. In no event will Payor's payment exceed 100 percent of the rates as set forth in Section 5 of this Agreement. The total payment by Payor, the Beneficiary and any third party will not exceed 100 percent of usual and customary charges, with the third party and Beneficiary payments being applied first.
- F. Payor agrees to notify PPO in writing of any Client in arrears of claims funding or premium payment beyond thirty (30) days. Upon notification of such event, PPO may terminate this Agreement for that Client within thirty (30) days of such notification.

#### PART VII. UTILIZATION REVIEW

- A. Payor agrees to cooperate with the Utilization Review program implemented by PPO with respect to Providers, a summary which is attached hereto as Exhibit "F". The Utilization Review program shall be reviewed and approved by Payor. In the event, however, that a Payor elects to use its own utilization review plan, PPO agrees to cooperate with Payor or its designated Utilization Management company, in the implementation of its Utilization Management program, as set forth in Exhibit "F". PPO warrants that its contracts with Providers provide that the Utilization Review program will be applicable to all Providers.
- B. All Physician and Mental Health Providers shall be free to exercise absolute discretion in the conduct of any and all activities which may reasonably be considered as constituting the practice of medicine. The professional responsibility to Beneficiaries for the delivery of Covered Services under this Agreement shall at all times remain with the Physician Provider and Mental Health professionals. Neither PPO nor Payor shall in any way interfere with the professional judgment of the Provider in the delivery of professional Covered Services. Mental Health professionals shall practice within the guidelines established by the American Psychiatric Association (APA) and the American Psychological Association (APA). The professional responsibility to Beneficiaries for the delivery of covered services under this Agreement shall at all times remain with the Provider. The parties acknowledge that utilization review determinations relate solely to benefit entitlement, and no utilization management program shall be construed to require a Provider to omit essential health care services necessary for treatment of the medical condition of a Beneficiary solely to minimize utilization.

#### PART VIII. PANEL OF PROVIDERS; CONTINGENCIES

- A. Immediately upon the execution of this Agreement, PPO may individually communicate the rate information and other terms of this Agreement to all Providers participating in PPO's Program.

Based on PPO's contracts with Providers, each individual provider shall have twenty (20) days within which to agree in writing to provide Covered Services to Beneficiaries of Payor at the rates set forth herein.

- B. Subject to Section 8 (c) (i) below, within thirty (30) days from the date of this Agreement, PPO shall submit to Payor the following:
- (i) A list which sets forth the panel of Physician Providers who have agreed to furnish Covered Services to Beneficiaries at the rates set forth herein, such list to include the name, phone number, and medical specialty of each such Physician and Mental Health Provider; and
  - (ii) A list of Hospital and Organizational Providers which have agreed to furnish hospital services to Beneficiaries at the rates set forth herein for hospital services.
  - (iii) A list of other Providers which have agreed to furnish services at the rates set forth herein.
- C. This Agreement is contingent upon the following:
- (i) The determination by PPO that a sufficient number of Providers have contracted to provide Covered Services at the rates set forth herein to adequately serve the Beneficiaries of Payor, such determination to be evidenced by the delivery to Payor by PPO of the lists referred to in Section 8 (b) above; and
  - (ii) The written acknowledgment of Payor, within ten (10) days following the delivery to Payor of the lists referred to in Section 8 (b) above, of the panel of Physician, Hospital, Mental Health, Organizational and Other Providers that have agreed to provide health care services to Beneficiaries of Payor at the rates set forth herein.
- D. If either of the contingencies set forth in Section 8 (c) above are not met, this Agreement may be immediately canceled by either party.
- E. PPO's agreements with Providers shall require such Providers to prepare and maintain medical records as are required by law, regulations, and practices. Such records shall be treated as confidential so as to comply with all state and federal laws and regulations regarding the confidentiality of medical records. To the extent permitted by law, Payor shall be allowed access to such patient records. Any copies required by Payor shall be at Payor's expense at a reasonable charge.

#### PART IX. MISCELLANEOUS PROVISIONS

- A. Payor, where possible and practical, shall arrange for representatives of PPO to have reasonable access to Beneficiaries for the purposes of explaining, implementing, and promoting the Program and the Plan.
- B. It is agreed that inpatient hospital cases may be randomly audited by Payor, or its duly appointed representative which shall be mutually acceptable to both the Payor and the PPO.

- C. During the term hereof, each party hereby consents to the use of its name and identity in any marketing, advertising, or solicitation campaigns, provided, however, that such party has the right to require its prior written consent to such uses.
- D. Notwithstanding any other provision of this Agreement, the parties agree that either party may amend the terms of the Agreement by written notice to the other party in the following manner. A party desiring to amend the Agreement (the "Amending Party") shall provide written notice to the other party (the "Receiving Party"), in the manner set forth in this Agreement, setting forth the text of the proposed amendment. The Receiving Party shall be deemed to have agreed to and accepted the proposed amendment unless the Receiving Party objects to the proposed amendment by written notice delivered to the Amending Party within thirty (30) days following receipt by the Receiving Party of the notice of proposed amendment. If the Receiving Party objects to the proposed amendment in the manner set forth above, the proposed amendment shall not be effective.
- E. Waiver by either party of the performance of any obligation on any occasion shall not constitute a further or continuing waiver of such performance.
- F. This Agreement is entered into by and between the parties hereto for their own benefits only. There is no intent by either party to create or establish third party beneficiary status or rights or their equivalent in any Beneficiary, Provider, or other third party which may be affected by the operation of this Agreement, and no such third party shall have any rights to enforce any right or enjoy any benefit created or established under this Agreement. The parties reserve the right to modify or terminate this agreement without notice to, or consent of, any Beneficiaries, Providers, or other third party.
- G. Each party agrees that materials and information given by one party to the other in performing this Agreement shall be confidential and proprietary. The terms and conditions of this agreement are confidential and shall not be disclosed to any third party except as set forth herein.
- H. In the event that the operations of either party are interrupted by war, fire, insurrection, labor troubles, riots, the elements, earthquakes, acts of God, or material and persistent failure or refusal of Providers to perform their contractual obligations with PPO, the provisions of this Agreement may be suspended for the duration of such interruption without liability to the other party. Should a substantial part of the services which either party has agreed to provide to the other hereunder be interrupted pursuant to such event for a period in excess of thirty (30) days, either party shall have the right to terminate this Agreement upon thirty (30) days written notice to the other.
- I. This Agreement may not be assigned by either party without the prior written consent of the other party. Such consent will not be unreasonably withheld. PPO may subcontract its rights and obligations hereunder, provided that PPO will remain responsible for the performance of the agreement.
- J. This Agreement shall extend to and be binding upon and inure to the successors and assigns of the parties.
- K. Any notice required to be given pursuant to the terms of this Agreement shall be in writing and may be personally delivered or sent by U.S. Certified Mail, return receipt requested, postage prepaid, addressed as follows:

If to PPO: **Executive Director  
HEALTHCHOICE, INC.  
102 West Pineloch Ave., Suite 23  
Orlando, FL 32806**

If to Payor: **Web-TPA  
8500 Freeport Pkwy South  
Irving, Texas 75063**

- L. This Agreement and the Exhibits hereto contain the entire Agreement between the parties relating to the rights granted and the obligations assumed by this Agreement. Any prior agreements, promises, negotiations, or representations relating to the subject matter of this Agreement not set forth herein are of no force or effect.
- M. This Agreement shall be governed by and construed in accordance with the laws of the State of Florida, and venue for proceedings to enforce the terms hereof shall be in Orange County, Florida.
- N. This Agreement may be executed in two (2) counterparts, each of which shall be deemed an original, but both of which together shall constitute one and the same Agreement.
- O. This Agreement creates an independent contractor relationship between the parties, and shall not be deemed to create an employment, partnership, or joint venture relationship.
- P. This Agreement shall be construed in such a manner to comply with all federal, state, and local laws, regulations, and ordinances. If any provision of this Agreement is held to be invalid, void, or unenforceable, the remaining provisions shall nevertheless remain in full force and effect unless the absence of the invalid, void, or unenforceable provision or provisions causes this Agreement to fail in its essential purposes.
- Q. The headings of the various sections of this Agreement are merely for convenience and do not, expressly or by implication, limit, define, or extend the specific terms of any sections hereof.
- R. Ambiguity as to the meaning of any of the provisions of this Agreement shall not be interpreted against a party solely because that party may have originally drafted the specific provision in question.
- S. Where used herein, the singular shall include the plural, and vice-versa, and the masculine shall include the feminine and neuter, and vice-versa.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the days and year set forth above.

**HEALTHCHOICE, INC.,**

By: \_\_\_\_\_

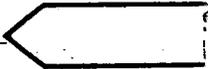
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**Web-TPA**

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