SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K
ANNUAL REPORT PURSUANT TO SECTION 13 OF
THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 1996
Commission File No. 1-11993

MIM CORPORATION
(Exact name of registrant as specified in its charter)

Delaware	05-0489664
(State of incorporation)	(IRS Employer Identification No.)

One Blue Hill Plaza, Pearl River, New York 10965
(914) 735-3555
(Address and telephone number of Principal Executive Offices)

Securities registered pursuant to Section 12(b) of the Act: None

Securities registered pursuant to Section 12(g) of the Act:
Common Stock, $.0001 par value per share
(Title of class)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding twelve months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes x No
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Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. x
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The aggregate market value of the registrant's Common Stock (its only voting stock) held by non-affiliates of the registrant as of March 25, 1997 was approximately $43.2 million. (Reference is made to the final paragraph of Part II, Item 5 herein for a statement of the assumptions upon which this calculation is based.)

On March 25, 1997 there were outstanding 12,083,300 shares of the registrant's Common Stock.

Documents Incorporated by Reference

Portions of the registrant's definitive proxy statement relating to its scheduled June 1997 annual meeting of stockholders (which proxy statement is expected to be filed with the Commission not later than 120 days after the end of the registrant's last fiscal year) are incorporated by reference into Part III of this report.

PART I

Item 1. Business

Overview

MIM Corporation (the "Company") is a pharmacy management organization that provides a broad range of services to the pharmaceutical health care industry designed to promote the cost-effective delivery of pharmacy benefits to the public. The Company targets organizations involved in three key industry segments -- sponsors of public and private health plans (such as HMOs and other managed care organizations), retail pharmacies and pharmaceutical manufacturers and distributors -- and offers services providing financial benefits to each of them. The Company works with plan sponsors and local health care professionals to design, implement and manage innovative pharmacy benefit management ("PBM") programs to control pharmacy benefit costs under the plans, primarily through financial risk sharing arrangements and clinically appropriate substitution of generic drugs for equivalent but more expensive brand name drugs. The Company offers suppliers of generic drugs the potential to increase sales and market share through "preferred generic" marketing programs to participating pharmacies and increases in generic drug utilization encouraged by the Company's PBM programs. In turn, retail pharmacies receive financial incentives for supporting the Company's PBM and preferred generics programs as well as discounts on drug purchases and other management and support services.

The Company was incorporated in Delaware in March 1996 for the purpose of combining the businesses and operations of Pro-Mark Holdings, Inc. and MIM Strategic Marketing, LLC, which became 100% and 90% owned subsidiaries, respectively, of the Company in May 1996. The Company completed its initial public offering in August 1996.

PBM Services

The Company offers plan sponsors a broad range of services that are designed to ensure the cost-effective delivery of clinically acceptable pharmacy benefits. The Company's benefit management programs include a number of design features and fee structures that are tailored to suit a customer's particular service and cost requirements. In addition to traditional fee-for-service arrangements, the Company offers alternative methodologies for pricing its various benefit management packages, including charging a fixed fee per capita (a "capitated" program), as well as sharing costs exceeding established per capita amounts or sharing savings where costs are less than established per capita amounts. Benefit parameters are managed through a point-of-sale ("POS") claims processing system through which real-time electronic messages are transmitted to pharmacists to ensure compliance with specified parameters before services are rendered. The Company's organization and programs are clinically oriented, with a high proportion of staff having pharmacological certification, training and experience. The Company uses commissioned independent agents and brokers, as well as its own employees, to solicit business from plan sponsors.

Benefit management services available to customers of the Company include the following:

Formulary Design and Compliance. The Company offers flexible formulary designs to meet the plan sponsor's requirements. Many plan sponsors do not restrict coverage to a specific list of pharmaceuticals and are said to have "no" formulary or an "open" formulary that generally covers all FDA-approved drugs except certain classes of excluded pharmaceuticals (such as certain vitamins and cosmetic, experimental, investigative or over-the-counter drugs). As a result of rising program costs, the Company believes that both public and private health plans have become increasingly receptive to restricting the drugs covered in any given therapeutic class. Once a determination has been made by a plan sponsor to utilize a "restricted" or "closed" formulary, the Company actively involves local Pharmacy and Therapeutics committees (consisting of local plan sponsors, prescribers, pharmacists and other

health care professionals) to design clinically acceptable formularies in order to control costs. The composition of the formulary is subject to the final approval of the plan sponsor.

Controlling program costs through formulary design focuses on two areas to the extent consistent with acceptable medical and pharmacy practice and applicable law: (i) generic substitution, which involves selection of generic drugs as a cost-effective alternative to bio-equivalent brand name drugs, and (ii) therapeutic interchange, which involves selection of the lowest cost brand name drug within a therapeutic category or, when available, a bio-equivalent generic drug. Increased usage of generic drugs by Company-managed programs also enables the Company to obtain purchasing concessions and other financial incentives on generic drugs, which may be shared with plan sponsors. While brand name drug rebates are also negotiated under certain circumstances, the Company believes that it is less dependent on such rebates than certain larger pharmacy benefit managers, particularly those that are owned by drug manufacturers.

The primary method for assuring formulary compliance is that pharmacists will not be reimbursed for dispensing non-formulary drugs, subject to certain limited exceptions. The Company also provides financial incentives to pharmacists to utilize preferred status products. Formulary compliance is managed with the active assistance of participating network pharmacists, primarily through prior authorization procedures, on-line POS edits as to particular subscribers and other network communications. Overutilization of medication is monitored and managed through quantity limitations, based upon nationally recognized standards and guidelines regarding maintenance vs. non-maintenance therapy and the use of certain therapeutic classes of drugs and specific medications. Step protocols, which are procedures requiring that preferred therapies be tried and shown ineffective before less favored therapies are covered, also are established by the Company in conjunction with local Pharmacy and Therapeutics committees to control improper utilization of certain high-risk or high-cost medications.

Clinical Services. The Company's formularies typically provide a selection of covered drugs within each major therapeutic class to appropriately treat most medical conditions. However, provision is made for covering non-formulary drugs (other than excluded products) when shown to be clinically appropriate. Since non-formulary drugs ordinarily are automatically rejected for coverage by the real-time POS system, procedures are employed to override restrictions on non-formulary medications for a particular patient and period of treatment. Restrictions on the use of certain high-risk or high-cost formulary drugs may be similarly overridden through prior authorization procedures. Non-formulary overrides and prior authorizations are processed on the basis of documented, clinically-supported medical necessity and typically are granted or denied within 24 hours after request. Requests for, and appeals of denials of, coverage in these cases are handled by the Company through its staff of trained pharmacists, nationally certified pharmacy technicians and board certified pharmacotherapy specialists, subject to the plan sponsor's ultimate decisional authority over all such appeals. Further, in case of a medical emergency as determined by the dispensing pharmacist, the Company authorizes, without prior approval, short-term supplies of antibiotics and certain other medications.

Drug Usage Evaluation. Drug usage is evaluated on a concurrent, prospective and retrospective basis, utilizing the real-time POS system and proprietary information systems, for multiple drug interactions, drug-health condition interactions, duplication of therapy, step therapy protocol enforcement, minimum/maximum dose range edits, compliance with prescribed utilization levels and early refill notification. The Company also maintains an on-going drug utilization review program in which select medication therapies are reviewed and data collected, analyzed and reported for management and educational applications.

Pharmacy Data Services. The Company utilizes claims data to generate reports for management and plan sponsor use, including drug utilization review, quality assurance, claims analysis and rebate contract administration. The Company has developed systems to provide plan sponsors with real-time access to pharmacy, financial, claims, prescriber, subscriber and dispensing data.

Disease Management. The Company designs and administers programs designed to maximize the benefits of pharmaceutical use as a tool in achieving therapy goals for certain targeted diseases. Programs focus on preventing high risk events, such as asthma exacerbation or stroke, through appropriate use of pharmaceuticals, while eliminating unnecessary or duplicate therapies. Key components of these programs include health care provider

training, integration of care between health disciplines, monitoring of patient compliance, measurement of care process and quality, and providing feedback for continuous improvement in achieving therapy goals.

At December 31, 1996, the Company provided PBM services to 26 sponsors with approximately 1.1 million plan members, including eight sponsors with approximately 1.0 million members receiving mandated health care benefits to formerly Medicaid-eligible and certain uninsured state residents under Tennessee's TennCare (R) Medicaid waiver program. See "The TennCare Program" below. As of March 25, 1997 the Company has added contracts and commitments to service an additional approximately 300,000 plan members.

Since its initial public offering the Company has focused its marketing efforts on large public health programs, particularly in states with high Medicaid and Medicare populations, and on private health plans and affinity groups throughout the United States. At March 25, 1997, approximately one-third of the plan members covered by the Company's programs were serviced under risk-based contracts.

Preferred Generics Programs

The Company's preferred generics programs encourage pharmacies to stock a particular manufacturer's generic drugs in lieu of brand name or other generic drugs in the same therapeutic class by arranging for discounts on the purchase of preferred generics by pharmacies. Under Company-managed PBM programs, the Company also provides financial incentives to pharmacies to dispense preferred generics. These arrangements and incentives are designed to encourage participating pharmacies to dispense and sell preferred generics to all of their customers, including those not covered by Company-managed pharmacy benefit plans. In return, the Company receives fees from the preferred suppliers related to incremental growth in the suppliers gross margins or unit sales. To date, the Company has contracted with five generic drug suppliers for its preferred generics programs.

The TennCare Program

RxCare of Tennessee, Inc. ("RxCare), a pharmacy services administrative organization owned by the Tennessee Pharmacists Association and representing approximately 1,200 retail pharmacies, initially retained the Company in 1993 to assist in obtaining health plan pharmaceutical benefit business for Tennessee pharmacies and related services, including pharmacy benefit design and pricing. In January 1994 the State of Tennessee instituted its TennCare program by contracting with plan sponsors to provide mandated health services to TennCare beneficiaries on a capitated basis. In turn, certain of these plan sponsors contracted with RxCare to provide TennCare-mandated pharmaceutical benefits to their TennCare beneficiaries through RxCare's network of retail pharmacies, in most cases on a corresponding capitated basis.

Since January 1994, the Company has been providing a broad range of PBM services with respect to RxCare's TennCare and private pharmaceutical benefit businesses under an agreement with RxCare formalized in March 1994 and thereafter amended (the "RxCare Contract"). The Company assists RxCare in designing and marketing its PBM services, and performs essentially all of RxCare's obligations under its pharmacy benefit contracts with health plan sponsors, pays certain amounts to RxCare and is compensated by sharing with RxCare the profit, if any, from activities under RxCare's contracts with the sponsors.

As of December 31, 1996 the Company had contracts to service eight TennCare sponsors with 1.0 million members under the RxCare Contract. RxCare's contracts with Blue Cross and Blue Shield of Tennessee, Tennessee Primary Care Network, Inc. and Tennessee Health Partnership accounted for approximately 47%, 18% and 11%, respectively, of the Company's revenues in 1996. Effective March 31, 1997, RxCare's contract with Blue Cross (the "Blue Cross Contract") has been cancelled and replaced by a non-risk clinical services agreement directly with the Company.

Competition

The PBM and generic drug distribution businesses are each highly competitive, and many of the Company's current and potential competitors have considerably greater financial, technical, marketing and other resources than the Company. The pharmacy benefit management business includes a number of large, well capitalized companies with nationwide operations and many smaller organizations typically operating on a local or regional basis. Some of the larger organizations are owned by or otherwise related to a brand name drug manufacturer and may have significant influence on the distribution of pharmaceuticals. Among larger companies offering pharmacy benefit management services are Medco Containment Services, Inc. (a subsidiary of Merck & Co., Inc.), Caremark International Inc., PCS, Inc. (a subsidiary of Eli Lilly & Company), Express Scripts, Inc., Advance ParadigM, Inc., Value Health, Inc., Diversified Pharmaceutical Services, Inc. (a subsidiary of SmithKline Beecham) and National Prescription Administrators, Inc. Numerous insurance and Blue Cross and Blue Shield plans, managed care organizations and retail drug chains also have their own pharmacy benefit management capabilities.

Generic drugs are distributed by numerous generic drug distributors, drug wholesalers and mail order suppliers. Generic drug distributors and wholesalers generally offer a broad line of generic drugs from a variety of sources to a diverse customer base, typically including independent retail and chain pharmacies, government agencies and managed care organizations. Chain pharmacies use their size to procure pharmaceuticals on advantageous terms, and independent pharmacies frequently are offered opportunities through trade and wholesaler organizations to join group purchasing efforts.

Competition in both the PBM and generic drug distribution businesses to a large extent is based upon price, although other factors, including quality and breadth of services and products, also are important. The Company believes that its ability and willingness to assume or share (where appropriate) its customers' financial risks, its independence from brand name drug manufacturers and its retail pharmacy-based orientation represent distinct and unusual competitive advantages in the PBM business.

Government Regulation

The Company believes that it is in substantial compliance with all legal requirements material to its operations. Among the various Federal and state laws and regulations which may govern or impact the Company's current and planned operations are the following:

Anti-Kickback Laws. Subject to certain statutory and regulatory exceptions (including exceptions relating to certain managed care, discount, group purchasing and personal services arrangements), Federal law prohibits the payment or receipt of remuneration to induce, arrange for or recommend the purchase of health care items or services paid for in whole or in part by the Medicare or state health care programs (including Medicaid and TennCare), and certain state laws may extend the prohibition to items or services that are paid for by private insurance and self-pay patients. The Company's arrangements with RxCare and other pharmacy network administrators, drug manufacturers, marketing agents, brokers, health plan sponsors, pharmacies and others parties routinely involve payments to or from persons who provide or purchase, or recommend or arrange for the purchase of, items or services paid in part by the TennCare program or by other programs covered by such laws. Management carefully considers the import of such "anti-kickback" laws when structuring its operations, and believes the Company is in compliance therewith. However, the laws in this area are in flux and uncertain in their application, and there can be no assurance that one or more of such arrangements will not be challenged or found to violate such laws. Violation of the Federal anti-kickback statute could subject the Company to substantial criminal and civil penalties, including exclusion from the Medicare and Medicaid (including TennCare) programs.

Antitrust Laws. Numerous lawsuits have been filed throughout the United States by retail pharmacies against drug manufacturers challenging certain brand drug pricing practices under various state and Federal antitrust laws. A settlement in one such suit would require defendant drug manufacturers to provide the same types of discounts on pharmaceuticals to retail pharmacies and buying groups as are provided to managed care entities to the extent that their respective abilities to affect market share are comparable, a practice which, if generally followed in the

industry, could increase competition from pharmacy chains and buying groups and reduce the availability to the Company of certain discounts, rebates and fees currently received in connection with its drug purchasing and formulary administration programs. In addition, to the extent that the Company or an associated business appears to have actual or potential market power in a relevant market, business arrangements and practices may be subject to heightened scrutiny from an anti-competitive perspective and possible challenge by state or Federal regulators or private parties. For example, RxCare, which was investigated and found by the Federal Trade Commission to have potential market power in Tennessee, entered into a consent decree in June 1996 agreeing not to enforce a policy which had required participating network pharmacies to accept reimbursement rates from RxCare as low as rates accepted by them from other pharmacy benefits payors. To date, enforcement of antitrust laws have not had any material affect on the Company's business.

Other State Laws. Many states have statutes and regulations that do or may impact the Company's business operations. In some states, pharmacy benefit managers may be subject to regulation under insurance laws or laws licensing HMOs and other managed care organizations, in which event requirements could include the maintenance of reserves, required filings with regulatory agencies, and compliance with disclosure requirements and other regulation of the Company's operations. State insurance laws also may affect the structuring of certain risk-sharing programs offered by the Company. A number of states have laws designed to restrict limitations on the consumer's choice of pharmacies, or requiring that the benefits of discounts negotiated by managed care organizations be passed along to consumers in proportionate reductions of co-payments. Some states require that pharmacies be permitted to participate in provider networks if they are willing to comply with network requirements, while other states require pharmacy benefit managers to follow certain prescribed procedures in establishing a network and admitting and terminating its members. Many states require that Medicaid obtain the lowest prices from a pharmacy, which may limit the Company's ability to reduce the prices it pays for drugs below Medicaid prices. States have a variety of laws regulating pharmacists' ability to switch prescribed drugs or to split fees, which could impede the Company's business strategy, and certain state laws have been the basis for investigations and multi-state settlements requiring the discontinuance of certain financial incentives provided by manufacturers to retail pharmacies to promote the sale of the manufacturers' drugs.

While management believes that the Company is in substantial compliance with all existing laws and regulations material to the operation of its business, such laws and regulations are subject to rapid change and often are uncertain in their application. As controversies continue to arise in the health care industry (for example, regarding the efforts of plan sponsors and pharmacy benefit managers to limit formularies, alter drug choice and establish limited networks of participating pharmacies), Federal and state regulation and enforcement priorities in this area can be expected to increase, the impact of which on the Company cannot be predicted. There can be no assurance that the Company will not be subject to scrutiny or challenge under one or more of these laws or that any such challenge would not be successful. Any such challenge, whether or not successful, could have a material adverse effect upon the Company's business and results of operations. Further, there can be no assurance that the Company will be able to obtain or maintain any of the regulatory approvals that may be required to operate its business, and the failure to do so could have a material adverse effect on the Company's business and results of operations.

Employees

At March 7, 1997, the Company employed a total of 120 people including 26 licensed pharmacists. The Company's employees are not represented by any union and, in the opinion of management, the Company enjoys good relations with its employees.

Item 2. Properties

The Company's corporate headquarters are located in leased office space in Pearl River, New York. The Company also leases office space in South Kingstown, Rhode Island, Nashville, Tennessee and Memphis, Tennessee.

Item 3. Legal Proceedings

On March 5, 1996, Pro-Mark Holdings, Inc. ("Pro-Mark"), a subsidiary of MIM Corporation, was added as a third-party defendant in a proceeding in the Superior Court of the State of Rhode Island, and on September 16, 1996 the third-party complaint was amended to add MIM Corporation as a third-party defendant. The third-party plaintiffs, Medical Marketing Group, Inc. ("MMG"), PPI Holding, Inc. ("PPI Holding") and Payer Prescribing Information, Inc. ("PPI"), allege in the amended third-party complaint: (i) that the Company employed E. David Corvese (the Company's Vice Chairman) with knowledge of covenants not to compete in effect between Mr. Corvese and PPI, PPI Holding and MMG that prevented Mr. Corvese from competing in the area of the collection, analysis or marketing of data for the pharmaceutical or health care industries relating to physician practice demographics and the influence of managed care plans; (ii) that Mr. Corvese breached his employment agreement with PPI and his fiduciary duties to PPI by not devoting his full business time and attention to PPI from June 1993 through November 1993 (when his employment was terminated by PPI), and (iii) that the Company interfered with the contractual relationship between the parties and misappropriated MMG's and PPI's confidential information through the Company's employment of Mr. Corvese. The amended third-party complaint seeks to enjoin the Company from using confidential information allegedly misappropriated from MMG and PPI and seeks an unspecified amount of compensatory and consequential damages, interest and attorneys' fees. The Company believes that the third-party plaintiff's allegations are without merit; however, loss of this litigation could have a material adverse effect on the Company's business and results of operations.

Item 4. Submission of Matters to a Vote of Security Holders

No matters were submitted to a vote of the Company's security holders during the fourth quarter of fiscal year 1996.

Executive Officers of the Company

The following information is furnished in this Part I pursuant to Instruction 3 to Item 401(b) of Regulation S-K. The executive officers of the Company are as follows:

Name	Age	Position
John H. Klein.....	51	Chairman of the Board, Chief Executive Officer and Director
E. David Corvese.....	41	Vice Chairman of the Board and Director
Richard H. Friedman.....	46	Chief Financial Officer, Chief Operating Officer, Treasurer and Director
Todd R. Palmieri.....	32	Executive Vice President--Business Development and Director
Barry A. Posner.....	33	Secretary and General Counsel

John H. Klein joined the Company in April 1996 and was elected Chief Executive Officer, Chairman of the Board and a director of the Company in May 1996. From May 1989 to December 1994, Mr. Klein served as President, Chief Executive Officer, a director and a member of the Executive Committee of the Board of Directors of Zenith Laboratories, Inc. ("Zenith"), a manufacturer of multi-source generic pharmaceutical drugs. In December 1994, Zenith was acquired by IVAX Corporation ("IVAX"), an international health care company and a major multi-source generic pharmaceutical manufacturer and marketer. From January 1995 to January 1996, Mr. Klein was President of IVAX' North American Multi-Source Pharmaceutical Group and each of its operating companies, including Zenith and Zenith Goldline (collectively, "NAMPG"). From January 1995 to January 1996, he was also an executive officer and a member of the Executive Committee of IVAX. Mr. Klein has served as Chairman of the Generic Pharmaceutical Industry Association since March 1995.

E. David Corvese has served as a director of the Company since March 1996 and as Vice Chairman since May 1996. Mr. Corvese has served as Chairman of Pro-Mark Holdings, Inc., a Delaware corporation and a wholly-owned subsidiary of the Company ("Pro-Mark"), since June 1995 and also served as President and Chief Executive Officer of Pro-Mark from March 1994 to June 1995. From June 1991 to November 1993, Mr. Corvese served as President of Payer Prescribing Information, Inc. ("PPI"), a company engaged in the business of providing informational products, market analysis and consulting services to the pharmaceutical industry. Mr. Corvese is also a past President of the Rhode Island Pharmaceutical Association and is a member of the American Pharmaceutical Association, the American Society of Hospital Pharmacists and the Rhode Island Society of Hospital Pharmacists.

Richard H. Friedman joined the Company in April 1996 and was elected Chief Financial Officer, Chief Operating Officer, Treasurer and a director of the Company in May 1996. From February 1992 to December 1994, Mr. Friedman served as Chief Financial Officer and Vice President of Finance of Zenith. From January 1995 to January 1996, he was Vice President of Administration of NAMPG.

Todd R. Palmieri has served as Executive Vice President--Business Development and a director of the Company since May 1996 and as President of MIM Strategic Marketing, LLC, a Rhode Island limited liability company and majority-owned subsidiary of the Company, since December 1995. From December 1993 to August 1995, Mr. Palmieri served as Chief Financial Officer and a director of Pro-Mark. From January 1992 to September 1993, he served as Vice President--Operations and Product Development of PPI. From March 1991 to May 1992, Mr. Palmieri served as Vice President--Marketing and Business Development for Cole Associates Inc., a company engaged in pharmaceutical managed care marketing and consulting.

Barry A. Posner joined the Company in March 1997 as General Counsel and was elected as the Company's Secretary at that time. From September 1990 through March 1997, Mr. Posner was associated with the Stamford, Connecticut law firm of Finn Dixon & Herling LLP, where he practiced corporate law, specializing in the areas of mergers and acquisitions and securities law, and commercial real estate law.

Executive officers are elected or appointed by, and serve at the pleasure of, the Board of Directors. Each of the above-named executive officers has an employment agreement with the Company providing for, among other things, serving in the executive position(s) listed herein-above.

PART II

Item 5. Market For Registrant's Common Equity and Related Stockholder Matters

The Company's Common Stock began trading on The Nasdaq National Market tier of The Nasdaq Stock Market on August 15, 1996 under the symbol: MIMS. The following table represents the high and low sales prices for the Company's Common Stock for the sole full calendar quarter since its initial trading date. Such prices are interdealer prices, without retail markup, markdown or commissions, and may not necessarily represent actual transactions.

1996	High	Low
Fourth Quarter	$ 15.50	$ 4.00

The Company has never paid cash dividends on its Common Stock and does not anticipate doing so in the foreseeable future.

As of March 25, 1997 there were 57 stockholders of record in addition to approximately 1,700 stockholders whose shares were held in nominee name.

For purposes of calculating the aggregate market value of the shares of Common Stock held by non-affiliates, as shown on the cover page of this report, it has been assumed that all the outstanding shares were held by non-affiliates except for the shares held by directors and executive officers of the Company. However, this should not be deemed to constitute an admission that all directors and executive officers of the Company are, in fact, affiliates of the Company, or that there are not other persons who may be deemed to be affiliates of the Company. Further information concerning stockholdings of executive officers, directors and principal stockholders is included in the Company's definitive proxy statement filed or to be filed with the Securities and Exchange Commission.

Item 6. Selected Consolidated Financial Data

The selected consolidated financial data presented below should be read in conjunction with Item 7 of this report and with the Company's Consolidated Financial Statements and notes thereto appearing elsewhere in this report.

	Year Ended December 31,			Period from Inception (June 22,1993) through
	1996	1995	1994	December 31, 1993
	(in thousands, except per share amounts)			
Statement of Operations Data				
Revenue	$ 283,159	$213,929	$109,326	$122
Net income (loss)	($31,754)(1)	($6,772)	($2,456)	$40
Net income (loss) per common share	($3.32)	($1.43)	($0.55)	$0.01
Weighted average shares outstanding	9,557	4,732	4,500	4,500

	December 31,			
	1996	1995	1994	1993
	(in thousands)			
Balance Sheet Data				
Cash and cash equivalents	$ 1,834	$ 1,804	$ 2,933	$ --
Investment securities	37,038	--	--	--
Working capital (deficit)	19,569	(12,080)	(5,087)	(3)
Total assets	61,800	18,924	15,260	93
Stockholders' equity (deficit)	30,143	(11,524)	(3,693)	41

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(1) After recording a $26.6 million nonrecurring non-cash stock option charge and a $3.5 million reserve in connection with the termination of the Blue Cross Contract. See "Business -- TennCare Program." Excluding these items, the net loss for 1996 would have been $1,614, or $.17 per common share.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

This Report contains statements which constitute forward looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. The matters discussed in this Report include statements regarding the intent, belief or current expectations of the Company, its directors or its officers with respect to the future operating performance of the Company and the results and the effect of legal proceedings. Investors are cautioned that any such forward looking statements are not guarantees of future performance and involve risks and uncertainties, and that actual results may differ materially from those in the forward looking statements as a result of various factors. The accompanying information contained in this Report identifies important factors that could cause such differences.

Overview

Virtually all of the Company's revenues to date have been derived from operations in the State of Tennessee in conjunction with RxCare. The Company assisted RxCare in defining and marketing pharmacy benefit services to private health plan sponsors on a consulting basis in 1993, but did not commence substantial operations until January 1994 when RxCare began servicing several of the health plan sponsors involved in the newly instituted TennCare state health program. See "Business -- The TennCare Program." At December 31, 1996, the Company provided pharmacy benefit management services to 26 plan sponsors with an aggregate of approximately 1.1 million plan members, primarily on a capitated basis in Tennessee.

Results of Operations

Year ended December 31, 1996 compared to year ended December 31, 1995

For the year ended December 31, 1996, the Company recorded revenue of $283.2 million compared with 1995 revenue of $213.9 million. The increase of $69.3 million in revenue was due primarily to the addition of the Blue Cross Contract in April 1995 (representing approximately $36 million of such increase) and increased revenue from new and renegotiated contracts of approximately $33 million. In 1996, approximately 82% of the Company's revenue was generated through capitated contracts, compared with 90% during 1995.

Cost of revenue for 1996 increased to $278.1 million compared with 1995 cost of revenue of $213.4 million for the same reasons revenues increased as described above. As a percentage of revenue, cost of revenue decreased from 99.8% in 1995 to 98.2% in 1996. In an effort to stem future losses and increase profitability, the Company through RxCare terminated the capitated Blue Cross Contract effective March 31, 1997. Although this contract previously had been renegotiated and extended, high utilization rates continued to hamper the Company's ability to gain profitability under this contract even though the Company was able to lower the average cost of each prescription. As a result of this termination, the Company has reserved $3.5 million at December 31, 1996 to cover future claims in excess of capitated payments to the Company. Excluding this contract, the Company would have earned $2.2 million in 1996 before taking the stock option charge (As described below). The Blue Cross Contract represents approximately 495,000 lives and accounted for $132.8 million of revenue and $7.3 million in net losses in 1996. Subsequent to the termination of this contract, the Company has negotiated a new contract directly with an affiliate of Blue Cross to begin on April 1, 1997. The new contract eliminates capitation risk to the Company and provides for the Company to be paid for certain administrative and clinical consulting services on a fee-for-service basis. The termination of the Blue Cross Contract will reduce revenues by approximately $130 million on an annualized basis.

General and administrative expenses were $11.6 million in 1996 and $8.0 million in 1995, an increase of 45.0%. The $3.6 million increase was attributable to increases in operations, sales and marketing and headquarter personnel to support the anticipated needs of the business as well as increases in consulting and legal fees,

depreciation expense and costs related to further development of the Company's management information systems. As a percentage of revenue, general and administrative expenses increased from 3.8% in 1995 to 4.1% in 1996.

For the year ended December 31, 1996, the Company recorded a net loss of $5.1 million, or $0.54 per share (before recording a $26.6 million nonrecurring, non-cash stock option charge representing the difference between the exercise price and the deemed fair market value of the Common Stock at the date of grant of options to purchase an aggregate of 3,600,000 shares of Common Stock granted by the Company's principal stockholder to certain executive officers and directors of the Company) compared with a 1995 net loss of $6.8 million, or $1.43 per share. This improvement was a result of the above-described changes in revenue and expenses. After recording the effect of the stock option charge, the Company reported a net loss of $31.8 million, or $3.32 per share, for 1996.

Year ended December 31, 1995 compared to the year ended December 31, 1994

For the year ended December 31, 1995, the Company recorded $213.9 million in revenue compared with revenue of $109.3 in 1994. The $104.6 million increase in revenue was primarily due to the addition of the Blue Cross Contract in April 1995. In 1995, approximately 90% of the Company's revenue was generated through capitated contracts, compared with 85% during 1994.

Cost of revenue for 1995 increased to $213.4 million compared with 1994 cost of revenue of $106.7 million due primarily to the addition of the Blue Cross Contract. As a percentage of revenue, cost of revenue increased from 97.6% in 1994 to 99.8% in 1995, primarily due to an increase in claims paid as a result of the addition of the Blue Cross Contract. The drug utilization rate of Blue Cross participants was significantly higher than rates previously experienced under other contracts, resulting in losses under that contract of $10 million during 1995, including the accrual of $4.5 million to cover the expected losses to be incurred under the remainder of the original contract, which expired on June 30, 1996. Claims expense (after giving effect to such accrual) was 107% of capitation revenues under the contract.

General and administrative expenses were $8.0 million in 1995 and $5.3 million in 1994, an increase of 50.9%. Of the $2.7 million increase, $2.0 million was the result of a charge relating to an advance to RxCare in 1995 which the Company has fully reserved for. The remainder of the increase is largely attributable to the costs of additional personnel to support expanded marketing efforts. As a percentage of revenue, general and administrative expenses decreased from 4.8% in 1994 to 3.8% in 1995.

For the year ended December 31, 1995, the Company recorded a net loss of $6.8 million, or $1.43 per share, compared with a net loss of $2.5 million, or $0.55 per share, for 1994. The increase in the net loss was a result of the above-described changes in revenue and expenses.

Liquidity and Capital Resources

For the year ended December 31, 1996, net cash used by the Company for operating activities totaled $7.6 million, primarily due to the funding of a $3.4 million net cash operating loss (caused primarily by the Blue Cross Contract as discussed previously) and an increase in accounts receivable of $4.6 million. The Company generated net cash of $46.5 million from financing activities primarily related to the Company's initial public offering, and used $38.9 million net cash in investing activities, reflecting use of the balance of the public offering proceeds to purchase investment securities.

At December 31, 1996, the Company had working capital of $19.6 million, compared to a $12.1 million working capital deficit at December 31, 1995. Cash and cash equivalents were $1.8 million at December 31, 1996 and 1995. The Company had investment securities held to maturity of $37.0 million at December 31, 1996. The investments are primarily corporate debt securities rated A or better.

At December 31, 1996, the Company had, for tax purposes, unused net operating loss carryforwards of approximately $6.1 million that may be available to offset future taxable income, if any, and which will begin expiring in 2008. Use of these carryforwards may be limited by the Tax Reform Act of 1986.

The Company believes that its improved financial condition and capital structure since the initial public offering has enhanced its ability to negotiate and obtain additional contracts with plan sponsors and other potential customers. Except as discussed below, the Company believes that it has sufficient cash on hand or available to fund the Company's anticipated working capital and other cash needs for the foreseeable future. The Company intends to offset, against profit sharing amounts, if any, due RxCare in the future under the RxCare Contract, approximately $8.9 million representing RxCares share of the Company's cummulative losses and amounts previously advanced or paid to RxCare.

As part of its continued efforts to expand its pharmacy management business, the Company expects to incur additional sales and marketing expenses. The Company also may pursue joint venture arrangements, business acquisitions and other transactions designed to expand its pharmacy management business, which the Company would expect to fund from cash on hand or future indebtedness or, if appropriate, the sale of equity securities of the Company.

Other Matters

The Company's pharmaceutical reimbursement claims have historically been subject to a significant increase over annual averages from October through February, which the Company believes is due to increased medical problems during the colder months.

Changes in prices charged by manufacturers and wholesalers for pharmaceuticals affect the Company's cost of revenue. The Company does not believe that inflation has had a material impact on the results of its operations.

The TennCare program has been controversial since its inception and has generated government investigations and adverse publicity. There can be no assurances that the Company's association with the TennCare program will not adversely affect the Company's business in the future.

Item 8. Financial Statements and Supplementary Data

REPORT OF INDEPENDENT PUBLIC ACCOUNTANTS

To MIM Corporation and Subsidiaries:

We have audited the accompanying consolidated balance sheets of MIM Corporation and Subsidiaries as of December 31, 1996 and 1995 and the related consolidated statements of operations, stockholders' equity (deficit) and cash flows for each of the three years in the period ended December 31, 1996. These consolidated financial statements and the schedule referred to below are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of MIM Corporation and Subsidiaries as of December 31, 1996 and 1995 and the results of their operations and their cash flows for each of the three years in the period ended December 31, 1996, in conformity with generally accepted accounting principles.

Our audits were made for the purpose of forming an opinion on the basic financial statements taken as a whole. The schedule listed in the index to the financial statements is presented for the purpose of complying with the Securities and Exchange Commissions's rules and is not part of the basic financial statements. This schedule has been subjected to the auditing procedures applied in our audits of the basic financial statements, and in our opinion, fairly states in all material respects the financial data required to be set forth therein in relation to the basic financial statements taken as a whole.

Arthur Andersen LLP

Roseland, New Jersey
February 24, 1997

MIM CORPORATION AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
DECEMBER 31,
(In thousands, except for share amounts)

	1996	1995
ASSETS		
Current assets		
Cash and cash equivalents	$ 1,834	$ 1,804
Investment securities	28,113	--
Receivables, less allowance for doubtful accounts of $1,088 and $360 at December 31, 1996 and 1995	18,646	14,823
Prepaid expenses and other current assets	1,129	481
Total current assets	49,722	17,108
Investment securities, net of current portion	8,925	--
Property and equipment, net	2,423	1,807
Due from affiliates, less allowance for doubtful accounts of $2,157 and $1,957 at December 31, 1996 and 1995	628	--
Other assets, net	102	9
Total assets	$ 61,800	$ 18,924
LIABILITIES AND STOCKHOLDERS' EQUITY (DEFICIT)		
Current liabilities		
Current portion of capital lease obligations	$ 213	$ 216
Accounts payable	1,562	1,071
Claims payable	17,278	19,294
Payables to plan sponsors and others	10,174	8,436
Accrued expenses	926	171
Total current liabilities	30,153	29,188
Capital lease obligations, net of current portion	375	110
Commitments and contingencies (Note 6)		
Minority interest	1,129	1,150
Stockholders' equity (deficit)		
Preferred stock, $.0001 par value; 5,000,000 shares authorized, no shares issued or outstanding	--	--
Common stock, $.0001 par value; 40,000,000 shares authorized, 12,040,600 and 8,023,800 shares issued and outstanding at December 31, 1996 and 1995	1	1
Additional paid-in capital	73,443	--
Accumulated deficit	(41,564)	(9,188)
Stockholder notes receivable	(1,737)	(2,337)
Total stockholders' equity (deficit)	30,143	(11,524)
Total liabilities and stockholders' equity (deficit)	$ 61,800	$ 18,924

The accompanying notes are an integral part of these consolidated financial statements.

MIM CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS

YEARS ENDED DECEMBER 31,

(In thousands, except for per share amounts)

	1996	1995	1994
Revenue	$283,159	$213,929	$109,326
Cost of revenue	278,068	213,398	106,717
Gross profit	5,091	531	2,609
General and administrative expenses	11,619	8,048	5,256
Non-cash stock option charge	26,640	--	--
Loss from operations	(33,168)	(7,517)	(2,647)
Interest income, net	1,393	745	191
Loss before minority interest	(31,775)	(6,772)	(2,456)
Less: minority interest	(21)	--	--
Net loss	$(31,754)	$ (6,772)	$ (2,456)
Net loss per common share	$(3.32)	$(1.43)	$(0.55)
Weighted average shares outstanding	9,557	4,732	4,500

The accompanying notes are an integral part of these consolidated financial statements.

MIM CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY (DEFICIT)
(In thousands)

	Common Stock	Additional Paid-In Capital	Retained Earnings (Accumulated Deficit)	Stockholder Notes Receivable	Total Stockholders' Equity (Deficit)
Balance, December 31, 1993	$ 1	$ --	$ 40	$ --	$ 41
Stockholder loans	--	--	--	(1,278)	(1,278)
Net loss	--	--	(2,456)	--	(2,456)
Balance, December 31, 1994	1	--	(2,416)	(1,278)	(3,693)
Stockholder loans, net	--	--	--	(1,059)	(1,059)
Net loss	--	--	(6,772)	--	(6,772)
Balance, December 31, 1995	1	--	(9,188)	(2,337)	(11,524)
Stockholder loans, net	--	--	--	(22)	(22)
Stockholder distribution	--	--	(622)	622	--
Net proceeds from initial public offering	--	46,786	--	--	46,786
Non-cash stock option charge	--	26,640	--	--	26,640
Non-employee stock option compensation expense	--	17	--	--	17
Net loss	--	--	(31,754)	--	(31,754)
Balance, December 31, 1996	$ 1	$ 73,443	$(41,564)	$(1,737)	$ 30,143

The accompanying notes are an integral part of these consolidated financial statements.

MIM CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

YEARS ENDED DECEMBER 31,

(In thousands)

	1996	1995	1994
Cash flows from operating activities:			
Net loss	$(31,754)	$(6,772)	$ (2,456)
Adjustments to reconcile net loss to net cash (used in) provided by operating activities:			
Net loss allocated to minority interest	(21)	--	--
Depreciation and amortization	781	366	92
Stock option charges	26,657	--	--
Provision for losses on receivables and due from affiliates	928	1,977	340
Changes in assets and liabilities:			
Receivables	(4,551)	(4,728)	(10,455)
Prepaid expenses and other current assets	(648)	98	(530)
Accounts payable	491	(376)	1,447
Claims payable	(2,016)	9,031	10,263
Payables to plan sponsors and others	1,738	2,003	6,433
Accrued expenses	755	(202)	359
Net cash (used in) provided by operating activities	(7,640)	1,397	5,493
Cash flows from investing activities:			
Purchase of property and equipment	(870)	(802)	(810)
Purchase of investment securities	(37,038)	--	--
Stockholder notes receivable, net	(22)	(1,059)	(1,278)
Due from affiliates, net	(828)	(1,759)	(236)
(Increase) decrease in other assets	(93)	164	(168)
Net cash used in investing activities	(38,851)	(3,456)	(2,492)
Cash flows from financing activities:			
Principal payments on capital lease obligations	(265)	(220)	(68)
Proceeds from initial public offering	46,786	--	--
Minority interest investment	--	1,150	--
Net cash provided by (used in) financing activities	46,521	930	(68)
Net increase (decrease) in cash and cash equivalents	30	(1,129)	2,933
Cash and cash equivalents--beginning of period	1,804	2,933	--
Cash and cash equivalents--end of period	$ 1,834	$ 1,804	$ 2,933
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION:			
Cash paid during the period for:			
Income taxes	$ --	$ 286	$ 72
Interest	$ 55	$ 31	$ 6
SUPPLEMENTAL DISCLOSURE OF NON-CASH TRANSACTIONS:			
Equipment acquired under capital lease obligations	$ 527	$ 109	$ 505
Distribution to stockholder through cancellation of stockholder notes receivable	$ 622	$ --	$ --

The accompanying notes are an integral part of these consolidated financial statements.

MIM CORPORATION AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

(In thousands, except for share and per share amounts)

NOTE 1--NATURE OF BUSINESS

Corporate Organization

MIM Corporation was incorporated in Delaware in March 1996 for the purpose of combining the businesses and operations of Pro-Mark Holdings, Inc., a Delaware corporation ("Pro-Mark"), and MIM Strategic Marketing, LLC, a Rhode Island limited liability company ("MIM Strategic"), (the "Formation"). The Formation was effected in May 1996. Previously, Pro-Mark Drug Benefit Management Services, LLC, a Rhode Island limited liability company formed in June 1993 ("Pro-Mark DBMS"), had merged into Pro-Mark in April 1994. Pro-Mark is a wholly-owned subsidiary of MIM Corporation, and MIM Strategic is 90%-owned by MIM Corporation. As used in these notes, the "Company" refers to MIM Corporation and its subsidiaries and predecessors.

Prior to the Formation, Pro-Mark DBMS, Pro-Mark and Strategic were controlled by an officer of the Company and his family who collectively hold a direct or indirect controlling interest in MIM Corporation. All of these companies are under common control. The Formation has been accounted for using the carryover basis of accounting, and MIM Corporation's consolidated financial statements include the accounts and operations of Pro-Mark DBMS, Pro-Mark and MIM Strategic for all periods presented from the date each entity was formed.

At incorporation, the authorized capital stock of MIM Corporation consisted of 1,500,000 shares of common stock, $0.001 par value. In May 1996, the certificate of incorporation of MIM Corporation was amended and restated to provide for authorized capital stock consisting of 40,000,000 shares of common stock, $0.0001 par value ("Common Stock"), and 5,000,000 shares of Preferred Stock, $0.0001 par value. In May 1996, 8,023,800 shares of Common Stock were issued in connection with the Formation.

In the Formation, MIM Corporation acquired all of the outstanding stock of Pro-Mark and 90% of the ownership and membership interest in MIM Strategic. In exchange, Pro-Mark's stockholders received 150 shares of Common Stock of MIM Corporation for each Pro-Mark share (or an aggregate of 4,500,000 shares of Common Stock), and certain members of MIM Strategic received an aggregate of 3,523,800 shares of Common Stock for their 90% interest in MIM Strategic. Zenith Goldline Pharmaceuticals, Inc., a Florida corporation ("Zenith Goldline"), has held a 10% interest in MIM Strategic since its inception and did not participate in the Formation.

In the Formation, outstanding stock options granted by Pro-Mark to employees and key contractors were exchanged for options from MIM Corporation on substantially similar terms (see Note 8). Except as otherwise indicated, all stock and stock option amounts (including share, per share par value and exercise price) pertaining to Pro-Mark DBMS, Pro-Mark and MIM Strategic prior to the Formation have been restated to reflect the equivalent amounts pertaining to Common Stock as if the Formation had already occurred.

MIM Strategic was formed in 1995 by MIM Holdings, LLC ("MIM Holdings"), which is controlled by an officer of the Company and his family. MIM Holdings and Zenith Goldline contributed various intangibles and $1,150 in cash, respectively, to the capital of MIM Strategic in exchange for their 90% and 10% interests, respectively, in MIM Strategic. No accounting recognition has been given to the intangibles for financial reporting purposes since their value is not objectively determinable, and the entire $1,150 of capital contributed by Zenith Goldline has been presented as minority interest in the accompanying consolidated balance sheets. Profits and losses of MIM Strategic are allocated 90% to the Company and 10% to Zenith Goldline.

Business

The Company's revenues have been derived primarily from agreements to provide pharmacy benefit management services to sponsors of public and private health plans. To date, these services primarily have been provided to sponsors of Tennessee-based plans who have entered into pharmacy benefit management contracts with RxCare of Tennessee, Inc. ("RxCare"), a subsidiary of the Tennessee Pharmacists Association, including contracts ("TennCare contracts") to provide mandated pharmaceutical services to formerly Medicaid-eligible and uninsured and uninsurable Tennessee residents under the State's TennCare Medicaid waiver program ("TennCare").

Under an agreement with RxCare formalized in March 1994 and thereafter amended (the "RxCare Contract"), the Company is responsible for operating and managing RxCare's pharmacy benefit management contracts. In return for receipt of all sponsor payments due RxCare under its pharmacy benefit management contracts and all rebates negotiated with pharmaceutical manufacturers in connection with RxCare programs, the Company implements and enforces the drug benefit programs, bears all program costs including payments to dispensing pharmacies and certain payments to RxCare and sponsors, and shares with RxCare the remaining profit, if any, under the pharmacy benefit management contracts (see Note 2). The RxCare Contract is scheduled to expire in December 1998 unless renewed in accordance with its terms.

The Company also markets prescription and over-the-counter pharmaceutical products to pharmacies and pharmacy-buying networks through its preferred generics programs.

NOTE 2--SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make certain estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Revenue Recognition

Capitated Agreements. Certain pharmacy benefit management contracts are capitated agreements pursuant to which the Company receives a fixed monthly fee for each member enrolled in a particular health plan. In exchange for this fee the Company is obligated to provide covered pharmacy services to plan members. Typically, capitated agreements have a one-year term and are subject to automatic renewal unless notice of termination is given. These contracts are subject to earlier termination upon the occurrence of certain events.

Capitation payments under TennCare contracts are based upon the latest eligible member data provided by the State of Tennessee. On a monthly basis, the Company receives payments (and recognizes revenue) for those members eligible for the current month, plus or minus capitation amounts for those persons determined to be retroactively eligible or ineligible for prior months under the contract. The amounts for retroactive capitation payments are based upon management's estimates and are included in receivables in the accompanying consolidated balance sheets. The related receivables at December 31, 1996 and 1995 were approximately $1,056 and $1,740, respectively. The related capitated revenue for the years ended December 31, 1996, 1995 and 1994 was approximately $232,395, $192,625 and $93,100, respectively.

Fee-for-Service Agreements. Certain pharmacy benefit management contracts are fee-for-service agreements pursuant to which the Company is paid by the plan sponsor an amount reflecting the cost of a prescription plus a service fee. Under these contracts, the Company is obligated to pay network pharmacies for pharmacy services provided to plan members only to the extent that the plan sponsor pays the Company for the cost of the service. Fee-for-service revenue is recognized at the time a pharmacy prescription claim is received. The related fee-for-service revenue for the years ended December 31, 1996, 1995 and 1994 was approximately $49,941, $16,525 and $14,072, respectively.

Receivables. Receivables include amounts due from plan sponsors under the Company's pharmacy benefit management contracts and amounts due from pharmaceutical manufacturers, which represent rebates and service fees resulting from the distribution of certain drugs through retail pharmacies.

Cost of Revenue. Cost of revenue includes pharmacy claims, fees paid to pharmacists and other direct costs associated with pharmacy management and claims processing operations, offset by fees received from pharmaceutical manufacturers in connection with the Company's pharmacy management programs.

Payables to Plan Sponsors and Others

Certain pharmacy benefit management contracts provide for an income or loss share with the plan sponsor. The income or loss share is calculated by deducting all related costs and expenses from revenues earned under the contract. To the extent revenues exceed costs, the Company records a payable representing the plan sponsor's share of the profit attributable to that contract, and to the extent costs exceed revenues the Company records a receivable. Agreements between RxCare and certain plan sponsors also provide for the sharing of pharmaceutical manufacturers' rebates with the plan sponsor. The Company is also obligated to share with RxCare the cumulative profit, if any, under the Company's agreement with RxCare (see Note 4). The Company estimates that any difference between the recorded liability on the accompanying consolidated balance sheets and the ultimate exposure under those contract provisions will not have a material adverse effect on the consolidated financial statements.

Cash and Cash Equivalents

For the purpose of the accompanying consolidated statements of cash flows, cash and cash equivalents are defined as demand deposits and overnight investments at banks.

Property and Equipment

The Company provides for depreciation and amortization using the straight-line method over the estimated useful lives of assets ranging from three to five years or in the case of leases, over the life of the lease. Maintenance and repairs are expensed as incurred.

Long-Lived Assets

During 1995, the Company adopted the provisions of Statement of Financial Accounting Standards No. 121, ''Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to be Disposed of'' (''SFAS 121''). SFAS 121 requires, among other things, that an entity review its long-lived assets and certain related intangibles for impairment whenever changes in circumstances indicate that the carrying amount of an asset may not be fully recoverable. As a result of its review, the Company does not believe that any impairment currently exists related to its long-lived assets.

Claims Payable

The Company is responsible for all covered prescriptions provided to plan members during the contract period. At December 31, 1996 and 1995, certain prescriptions were dispensed to members for which the related claims had not yet been presented to the Company for payment. Estimates of $3,296 and $3,823 at December 31, 1996 and 1995, respectively, have been accrued for these claims in the accompanying consolidated balance sheets. Unpaid claims incurred and reported amounted to $10,482 and $10,971 at December 31, 1996 and 1995, respectively.

The Company has experienced losses on one of its TennCare contracts since the contract was entered into as of April 1, 1995. The Company, through RxCare, has exercised its option to terminate the contract on March 31, 1997, before its scheduled expiration date of December 31, 1997. As a result of this termination, the Company has accrued $3,500 to cover the expected losses to be incurred through the termination date. At December 31, 1995 the Company also included an accrual of $4,500 to cover management's estimate of losses to be incurred during the remainder of the original contract, which expired on June 30, 1996. These amounts are included in claims payable in the accompanying consolidated balance sheets.

Minority Interest

The minority interest in the loss of MIM Strategic is reflected as a reduction of net loss in the accompanying consolidated statements of operations.

Income Taxes

The Company accounts for income taxes under the provisions of Statement of Financial Accounting Standards No. 109, ''Accounting for Income Taxes'' (''SFAS 109''). SFAS 109 utilizes the liability method, and deferred taxes are determined based on the estimated future tax effects of differences between the financial statement and tax bases of assets and liabilities at currently enacted tax laws and rates.

Disclosure of Fair Value of Financial Instruments

The Company's financial instruments consist mainly of cash and cash equivalents, investment securities (see Note 3), accounts receivable and accounts payable. The carrying amounts of cash and cash equivalents, accounts receivable and accounts payable approximate fair value due to their short-term nature.

Accounting for Stock-Based Compensation

The Financial Accounting Standards Board has issued Statement of Financial Accounting Standards No. 123, ''Accounting for Stock-Based Compensation'' (''SFAS 123'') which encourages, but does not require that an entity account for employee stock compensation under a fair value-based method. SFAS 123 allows an entity to continue to measure compensation cost for employee stock-based compensation plans using the intrinsic value-based method of accounting prescribed by APB Opinion No. 25, ''Accounting for Stock Issued to Employees'' (''APB 25''). Effective for fiscal years beginning after December 15, 1995, entities electing to remain with accounting under APB 25 are required to make pro forma disclosures of net income and earnings per share as if the fair value-based method of accounting under SFAS 123 had been applied. The Company will continue to account for employee stock-based compensation under APB 25 and has made the pro forma disclosures required under SFAS 123 (see Note 8).

(In thousands, except for share and per share amounts)

Earnings Per Share

Net income (loss) per share is calculated based on the weighted average number of common shares outstanding during the period plus, in periods in which they have a dilutive effect, the effect of the common shares contingently issuable from stock options. Common shares outstanding and per share amounts reflect the Formation (see Note 1) and are considered outstanding from the date each entity was formed.

NOTE 3 - INVESTMENT SECURITIES

In May 1993, the Financial Accounting Standards Board (FASB) issued Statement of Financial Accounting Standards (SFAS) No. 115, "Accounting for Certain Investments in Debt and Equity Securities" (SFAS No. 115). This statement requires investments in debt securities to be classified as held-to-maturity and measured at amortized cost only if the Company has the positive intent and ability to hold such securities to maturity. Investments in debt securities that are not classified as held-to-maturity and equity securities that have readily determinable fair values are classified as trading securities or available-for-sale securities. Trading securities are investments purchased and held principally for the purpose of selling in the near term; available-for-sale securities are investments not classified as trading or held-to-maturity. Unrealized holding gains and losses for trading securities are included in earnings; unrealized holding gains and losses for available-for-sale securities are reported as a separate component of stockholders' equity, net of applicable income taxes. Dividend and interest income, including amortization of premiums and discounts, is recorded in earnings for all categories of investment securities. Discounts and premiums related to debt securities are amortized using a method which approximates the level-yield method. Management reviews all reductions in value below book value to determine if the impairment is other than temporary. If the impairment is determined to be other than temporary in nature, the carrying value of the security is written down to the appropriate level by a charge to earnings.

The Company's investment securities are classified as held-to-maturity as of December 31, 1996. The following presents amortized cost (which approximates fair value), of these securities as of December 31, 1996. Gross unrealized gains and losses were insignificant.

	Amortized Cost
Held-to-maturity securities:	
U.S. government	$ 1,000
States and political subdivision	545
Corporate securities	35,493
Total investment securities	$37,038

The contractual maturities of all held-to-maturity securities at December 31, 1996 are as follows:

	Amortized Cost
Due in one year or less	$28,113
Due after one year through five years	8,925
Total investment securities	$37,038

NOTE 4--RELATED PARTY TRANSACTIONS

Due to/from Affiliates

During 1994 the Company loaned $150 to a relative of an officer of the Company in return for a demand note bearing interest at the prime rate (8.5% at December 31, 1994). The full amount of principal and interest was repaid in 1995.

In 1994 the Company made approximately $40 of short-term advances to an officer of the Company. These advances were repaid in full during 1995.

During 1995 the Company advanced RxCare approximately $1,957 to fund the losses RxCare had incurred in connection with one of its pharmacy benefit management contracts that is currently being managed by the Company under the Company's agreement with RxCare. Although the Company does not intend to seek repayment of the advance, the Company intends to offset such amount against future profit sharing amounts, if any, due to RxCare under the Company's agreement with RxCare. As RxCare's revenue is largely dependent upon the Company's results of operations in Tennessee, the collectibility of this amount is uncertain, and a full reserve has been recorded against the advance. During October 1996, the Company advanced approximately $349 directly to individual pharmacies in Tennessee on behalf of RxCare. The amount is included in due from affiliates at December 31, 1996.

As part of its agreement with RxCare, the Company is obligated to share with RxCare the Company's cumulative profit, if any, from the RxCare pharmacy benefit management contracts. Based on estimated results of operations for 1994, the Company accrued $473 during 1994 which was paid in 1995. Although actual operations for 1994 were subsequently determined not to be profitable, the Company does not intend to request repayment of the fee but intends to offset such amount against future profit sharing amounts. No amount was due RxCare for the years ended December 31, 1996 or 1995.

The Company is currently marketing and promoting certain preferred generic drugs of Zenith Goldline pursuant to two three-year contracts entered into in December 1995. In return, the Company is entitled to receive fees based on a percentage of the growth in Zenith Goldline's gross margins from related sales. Included in due from affiliates at December 31, 1996 is management's estimate of revenues earned under these agreements.

During 1996, the Company made short-term advances to MIM Holdings and Alchemie Properties, LLC (''Alchemie'') of $99 and $25, respectively. Alchemie is controlled by an officer of the Company. Repayments by MIM Holdings and Alchemie through December 31, 1996 were $13 and $25, respectively. Originally scheduled to be repaid by September 30, 1996 without interest, the remaining $86 principal amount owed by Holdings is due and payable on September 30, 1997 together with 10% interest accruing on the unpaid balance since September 1996, pursuant to an unsecured promissory note that, together with interest, are due and payable on September 30, 1997. The principal balance and accrued interest at December 31, 1996 of $88 is included in due from affiliates. MIM Holdings is controlled by a Company officer and his family.

In June 1996, an executive officer of the Company loaned $500 to the Company for working capital purposes pursuant an unsecured, 10% promissory note that is payable upon demand. The loan amount plus $2.5 for interest and fees was repaid by December 31, 1996.

Other Activities

Pursuant to the RxCare Contract, which expires in December 1998, the Company makes monthly payments to RxCare to defray the cost of office space and equipment provided by RxCare on behalf of the Company and to provide RxCare with cash flow to meet its operating expenses. Expenses under this agreement were $240, $140 and $100 for the years ended December 31, 1996, 1995 and 1994, respectively. In addition, from November 1995 through October 1996 the Company paid RxCare $6.5 monthly to cover expenses associated with a regional cost containment initiative.

In December 1994, the Company entered into a ten-year agreement to lease a facility from Alchemie. The lease provides for monthly payments of $3 plus real estate taxes and condominium association fees. Rent expense was approximately $52, $60 and $5 for the years ended December 31, 1996, 1995 and 1994, respectively. The future minimum rental payments under these agreements are included in Note 6 with the Company's other operating leases.

Consulting and Service Agreements

In January 1994, the Company entered into consulting agreements with three minority stockholders of the Company. These agreements expire in 1999 and provide for payments to be made as services are rendered. In 1994, payments of $75 were made to each consultant. No amounts were paid in 1995 or 1996.

In January 1994, the Company entered into a consulting agreement with an officer of RxCare which provided for payments by the Company of $5.5 per month, and additional compensation as agreed by the parties for special projects, through December 1996. The Company paid a total of $66 in both 1996 and 1995 and $516 in 1994. In December of 1996, $225 for the special projects was returned to the Company and treated as a reduction of general and administrative expenses.

In September 1995, the Company entered into a contract with MIM Holdings to receive management consulting services in return for monthly payments to MIM Holdings of $75. Consulting expenses amounted to $225 and $300 for the year ended December 31, 1996 and 1995, respectively. The contract was terminated on March 31, 1996.

A professional services agreement was entered into as of January 1, 1996 between MIM Holdings and the Company. Under this agreement, MIM Holdings provided the Company with operational professional services required to perform the Company's obligations under a Marketing Services Agreement with Zenith Goldline (see Note 1), for which the Company paid MIM Holdings $150 in 1996. The agreement was terminated in May 1996.

Stockholder Notes Receivable

In June 1994, the Company advanced to an officer approximately $979 for purposes of acquiring a principal residence, $975 of which is collateralized by a first mortgage on the residence. In exchange for the funds, the Company received two promissory notes, the aggregate outstanding principal balance of which was $955 and $979 at December 31, 1996 and 1995, respectively. The notes are due on June 15, 1997 and bear interest at 5.42% per annum payable monthly. Interest income on the notes for the years ended December 31, 1996, 1995 and 1994 was $52, $55 and $29, respectively.

In August 1994, the Company advanced to Alchemie $299 for the purposes of acquiring a building leased by the Company, of which approximately $280 was outstanding at December 31, 1996 and 1995. The note bears interest at a rate of 10% per annum with principal due on December 1, 2004. Interest income was $29 for the years ended December 31, 1996 and 1995, respectively, and $12 for the year ended December 31, 1994. The note is secured by a lien on Alchemie's rental income.

In December 1995, the Company advanced to MIM Holdings $800 for certain consulting services to be performed for the Company in 1996. During 1995, the Company also paid $278 for certain expenses on behalf of MIM Holdings including $150 for consulting services to MIM Holdings by an officer of RxCare. These amounts, totaling $1,078, were recorded as a stockholder note receivable at December 31, 1995. The Company has received a note from MIM Holdings for $456. As originally written, the note bore interest at 10% per annum, payable quarterly, with principal due on March 31, 2001. The note was rewritten in December 1996 to make all interest from January 1, 1996 to September 30, 1997 payable on September 30, 1997. Thereafter, interest will be paid

(In thousands, except for share and per share amounts)

quarterly, in arrears, until March 31, 2001. The note is guaranteed by an officer of the Company and further secured by the assignment to the Company of two notes due to MIM Holdings in the aggregate principal amount of $456. The remaining balance of $622 will not be repaid and was recorded as a stockholder distribution during the first quarter of 1996. The outstanding principal balance plus accrued interest at December 31, 1996 was $502.

NOTE 5--PROPERTY AND EQUIPMENT

Property and equipment, at cost, consists of the following at December 31,:

	1996	1995
Computer and office equipment, including equipment under capital leases	$ 2,794	$1,614
Furniture and fixtures	364	173
Leasehold improvements	506	480
	3,664	2,267
Less: Accumulated depreciation and amortization	(1,241)	(460)
	$ 2,423	$1,807

NOTE 6--COMMITMENTS AND CONTINGENCIES

Legal Proceedings

The Company is currently a third-party defendant in a proceeding in the Superior Court of the State of Rhode Island. The third-party complaint alleges that the Company interfered with certain contractual relationships and misappropriated certain confidential information. The third-party complaint seeks to enjoin the Company from using the allegedly misappropriated confidential information and seeks an unspecified amount of compensatory and consequential damages, interest and attorneys' fees. Although the Company believes that the third-party plaintiffs' allegations are without merit, the loss of this litigation could have a material adverse effect on the Company's financial position and results of operations.

Government Regulation

Various Federal and state laws and regulations affecting the healthcare industry do or may impact the Company's current and planned operations, including, without limitation, Federal and state laws prohibiting kickbacks in government health programs (including TennCare), Federal and state antitrust and drug distribution laws, and a wide variety of consumer protection, insurance and other state laws and regulations. While management believes that the Company is in substantial compliance with all existing laws and regulations material to the operation of its business, such laws and regulations are subject to rapid change and often are uncertain in their application. As controversies continue to arise in the healthcare industry (for example, regarding the efforts of plan sponsors and pharmacy benefit managers to limit formularies, alter drug choice and establish limited networks of participating pharmacies), Federal and state regulation and enforcement priorities in this area can be expected to increase, the impact of which on the Company cannot be predicted. There can be no assurance that the Company will not be subject to scrutiny or challenge under one or more of these laws or that any such challenge would not be successful. Any such challenge, whether or not successful, could have a material adverse effect upon

(In thousands, except for share and per share amounts)

the Company's financial position and results of operations. Violation of the Federal anti-kickback statute, for example, may result in substantial criminal penalties, as well as exclusion from the Medicare and Medicaid (including TennCare) programs. Further, there can be no assurance that the Company will be able to obtain or maintain any of the regulatory approvals that may be required to operate its business, and the failure to do so could have a material adverse effect on the Company's financial position and results of operations.

Non-Compete Covenant

In connection with his resignation from Zenith Laboratories, Inc. a manufactuer and distributor of generic drugs ("Zenith"), in January 1996 the Company's chief Executive Officer agreed that he would provide consultative services to Zenith through December 31, 1998 and that, until then, neither he, nor any business in which he has a direct or indirect interest, will own, manage or be employed or engaged by any business that is substantially competitive with any material portion of the business of Zenith or its subsidiaries as conducted in early 1996. Such covenant may restrict the Company's ability to compete in certain areas including its preferred generics business and any future drug distribution business.

Employment Agreements

The Company has entered into employment agreements with certain key employees which expire at various dates through May 2000. Total minimum commitments under these agreements are approximately as follows:

1997	$1,400
1998	1,200
1999	1,200
2000	500
	$4,300

Other Agreements

The Company has various consulting agreements which will require payments of $480 in the aggregate through 1998. As discussed in Note 4, the Company rents its main facility from Alchemie. Rent expense for non-related party leased facilities and equipment was approximately $208, $116 and $95 for the years ended December 31, 1996, 1995 and 1994, respectively.

Operating Leases

The Company leases its facilities and certain equipment under various operating leases. The future minimum lease payments under these operating leases at December 31, 1996 are as follows:

1997	$ 203
1998	170
1999	164
2000	161
2001	152
Thereafter	329
	$1,179

(In thousands, except for share and per share amounts)

Capital Leases

The Company leases certain equipment under various capital leases. Future minimum lease payments under the capital lease agreements at December 31, 1996 are as follows:

1997	$251
1998	186
1999	158
2000	66
Total minimum lease payments	661
Less: amount representing interest	73
Obligations under leases	588
Less: current portion of lease obligation	213
	$375

NOTE 7--INCOME TAXES

The Company accounts for income taxes in accordance with SFAS 109. Under SFAS 109, deferred tax assets or liabilities are computed based on the differences between the financial statement and income tax bases of assets and liabilities as measured by currently enacted tax laws and rates. Deferred income tax expenses and credits are based on changes in the deferred assets and liabilities from period to period.

The effect of temporary differences which give rise to a significant portion of deferred taxes are as follows as of December 31, 1996 and 1995:

	1996	1995
Deferred tax assets:		
Reserves and accruals not yet deductible for tax purposes	$ 3,327	$ 2,952
Net operating loss carryforward	2,475	783
Subtotal	5,802	3,735
Less: valuation allowance	(5,734)	(3,669)
Total deferred tax assets	68	66
Deferred tax liabilities:		
Property basis differences	(68)	(66)
Total deferred tax liability	(68)	(66)
Net deferred taxes	$ --	$ --

It is uncertain whether the Company will realize full benefit from its deferred tax assets, and it has therefore recorded a valuation allowance. The Company will assess the need for the valuation allowance at each balance sheet date.

(In thousands, except for share and per share amounts)

There is no provision (benefit) for income taxes for the years ended December 31, 1996 and 1995. A reconciliation to the tax provision (benefit) at the Federal statutory rate is presented below:

	1996	1995
Tax benefit at statutory rate	$(10,796)	$(2,303)
State tax benefit, net of federal taxes	(2,096)	(447)
Provision for valuation allowance	2,065	2,747
Non-deductible executive stock option compensation charge	10,816	--
Other	11	3
Recorded income taxes	$ --	$ --

At December 31, 1996, the Company had, for tax purposes, unused net operating loss carryforwards of approximately $6,096 that may be available to offset future taxable income, if any, and which will begin expiring in 2008. The Tax Reform Act of 1986 contains provisions that limit the net operating loss carryforwards available to be used in any given year upon the occurrence of certain events, including significant changes in ownership.

NOTE 8--STOCKHOLDERS' EQUITY

Public Offering

On August 14, 1996, the Securities and Exchange Commission declared effective the Company's Registration Statement (under the Securities Act of 1933, as amended) for its initial public offering, and the Company entered into an Underwriting Agreement with Paine Webber Incorporated and Dillon, Read and Co. Inc., as representatives of the several underwriters, to sell 4,000,000 shares of Common Stock to the underwriters at the public offering price of $13.00 per share, less underwriting discounts and commissions of $.91 per share. On August 20, 1996, the Company received the net proceeds of the public offering from the underwriters. Net proceeds amounted to $46,786 after offering costs of $1,574.

Stock Option Plans

In 1994, Pro-Mark established the Pro-Mark Holdings, Inc. 1994 Stock Plan (the ''Pro-Mark Plan''). The Pro-Mark Plan provided for, among other awards, options to employees, contractors and consultants to purchase up to 60,000 shares of Pro-Mark common stock at an option price not less than 100% of the fair market value of the shares on the grant date. The period during which an option may be exercised varied, but no option could be exercised after 15 years from the date of grant. During 1994, options to purchase 3,738 shares of common stock were granted at $1.00 per share (560,700 shares of the Company's Common Stock at $0.0067 per share as a result of the Formation--see Note 1). During 1995, options to purchase 16,628 shares of common stock were granted at $1.00 per share (a total of 2,494,200 shares of the Company's Common Stock at $0.0067 per share as a result of the Formation--see Note 1). All of such options were deemed to have been granted at fair market value and were exchanged in the Formation for options under the Company's Plan (as defined below).

In May 1996, the Company adopted the MIM Corporation 1996 Stock Incentive Plan (the ''Plan''). The Plan provides for the granting of incentive stock options (ISOs) and non-qualified stock options to employees and key contractors of the Company. Options granted under the Plan generally vest over a three-year period, but vest in full upon a change in control of the Company or at the discretion of the Company's compensation committee, and generally are exercisable up to 15 years from the date of grant. The exercise price of ISOs granted under the Plan will not be less than 100% of the fair market value on the date of grant (110% for ISOs granted to more than a

(In thousands, except for share and per share amounts)

10% shareholder). If non-qualified stock options are granted at an exercise price less than fair market value on the grant date, the amount by which fair market value exceeds the exercise price will be charged to compensation expense over the period the options vest. The number of shares authorized for issuance under the Plan, initially 4,000,000, was increased to 4,372,718 in December 1996. At December 31, 1996, 272,337 shares remained available for grant under the Plan.

As of December 31, 1996 and 1995, the exercisable portion of outstanding options was 2,679,167 and 2,442,100, respectively. No options were exercisable at December 31, 1994. Stock option activity under the Plan through December 31, 1996 is as follows:

	Options	Average Price
Balance, December 31, 1993	--	--
Granted	560,700	$0.0067
Canceled	(8,400)	
Balance, December 31, 1994	552,300	$0.0067
Granted	2,494,200	$0.0067
Canceled	(24,600)	
Balance, December 31, 1995	3,021,900	$0.0067
Granted	1,124,902	$ 11.26
Canceled	(46,421)	
Exercised	(16,800)	
Balance, December 31, 1996	4,083,581	$ 2.99

In July 1996, the Company adopted the MIM Corporation 1996 Non-Employee Directors Stock Incentive Plan (the ''Directors Plan''). The purpose of the Directors Plan is to attract and retain qualified individuals to serve as non-employee directors of the Company (''Outside Directors''), to provide incentives and rewards to such directors and to associate more closely the interests of such directors with those of the Company's stockholders. The Directors Plan provides for the automatic granting of non-qualified stock options to Outside Directors joining the Company since the adoption of the Directors Plan. Each such Outside Director receives an option to purchase 20,000 shares of Common Stock upon his or her initial appointment or election to the Board of Directors. The exercise price of such options is equal to the fair market value of the Common Stock on the date of grant. Options granted under the Directors Plan generally vest over three years. A total of 100,000 shares of Common Stock are authorized for issuance under the Directors Plan. At December 31, 1996, options to purchase 40,000 shares of Common Stock were outstanding under the Directors Plan at an exercise price of $13.00 per share, none of which were exercisable.

Accounting for Stock-Based Compensation

The Company applies APB 25 and related interpretations in accounting for its stock option plans for options granted to employees and directors of the Company. In May 1996 the majority stockholder of the Company granted to three unrelated individuals with the Company (each of whom became a director of the Company and two of whom also became officers of the Company), options to purchase an aggregate of 3,600,000 shares of Common Stock owned by him at $0.10 per share. These options are immediately exercisable and have a term of ten years, subject to earlier termination upon a change in control of the Company, as defined. In connection with these options, under APB 25, for the year ended December 31, 1996 the Company recorded a nonrecurring, non-cash stock option charge (and a corresponding credit to additional paid-in capital) of $26,640, representing the difference between the exercise price and the deemed fair market value of the Common Stock at the date of grant.

(In thousands, except for share and per share amounts)

In July 1996, the majority stockholder also granted to one of these individuals an additional option (''additional option'') to purchase 1,860,000 shares of Common Stock owned by him at $13 per share. The additional option has a term of ten years, subject to earlier termination upon a change in control of the Company, as defined, or within certain specified periods following the grantee's death, disability or termination of employment for any reason. The additional option vests in installments of 620,000 shares each on December 31, 1996, 1997 and 1998, and is immediately exercisable upon the approval of a change in control of the Company, as defined, by the Company's Board of Directors and, if required, stockholders. During 1996, the Company also recorded compensation expense as a general and administrative charge of $17 in accordance with SFAS 123 for the fair value of options granted to certain non-employees of the Company.

Had compensation cost for the Company's stock option plans for employees and directors been determined based on the fair value method in accordance with SFAS 123, the Company's net loss would have been increased to the pro forma amounts indicated below for the years ended December 31,:

	1996		1995	
	As Reported	Pro Forma	As Reported	Pro Forma
Net loss	$(31,754)	$(32,131)	$(6,772)	$(6,779)
Net loss per common and common equivalent share	$ (3.32)	$ (3.36)	$ (1.43)	$ (1.43)
Weighed average shares outstanding	9,557	9,557	4,732	4,732

Because the method prescribed by SFAS No. 123 has not been applied to options granted prior to January 1, 1995, the resulting pro forma compensation expense may not be representative of the amount to be expected in future years. Pro forma compensation expense for options granted is reflected over the vesting period, therefore future pro forma compensation expense may be greater as additional options are granted.

The fair value of each option grant was estimated on the grant date using the Black-Scholes option-pricing model with the following weighted-average assumptions:

	1996	1995
Volatility	50%	50%
Risk-free interest rate	5%	5%
Expected life of options	4 years	4 years

The Black-Scholes option-pricing model was developed for use in estimating the fair value of traded options which have no vesting restrictions and are fully transferable. In addition, option-pricing models require the input of highly subjective assumptions including expected stock price volatility. Because the Company's employee stock options have characteristics significantly different from those of traded options, and because changes in the subjective input assumptions can materially affect the fair value estimate, in management's opinion, the existing models do not necessarily provide a reliable single measure of the fair value of its employee stock options.

(In thousands, except for share and per share amounts)

NOTE 9--CONCENTRATION OF CREDIT RISK

The majority of the Company's revenues have been derived from TennCare contracts pursuant to the RxCare Contract. The following table outlines contracts with plan sponsors having revenues which individually exceeded 10% of total revenues during the applicable time period:

	Plan Sponsor				
	A	B	C	D	E
Year ended December 31, 1994					
% of total revenue	60%	13%	15%	-	-
% of total accounts receivable at period end	49%	*	*	-	-
Year ended December 31, 1995					
% of total revenue	30%	*	*	45%	-
% of total accounts receivable at period end	*	*	*	28%	-
Year ended December 31, 1996					
% of total revenue	18%	*	*	47%	11%
% of total accounts receivable at period end	*	*	*	13%	14%

- ----------
* Less than 10%.

There were no other contracts representing 10% or more of the Company's total revenue for the years ended December 31, 1996, 1995 and 1994. It is possible that the State of Tennessee or the Federal government could require modifications to the TennCare program. The Company is unable to predict the effect of any such future changes to the TennCare program. Subsequent to year end the Company terminated one of its MCO contracts beginning April 1, 1997 which represented 1996 revenues and net losses of $132,846 and $7,321, respectively (see Note 2).

NOTE 10--PROFIT SHARING PLAN

The Company maintains a deferred compensation plan under Section 401(k) of the Internal Revenue Code. Under the plan, employees may elect to defer up to 15% of their salary, subject to Internal Revenue Service limits. The Company may make a discretionary matching contribution. The Company made no matching contributions for the years ended December 31, 1996, 1995 and 1994.

MIM Corporation and Subsidiaries

Schedule II -- Valuation and Qualifying Accounts
For the years ended December 31, 1996, 1995 and 1994

(In thousands)

	Balance at Beginning of Period	Charged to Costs and Expenses	Other Charges	Balance at End of Period
Year ended December 31, 1994				
Accounts receivable.....	$ 0	$ 340	$ 0	$ 340
Accounts receivable, other	$ 0	$ 0	$ 0	$ 0
Year ended December 31, 1995				
Accounts receivable.....	$ 340	$ 20	$ 0	$ 360
Accounts receivable, other	$ 0	$ 1,957	$ 0	$ 1,957
Year ended December 31, 1996				
Accounts receivable.....	$ 360	$ 728	$ 0	$ 1,088
Accounts receivable, other	$ 1,957	$ 200	$ 0	$ 2,157

Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure

Not applicable.

PART III

Incorporated by Reference

The information called for by Item 10 -- "Directors and Executive Officers of the Registrant" (other than the information concerning executive officers set forth after Item 4 herein), Item 11 -- "Executive Compensation", Item 12 -- "Security Ownership of Certain Beneficial Owners and Management" and Item 13 -- "Certain Relationships and Related Transactions" is incorporated herein by this reference to the Company's definitive proxy statement for its annual meeting of stockholders scheduled to be held in June 1997, which definitive proxy statement is expected to be filed with the Commission not later than 120 days after the end of the fiscal year to which this report relates.

PART IV

Item 14. Exhibits, Financial Statement Schedules, and Reports on Form 8-K

(a) Documents Filed as a Part of this Report

All other schedules not listed above have been omitted since they are not applicable or are not required, or because the required information is included in the consolidated financial statements or notes thereto.

3. Exhibits:

Exhibit Number	Description	Location
3.1	Amended and Restated Certificate of Incorporation of MIM Corporation	(1) (Exh. 3.1)
3.2	By-Laws of MIM Corporation	(1) (Exh. 3.2)
10.1	Drug Benefit Program Services Agreement between Pro-Mark Holdings, Inc. and RxCare of Tennessee, Inc. dated as of March 1, 1994, as amended January 1, 1995	(1) (Exh. 10.1)
10.2	Capitation Agreement between Blue Cross and Blue Shield of Tennessee and RxCare of Tennessee, Inc. dated as of April 1, 1995	(1) (Exh. 10.2)
10.3	Letter agreement between Blue Cross and Blue Shield of Tennessee, Inc., Voluntary State Health Plan, Inc. and RxCare of Tennessee, Inc. dated June 28, 1996 amending the Capitation Agreement between Blue Cross and Blue Shield of Tennessee and RxCare of Tennessee, Inc. dated as of April 1, 1995	(1) (Exh. 10.2(a))
10.4	Pharmaceutical Services Agreement between Tennessee Primary Care Network, Inc. and RxCare of Tennessee, Inc	(1) (Exh. 10.3)
10.5	Marketing Services Agreement between Zenith Goldline Pharmaceuticals, Inc. and MIM Strategic Marketing, LLC dated as of December 8, 1995	(1) (Exh. 10.4)
10.6	Pharmaceutical Reimbursement Agreement between Pro-Mark Holdings, Inc. and Zenith Goldline Pharmaceuticals, Inc. dated as of December 8, 1995	(1) (Exh. 10.5)
10.7	Software Licensing and Support Agreement between ComCoTec, Inc. and Pro-Mark Holdings, Inc. dated November 21, 1994	(1) (Exh. 10.6)
10.8	Provider Network Agreement (Agent) between Tennessee Health Partnership and RxCare of Tennessee, Inc. dated February 26, 1996	(3)
10.9	Promissory Notes of E. David Corvese and Nancy Corvese in favor of Pro-Mark Holdings, Inc. dated June 15, 1994	(1) (Exh. 10.9)
10.10	Promissory Note of Alchemie Properties, LLC in favor of Pro-Mark Holdings, Inc. dated August 14, 1994	(1) (Exh. 10.10)
10.11	Promissory Note of MIM Holdings, LLC in favor of MIM Strategic, LLC dated March 21, 1996	(2)
10.12	Promissory Note of MIM Holdings, LLC in favor of MIM Strategic, LLC dated December 31, 1996, replacing Promissory Note of MIM Holdings, LLC in favor of MIM Strategic, LLC dated March 21, 1996	(2)
10.13	Promissory Note of MIM Holdings, LLC in favor of MIM Strategic, LLC dated March 31, 1996	(1) (Exh. 10.11)
10.14	Promissory Note of MIM Holdings, LLC in favor of MIM Strategic, LLC dated December 31, 1996, replacing Promissory Note of MIM Holdings, LLC in favor of MIM Strategic, LLC dated March 31, 1996	(2)

10.15	Demand Note of MIM Corporation in favor of John H. Klein dated June 4, 1996	(1) (Exh. 10.12)
10.16	Management Agreement between MIM Holdings, LLC and Pro-Mark Holdings, Inc. dated August 31, 1995	(1) (Exh. 10.13)
10.17	Start-Up Professional Services Agreement between MIM Holdings, LLC and MIM Strategic, LLC dated as of January 1, 1996	(1) (Exh. 10.14)
10.18	On-Going Professional Services Agreement between MIM Holdings, LLC and MIM Strategic, LLC dated as of January 1, 1996	(1) (Exh. 10.15)
10.19	Employment Agreement between MIM Corporation and John H. Klein dated as of May 30, 1996*	(1) (Exh. 10.16)
10.20	Employment Agreement between MIM Corporation and E. David Corvese dated as of May 30, 1996*	(1) (Exh. 10.17)
10.21	Employment Agreement between MIM Corporation and Richard H. Friedman dated as of May 30, 1996*	(1) (Exh. 10.18)
10.22	Employment Agreement between MIM Corporation and Todd R. Palmieri dated as of May 30, 1996*	(1) (Exh. 10.19)
10.23	Stock Option Agreement between E. David Corvese and John H. Klein dated as of May 30, 1996*	(1) (Exh. 10.22)
10.24	Stock Option Agreement II between E. David Corvese and John H. Klein dated as of May 30, 1996*	(1) (Exh. 10.23)
10.25	Amendment No. 1 dated July 29, 1996 to Stock Option Agreement II between E. David Corvese and John H. Klein dated as of May 30, 1996*	(1) (Exh. 10.23(a))
10.26	Repurchase Agreement between E. David Corvese and John H. Klein dated as of May 30, 1996*	(1) (Exh. 10.24)
10.27	Amendment No. 1 dated July 29, 1996 to Repurchase Agreement between E. David Corvese and John H. Klein dated as of May 30, 1996*	(1) (Exh. 10.24(a))
10.28	Stock Option Agreement between E. David Corvese and Richard H. Friedman date as of May 30, 1996*	(1) (Exh. 10.25)
10.29	Stock Option Agreement between E. David Corvese and Leslie B. Daniels dated as of May 30, 1996*	(1) (Exh. 10.26)
10.30	Lease between Alchemie Properties, LLC and Pro-Mark Holdings, Inc. dated as of December 1, 1994	(1) (Exh. 10.27)
10.31	MIM Corporation 1996 Stock Incentive Plan*	(1) (Exh. 10.28)
10.32	MIM Corporation 1996 Stock Incentive Plan, as amended December 9, 1996*	(2)
10.33	MIM Corporation 1996 Non-Employee Directors Stock Incentive Plan*	(1) (Exh. 10.29)

10.34 Registration Rights Agreement-I between MIM Corporation and John H. Klein, Richard H. Friedman, Leslie B. Daniels, E. David Corvese and MIM Holdings, LLC dated July 29, 1996*.....(1) (Exh. 10.30)

10.35 Registration Rights Agreement-II between MIM Corporation and John H. Klein, Richard H. Friedman and Leslie B. Daniels dated July 29, 1996*.....(1) (Exh. 10.31)

10.36 Registration Rights Agreement-III between MIM Corporation and John H. Klein and E. David Corvese dated July 29, 1996*.....(1) (Exh. 10.32)

10.37 Stock Option Agreement between E. David Corvese and John H. Klein dated July 31, 1996*.....(1) (Exh. 10.33)

10.38 Amendment No. 1 dated August 12, 1996 to Stock Option Agreement between E. David Corvese and John H. Klein dated July 31, 1996*.....(1) (Exh. 10.33(a))

10.39 Registration Rights Agreement-IV between MIM Corporation and John H. Klein, Richard H. Friedman, Leslie B. Daniels, E. David Corvese and MIM Holdings, LLC dated July 31, 1996*.....(1) (Exh. 10.34)

10.40 Registration Rights Agreement-II between MIM Corporation and Richard H. Friedman and Leslie B. Daniels dated July 31, 1996*.....(1) (Exh. 10.35)

10.41 Indemnity letter from MIM Holdings, LLC dated August 5, 1996.....(1) (Exh. 10.36)

10.42 Guaranty of E. David Corvese in favor of MIM Corporation dated as of December 31, 1996.....(2)

10.43 Assignment from MIM Holdings, LLC to MIM Corporation dated as of December 31, 1996.....(2)

21 Subsidiaries of the Company.....(1) (Exh. 21)

27 Financial Data Schedule.....(2)

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(1) Incorporated by reference to the indicated exhibit to the Company's Registration Statement on Form S-1 (File No. 333-05327) which became effective on August 14, 1996.

(2) Filed herewith.

(3) Certain information has been omitted from this Exhibit pursuant to a request for confidential treatment filed with the Secretary of the Securities and Exchange Commission.

* Indicates a management contract or compensatory plan or arrangement required to be filed as an exhibit pursuant to Item 14(c) of Form 10-K.

(b) Reports on Form 8-K

The Company did not file any reports on Form 8-K during the last quarter of the fiscal year covered by this report.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, on March 28, 1997.

MIM CORPORATION

By /s/ John H. Klein

John H. Klein, Chairman of the Board
and Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title(s)	Date
/s/ John H. Klein John H. Klein	Chairman, Chief Executive Officer and Director (principal executive officer)	March 28, 1997
/s/ Richard H. Friedman Richard H. Friedman	Chief Operating Officer, Chief Financial Officer and Director (principal financial and accounting officer)	March 28, 1997
/s/ E. David Corvese E. David Corvese	Vice Chairman and Director	March 28, 1997
/s/ Todd R. Palmieri Todd R. Palmieri	Executive Vice President and Director	March 27, 1997
/s/ Leslie B. Daniels Leslie B. Daniels	Director	March 31, 1997
/s/ Louis A. Luzzi Louis A. Luzzi	Director	March 27, 1997
/s/ Scott R. Yablon Scott R. Yablon	Director	March 29, 1997

EXHIBIT INDEX

(Exhibits being filed with this Form 10-K)

10.8	Provider Network Agreement (Agent) between Tennessee Health Partnership and RxCare of Tennessee, Inc. dated February 26, 1996 (1)
10.11	Promissory Note of MIM Holdings, LLC in favor of MIM Strategic, LLC dated March 21, 1996
10.12	Promissory Note of MIM Holdings, LLC in favor of MIM Strategic, LLC dated December 31, 1996, replacing Promissory Note of MIM Holdings, LLC in favor of MIM Strategic, LLC dated March 21, 1996
10.14	Promissory Note of MIM Holdings, LLC in favor of MIM Strategic, LLC dated December 31, 1996, replacing Promissory Note of MIM Holdings, LLC in favor of MIM Strategic, LLC dated March 31, 1996
10.32	MIM Corporation 1996 Stock Incentive Plan, as amended December 9, 1996
10.42	Guaranty of E. David Corvese in favor of MIM Corporation dated as of December 31, 1996
10.43	Assignment from MIM Holdings, LLC to MIM Corporation dated as of December 31, 1996
27	Financial Data Schedule

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(1) Certain information has been omitted from this Exhibit pursuant to a confidential treatment request filed with the Secretary of the Securities and Exchange Commission.

Exhibit 10.8

NOTE: The Company is seeking confidential treatment with respect to certain information contained in this agreement. Therefore, such information, which is identified by a [*], has been omitted and filed separately with the Securities and Exchange Commission pursuant to Rule 24b-2 of the Securities and Exchange Act of 1934, as amended.

TENNESSEE HEALTH PARTNERSHIP
PROVIDER NETWORK AGREEMENT (AGENT)

This Agreement is made between TENNESSEE HEALTH PARTNERSHIP ("THP"), a Tennessee joint venture, and the entity named on the signature page of this Agreement ("Agent").

RECITALS

A. Agent has developed and established a network of Providers and has been duly authorized by each Provider to represent, legally bind and commit each Provider to provide Designated Covered Services to Enrollees pursuant to the terms of this Agreement.

B. THP desire to establish a network of health care providers to provide cost effective Covered Services to Enrollees.

C. THP further desires to arrange for the provision of Covered Services to Enrollees by network providers pursuant to a Master Agreement between THP and each Payor
.

D. THP and Agent mutually desire that each Provider become a member of such provider network for the purposes of providing Designated Covered Services to Enrollees.

E. References to Provider in this Agreement shall mean each Provider included in Agent's THP Network.

NOW, THEREFORE, in consideration of the above recitals and the mutual covenants of the parties set forth below, it is agreed as follows:

ARTICLE I
Definitions

The following definitions shall be used in the interpretation and implementation of this Agreement.

1.1 "Addendum" means any amendment or supplement to this Agreement identifying a Payor Plan and setting forth certain essential provisions of the Payor Plan that are necessary for Provider to provide and Payee to bill for Designated Covered Services provided to Enrollees covered under the master Agreement in a manner permitted by this Agreement and such Master Agreement. All provisions of each Addendum are incorporated herein by reference and shall be deemed a part of this Agreement. A list of all Addenda attached to this Agreement as of the time of its execution by the parties is set forth on the List of Addenda attached to this Agreement as Exhibit 2. Addenda may be deleted
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or added to this Agreement by THP as provided in Section 14.2 of this Agreement.

1.2 "Agent's THP Network" means the network of Providers established by Agent for the purpose of providing Designated Covered Services to Enrollees under this Agreement, each member of which is referred to as Provider and all members of which are referred to as Providers under this Agreement. Current members of Agents' THP Network are listed on Exhibit 4. This term shall not
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apply to any other network of health care providers formed by Agent for the purpose of serving Payor Plans not covered by this Agreement, notwithstanding that such other network includes all Providers included in Agent's THP Network.

1.3 "Agreement" means this Agreement, all Addenda and Exhibits to this Agreement, Applicable Policies and Procedures and all applicable State or federal requirements that are required by law or contract to be incorporated as a part of this Agreement.

1.4 "Applicable Policies and Procedures" means those medical policies and administrative rules, regulations and procedures adopted by THP or Payor that are applicable to a Payor Plan and that supplement, implement and apply to the terms of the Payor Plan, Master Agreement and this Agreement. Such policies and rules shall include, without limitation, provisions and requirements related to (i) the delivery and provision of, and payment for, Covered Services to Enrollees by Provider Panels, (ii) determination of Medical Necessity, Referral requirements and obtaining Prior Authorization for deliver of Covered Services, (iii) utilization and peer review, (iv) recordkeeping and data reporting and (iv) appeal and grievance procedures to aid in the resolution of disputes that may arise among THP, THP Providers, Payors, Enrollees and others. Applicable Policies and Procedures may be amended from time to time by THP or the appropriate Payor without the consent of Agent or Provider. Notice of any such amendments shall be given to Provider in accordance with the provisions of Article XVII.
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1.5 "Clean Claims" means a properly completed claim for payment for Designated Covered Services received by THP from Agent or Provider that, in the determination of the Designated Paying Agent, is complete (i.e., requires no further information, documentation, adjustment or alteration by Provider in order to be processed or paid), that is not contested or denied by the Designated Paying Agent (i.e., not reasonably believed to be incorrect or fraudulent) and that is not subject to appeal or grievance procedures.

1.6 "Coordination of Benefits" means allocation of responsibility between two or more Payors to pay for health care services provided to the same Enrollee.

1.7 "Copayment" means an Enrollee's share of costs for Covered Services under a Payor Plan, including cost sharing expressed as coinsurance and deductibles under such Payor Plan.

1.8 "Covered Services" means those health care services and supplies that are (i) Medically Necessary, (ii) covered under a Payor Plan and (iii) to be provided to Enrollees by a Provider Panel pursuant to a Master Agreement. Covered Services are limited to the most appropriate, supply or level or care that is consistent with professionally recognized standards of medical practice within the Service Areas and Applicable Policies and Procedures.

1.9 "CPT" means the appropriate published edition of Current Procedural
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Terminology, a listing of descriptive terms and identifying codes for reporting
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medical services and procedures performed by health care providers, including all updates to such listing.

1.10 "Credentialing" means the process by which THP or Payor, or any designee of THP or Payor, certifies or recertifies the clinical credentials of THP Providers or Provider Affiliates.

1.11 "Designated Covered Services" means those Covered Services identified in Exhibit 1 attached to and made a part of this Agreement to be provided to
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Enrollees by Provider or Provider Affiliates pursuant to this Agreement.

1.12 "Designated Paying Agent" means the party designated in the Master Agreement as responsible for paying Payee for Designated Covered Services provided to Enrollees by Providers under the applicable Payor Plan.

1.13 "Drug Formulary" means the applicable listing of medications eligible for coverage as Covered Services under any prescription medication benefit offered in conjunction with a Payor Plan that is created, published and updated by THP or Payor.

1.14 "Emergency Care" means, with respect to each Payor Plan, emergency health care services as defined and determined in accordance with the terms of such Payor Plan or Applicable Policies and Procedures. The attending health care provider is exclusively responsible for making medical determinations and treatment decisions; however, payment for health care services rendered will be conditioned on (a) whether timely notification of the delivery of Emergency Care has been given to THP or Payor, if required under the applicable Payor Plan or Master Agreement and (b) THP's or Payor's subsequent review and determination as to whether such services constitute Covered Services under the applicable Master Agreement and are consistent with professionally recognized standards of practice within the Service Area and Applicable Policies and Procedures, Payee may appeal claims for payment of such services that are denied by THP through those Applicable Policies and Procedures related to THP Provider appeals.

1.15 "Enrollee" means a person covered under a Payor Plan who is entitled to the provision of Covered Services by a Provider Panel pursuant to a Master Agreement.

1.16 "Excluded Services" means any health care services, including a Covered Service, that are not Designated Covered Services. Excluded Services rendered by provider to Enrollees are not to be compensated by THP or any Payor under this Agreement.

1.17 "Exhibit" means an exhibit so designate that is numbered and attached to this Agreement. Each Exhibit is incorporated into this Agreement.

1.18 "Fee Schedule" means the reimbursement schedule that may be agreed upon by Payee and THP subsequent to execution of this Agreement in accordance with Section 14.3.

1.19 "List of Addenda" means the list of Addenda attached to and made a part of this Agreement as Exhibit 2.

1.20 "Master Agreement" means an agreement between a Payor and THP that describes the terms and conditions under which THP will arrange for a Provider Panel to provide Covered Services to Enrollees under a Payor Plan and describes the terms and conditions under which such services shall be provided. If THP has developed and offered such Payor Plan to Payor, the Master Agreement shall also set forth the adoption or implementation of such Payor Plan by Payor and reference or describe the terms and conditions of such Payor Plan.

1.21 "Medical Director" means a physician duly licensed to practice medicine who is employed by or under contract with THP or Payor to monitor the provision of Covered Services to Enrollees.

1.22 "Medically Necessary" or "Medical Necessity" means or refers to Covered Services furnished by a Panel Provider or other health care provider that are determined to be medically necessary and appropriate pursuant to, in accordance with, and in the manner provided by the terms of the applicable Payor Plan, Master Agreement, and Applicable Policies and Procedures.

1.23 "Panel Provider" means, with respect to each Provider panel, each THP Provider that is assigned to such Provider Panel by THP pursuant to Section 5.1.

1.24 "Payee" means, with respect to each Payor Plan, the person or entity designated as the "Payee" in the Addendum identifying such Payor Plan. The Payee shall either be Agent, who shall receive and disburse payments from the Designated Paying Agent on behalf of all Providers and Provider Affiliates, or the provider who shall receive and disburse payments from the Designated Paying Agent for those Designated Covered Services provided by such Provider or Provider Affiliates to Enrollees. If Provider is designated Payee in an Addendum, Provider may change such designation to Agent by notifying THP of such change in writing, such change to take effect on the later of the next payment date following receipt of such notice or thirty (30) days following receipt of such notice.

1.25 "Payor" means an employer, insurance company, health maintenance organization, health plan, managed care organization, prepaid health services organization or other person, group or entity that adopts, implements, establishes, manages, administers or maintains a Payor Plan. To the extent such organization contracts with or designates a third party administrator or other entity to administer or assist in the administration of a Payor Plan, such administrator shall be deemed a Payor with respect to such Payor Plan.

1.26 "Payor Plan" means any benefit plan or program adopted, implemented, established, maintained or administered by a Payor for the purpose of providing, arranging for the provision of or making available health care services to participants in such plan or program.

1.27 "Primary Care Provider" means any THP Provider who (i) is designated as a primary care provider in his/her provider agreement with THP and (ii) is designated as a primary care provider by THP or Payor when assigned to a Provider Panel.

1.28 "Prior Authorization" means authorization of health care services for coverage as Designated Covered Services by THP or Payor prior to the Enrollee obtaining such services. Requests for Prior Authorization will be denied if THP determines that the health care services that are proposed for coverage are (a) not included as Covered Services under the applicable Master Agreement, (b) not Medically Necessary, (c) not Designated Covered Services or (d) in conflict with Applicable Policies and Procedures.

1.29 "Provider" means each health care provider that is a member of Agent's THP Network during the term of this Agreement.

1.30 "Provider Affiliate" means any individual health care provider that is (i) employed by or under contract with Provider, (ii) licensed, certified, trained or otherwise qualified to provide Designated Covered Services to Enrollees, (iii) Credentialed to provide Designated Covered Services by THP or Payor and (iv) authorized by THP to provide Designated Covered Services to Enrollees on behalf of Provider under this Agreement.

1.31 "Provider Panel" means those THP Providers who are authorized by THP or Payor to provide Covered Services to Enrollees under a Payor Plan pursuant to the terms of a Master Agreement.

1.32 "Referral" means the act and process through which THP or a THP Provider refers an Enrollee to a Panel Provider to obtain Covered Services.

1.33 "Service Area" means the geographic area served by a Provider Panel as established and identified from time to time pursuant to a Payor Plan, Master Agreement and/or Applicable Policies and Procedures.

1.34 "State" means any state of the United States of America in which Provider is to provide Designated Covered Services to Enrollees under this Agreement and, where appropriate, any department, agency, bureau or other subdivision thereof.

1.35 "TennCare" means the program administered by the State of Tennessee (currently pursuant to waiver granted by the Health Care Financing Administration, United States Department of Health and Human Services) under which the State pays a monthly prepaid capitated amount to managed care organizations for rendering or arranging necessary health care services to eligible persons, and any successor program implemented by the State.

1.36 "THP Provider" means a physician, other individual health care provider, hospital or other health care facility licensed, certified, trained or otherwise qualified to provide one or more Covered Services, or an independent practice association or medical group, each of whose members is licensed, certified, trained or otherwise qualified to provide one or more Covered Services, who contracts with THP to provide one or more Covered Services to Enrollees. Provider Affiliates shall not be deemed THP Providers for purposes of this Agreement and shall have the right to provide Designated Covered Services to Enrollees pursuant to this Agreement only as authorized under Section 2.3.
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ARTICLE II

Obligations of Provider, Agent and Payee

2.1 Participation in Provider Panels. Provider shall serve as a member of and participate in each Provider Panel to which Provider is appointed by THP pursuant to Section 5.1. The obligations of Provider under this Article II
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shall be separately applicable to each Payor Plan served by a Provider Panel to which Provider is appointed.

2.2 Services. Consistent with sound medical practice and in accordance with professionally recognized standards of medical practice in the Service Area for rendering quality medical care, Provider shall provide Designated Covered Services to those Enrollees entitled to receive such services from Provider under the terms of this Agreement and the applicable Master Agreement and Payor Plan. In providing such Designated Covered Services to Enrollees, Provider shall observe and comply with Applicable Policies and Procedures.

2.3 Provider Affiliates.

2.3.1 Designated Covered Services. Provider shall have the right to provide Designated Covered Services to Enrollees through one or more Provider Affiliates only if authorized to do so in writing by THP. THP may revoke such consent if the Provider Affiliate fails to comply with the terms and conditions of this Agreement imposed on Provider Affiliates. If requested by THP, each Provider Affiliate will execute and deliver to THP the form of Agreement, Release and Immunity attached to this Agreement as Exhibit 3. Where
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appropriate, all references to Provider in this Agreement shall be deemed to include all Provider Affiliates. Provider shall not authorize, permit or allow any Designated Covered Services to be delivered or provided by anyone other than Provider or a Provider Affiliate.

2.3.2 Payment of Provider Affiliates. Payee or Provider (as may be agreed between them) shall be solely and exclusively responsible for compensating all Provider Affiliates who provide Designated Covered Services to Enrollees under this Agreement and Payee and Provider shall indemnify and hold THP and the applicable Payor harmless from any liability, cost or expense related to or arising from any claim for payment or other compensation by a Provider Affiliate made against THP or such Payor. The sole and exclusive obligation of THP or any Payor to pay for Designated Covered Services rendered by Provider or any Provider Affiliate under this Agreement shall be to make payments directly to Payee pursuant to Section 4.1.

2.3.3 Provider Responsibility for Related Provider Affiliates. Provider shall be solely and legally responsible for the quality of Designated Covered Services or any other health care service that any related Provider Affiliate renders to Enrollees and for ensuring that Designated Covered Services provided by a related Provider Affiliate are within the scope of the related Provider Affiliate's license and training and meet professionally recognized standards of practice within the Service Area. For purposes of this Agreement, the term "related Provider Affiliate" shall mean a Provider Affiliate who is employed by provider or, in the case of a Provider that is an institution or facility, who is authorized by the bylaw, rules or regulations of such institution or facility to provide professional services to Enrollees at or on behalf of such institution or facility.

2.4 Referral, Prior Authorization and Managed Care Requirements. To the extent applicable to Provider, compensation for health care services is limited to Designated Covered Services rendered by provider which have been authorized by Referral and, when required under the Payor Plan or Master Agreement, have been rendered after Prior Authorization has been given by THP or Payor. Provider shall abide by Applicable Policies and Procedures governing Referrals, Prior Authorization, utilization management, and concurrent, retrospective and prospective review of Designated Covered Services. It is Provider's responsibility to follow Applicable Policies and Procedures and to provide sufficient information and reports in a timely manner for THP or Payor to complete its reviews.

2.5 Excluded Services. In order for Payee to be reimbursed by and Enrollee for Excluded Services, Provider must advise the Enrollee in writing, prior to providing Excluded Services to the Enrollee, that the services are not covered by this Agreement, will not be paid for by THP or Payor and that the Enrollee will be responsible for paying the Provider directly for such services. Further, if an Enrollee requests such Excluded Services, Enrollee must acknowledge in writing, in advance of the provision of services, that neither THP nor Payor shall be responsible for the payment of such services. Subject to the above requirements, Provider shall have the right to separately bill an Enrollee for Excluded Services.

2.6 Drug Formulary. Provider shall comply with the medication prescribing and dispensing guidelines set forth in the Drug Formulary applicable to each Payor Plan.

2.7 Accessibility of Designated Covered Services.

2.7.1 Provider Location. Provider must at all times maintain his/her/its primary office or location within the county and State identified as Provider's primary location on Exhibit 4.

2.7.2 Accessibility. Except as provided in Subsection 2.7.3,

Designated Covered Services shall be available and accessible to Enrollees from Provider during reasonable hours of operation, with provision for after-hour services, if applicable. If Provider is required to provide Emergency Care or any other Designated Covered Service as a full-time service, such service shall be available and accessible 24 hours a day, 7 days a week. Enrollees shall have access to Designated Covered Services that meets all requirements of each Payor Plan and Applicable Policies and Procedures. Under no circumstances

shall an Enrollee's access to care be less than access to care of other patients of Provider. Provider shall monitor the accessibility of care to enrollees, including where appropriate, average time to schedule an appointment and waiting time at scheduled appointments, and shall initiate corrective action where necessary to improve quality of care in accordance with that level of medical care recognized as acceptable professional standards in the Service Area and to comply with Applicable Policies and Procedures regarding same.

2.7.3 Closing or Limiting of Practice. Subject to the requirements of Section 3.1, if a Provider is an individual health care professional, then, upon the occurrence of exceptional circumstances, such as disability or illness or the closing of Provider's practice to all new patients, Agent or Provider may request that Provider not be required to accept additional Enrollees or other adjustments to his/her status as a THP Provider by giving written notice of such request to THP as soon as possible and, where an upcoming change in status is known or reasonably should be known to Provider in advance, at least sixty (60) days in advance of the effective date of such requested change. THP will then work with Agent and Provider to determine what accommodation, if any, can be made in Provider's obligations under this Agreement. Where an accommodation and resulting limitations are approved by THP, THP shall notify other THP Providers who are members of the applicable Provider Panels if deemed necessary for the proper operation of the network. Should Provider wish to have any limitations removed, Agent and Provider shall make that request in writing to THP, and THP shall consider when and on what terms the limitations may be removed. If THP and Provider cannot agree on an accommodation, THP may require that Provider be removed from Agent's THP Network as provided in Section 7.3. If removal occurs, any Enrollees assigned to such Provider shall be assigned to one or more other Providers who are members of the appropriate Provider Panel as provided in Section 7.8.

2.8 Treatment of Enrollees. Provider, Provider Affiliates and Provider's staff and administrative personnel shall endeavor to maintain a high level of customer service and satisfaction for each Payor Plan served by Provider as a member of a Provider Panel.

2.9 Reporting of Actions Against Provider or a Provider Affiliate. Agent or Provider shall notify THP within ten (10) calendar days of the occurrence of any of the following, such notice to include a brief description of such occurrence and the reasons therefor:

2.9.1 any action taken to restrict, suspend or revoke Provider's and/or a Provider Affiliate's license to provide any Designated Covered Service required by this Agreement;

2.9.2 any suit or arbitration action brought against Provider and/or a Provider Affiliate for malpractice;

2.9.3 any felony information or indictment or investigation instituted by the State or any federal agency with regulatory authority over Provider or any Provider Affiliate;

2.9.4 any disciplinary proceeding or action against Provider and/or a Provider Affiliate before an administrative agency of any Statue or any federal agency with regulatory authority over Provider or any Provider Affiliate;

2.9.5 any cancellation or material modification of the professional liability insurance required to be carried by Agent, Provider or any Provider Affiliate;

2.9.6 any action taken to restrict, suspend or revoke the participation of Provider or any Provider Affiliate in Medicare, CHAMPUS or TennCare;

2.9.7 any disciplinary action or action to terminate or restrict privileges at any hospital or other health care facility taken by such facility against Provider or any Provider Affiliate; and

2.9.8 any other event or situation which might materially affect the ability of Agent, Provider or any Provider Affiliate to carry out its, his or her duties and obligations under this Agreement.

Agent or Provider shall provide THP with a written summary of the final disposition of any such occurrence.

2.10 Quality of Covered Services

2.10.1 Warranties and Responsibilities. Provider shall be solely and legally responsible for the quality of Designated Covered Services or any other health care service that Provider renders to Enrollees and Agent and Provider specifically warrant and represent to THP as follows, with Agent's representations and warranties applying to all Providers:

(a) The Designated Covered Services that are to be furnished by Provider pursuant to this Agreement are and shall be within the scope of Provider's license and training, and Provider is and at all times during the term of this Agreement shall be professionally or otherwise qualified to provide such Designated Covered Services to Enrollees;

(b) Designated Covered Services provided by Provider under this Agreement shall meet professionally recognized standards of practice within the Service Area. Designated Covered Services shall be provided to Enrollees by Provider under this Agreement in accordance with the terms of the relevant Payor Plan, Master Agreement and this Agreement, and in compliance with Applicable Policies and Procedures, in the same manner and in accordance with the same standards of patient care afforded to Provider's other patients.

2.10.2 Cooperation With Utilization Management and Quality Improvement Programs. Agent and Provider agree to cooperate with and participate in, and cause all Provider Affiliates to cooperate with and participate in, the utilization management and quality improvement programs and procedures established by THP or Payor which are intended to measure and manage the costs, utilization and quality of Designated Covered Services provided by Provider and Provider Affiliates. Such programs shall be developed and established by THP or Payor and shall be implemented in accordance with the terms of Applicable Policies and Procedures which may be modified from time to time by THP or Payor to meet the objectives of such programs. Provider shall provide THP or Payor with summaries of or access to records maintained by Provider as required in connection with such programs, subject to any confidentiality requirements under the laws of the State. Provider shall not, however, be required to furnish THP or Payor with access to or otherwise disclose records, files, proceedings or other materials prepared or maintained by a medical review or peer review committee to the extent prohibited by law. Provider authorizes on behalf of Provider and each Provider Affiliate, in accordance with Subsection 2.12.5 of this Agreement, the release to and by THP and Payor of information necessary to carry out the utilization management and quality improvement programs of THP or Payor.

2.10.3 Compliance with Applicable Policies and Procedures. Provider and all Provider Affiliates shall abide by and comply with Applicable Policies and Procedures, including those applicable to Credentialing, Prior Authorization, prospective, concurrent and retrospective Medical Necessity review, utilization management, quality management, peer review, THP corrective action plans, Enrollee appeals and Provider grievance procedures.

Provider and all Provider Affiliates shall comply with all final determinations of THP and/or Payor peer review, Provider appeal and Enrollee grievance processes.

2.12 Record Keeping and Reporting Requirements.

2.12.1 Records. Provider shall maintain current medical and other records in accordance with accepted standards of all information relevant to Designated Covered Services provided to Enrollees, including, but not limited to services performed, charges, dates of service, medical/patient charts, prescription orders, diagnoses, documentation of orders for laboratory and other tests and test results, Referrals and other information necessary for the evaluation of the nature, necessity, quality, quantity, appropriateness and timeliness of such services.

2.12.2 Maintenance of Records. Provider shall maintain, for at least five (5) years after the date of the delivery of services and readily make available to THP, the State, the United States Department of Health and Human Services, and any other government agency with regulatory authority, medical and health records of Enrollees receiving Designated Covered Serviced and all related administrative records. Upon request, THP and such agencies shall have access at reasonable times to the books, records, and papers of Provider relating to Designated Covered Services, to the cost thereof and Copayments received from Enrollees.

2.12.3 Reporting Requirements. Provider shall comply with the encounter, clinical information or other reporting requirements of each Master Agreement and Payor Plan and shall utilize such encounter reporting forms as required by THP or Payor. Forms used in submitting such information shall be in a format approved by THP. Generally, HCFA 1500 and UB-92 forms will be approved unless otherwise required by the Payor Plan or an Addendum.

2.12.4 Confidentiality of Information. Agent and Provider shall assure that all material and information, in particular information relating to Enrollees, which is provided to or obtained by or through Provider's performance under this Agreement, whether verbal, written, taped, computerized, or otherwise, shall be maintained and treated as confidential information to the extent confidential treatment is required under State and federal laws. Neither Agent nor Provider shall use any such information in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Agreement. Except as expressly authorized by this Agreement, all information as to personal facts and circumstances concerning Enrollees obtained by Agent or Provider shall be treated as privileged communications, shall be held confidential and shall not be divulged without the written consent of the Enrollee, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical or other forms which does not identify particular Enrollees. The use or disclosure of information concerning Enrollees by Agent, Provider, or any Provider Affiliate shall be limited to purposes directly connected with the administration of this Agreement.

2.12.5 Access to Confidential Information. Subject to all applicable privacy and confidentiality laws, rules, and regulations (including those requiring patient consent where applicable), the medical records of Enrollees and administrative records related thereto shall be made available to each Panel Provider and to THP, any appropriate Payor, and their respective agents and representatives.

Agent and Provider shall allow THP and the appropriate Payor to inspect, audit and duplicate any and all data, billings, and other records maintained on Enrollees in such Payor's Plan. Inspection, audit and duplication shall occur after reasonable notice during regular working hours. Provider acknowledges that THP's quality management program includes provisions for records audit, peer review, Provider appeals and Enrollee grievance procedures. Certain records of THP with respect to quality management shall be made available for review by applicable State and federal regulatory agencies and by representatives of Payors if required by law or the terms of the Master Agreement. Ownership access to Agent's or Provider's records of Enrollees shall be controlled by applicable laws of each State and this Agreement. THP and each State and federal regulatory agencies shall also have access to such records as required by law and pursuant to the terms of Article VIII of this Agreement. Each Enrollee shall also be allowed access to his/her medical record as required by law.

2.12.6 Patient Consents. To the extent required by law, the party requesting access to patient records shall be required to furnish Provider with an appropriate patient consent form in order to obtain such access.

2.13 Insurance.

2.13.1 Professional Liability. During the term of this Agreement and for a period of three (3) years after termination, Agent and each Provider shall each maintain (and require all Provider Affiliates to maintain) (through regular or tail coverage) professional liability insurance covering the insured in amounts equal to $1,000,000 per claim and $3,000,000 in the aggregate of all claims per policy year. Agent, Provider and each Provider Affiliate will deliver to THP certificates of insurance or other evidence of insurance reasonably satisfactory to THP indicating that this insurance is in effect. THP shall be provided not less than 30 days' advance written notice prior to any cancellation, non-renewal or material change in this coverage and may require a certificate from the insuror to such effect.

2.13.2 General Liability. During the term of this Agreement, Agent, Provider and each Provider Affiliate shall each maintain general liability insurance with reasonable limits acceptable to THP against claims for damages arising as a result of personal injury or death caused, in whole or in part, by any act or omission of the insured or any of its agents, servants and employees.

2.14 Non-Discrimination. Neither Agent, Provider nor any Provider Affiliate shall discriminate against Enrollees solely on the grounds that the Enrollee files a complaint against Agent, Provider, a Provider Affiliate or THP, or because of the Enrollee's race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, physical handicap, or medical condition.

2.15 Reporting Changes of Provider Information. Agent or Provider shall immediately notify THP, in writing upon, and where possible at least 30 calendar days prior to, any change in the address, business telephone number, business hours, tax identification number, license number and, if applicable, Drug Enforcement Agency registration number of Provider or any Provider Affiliate.

2.16 Credentialing Requirements. Provider and each Provider Affiliate shall, prior to providing Designated Covered Services under this Agreement, meet THP's or Payor's Credentialing requirements for each applicable Payor Plan and Master Agreement..

2.17 License Requirements. Provider and Each Provide Affiliate shall maintain all appropriate licenses, certifications, training and standards required by applicable State and federal laws for the providing of Designated Covered Services under this Agreement.

2.18 Non-Solicitation. Neither Agent, Provider, any Provider Affiliate nor any entity or person associated with Agent, Provider or any Provider Affiliate shall use any membership lists or other information obtained pursuant to this Agreement or as a THP Provider to solicit Enrollees in any way on behalf of any health plan other than the contract plan in which the Enrollee is enrolled. Such solicitation shall be a material breach of this Agreement.

2.19 Requirements for Submission of Claims by Provider. With respect to those Designated Covered Services that Payee is to be compensated for based on the submission of a Clean Claim, claims for payment shall be paid only if submitted to Designated Paying Agent within 90 days after the date the Designated Covered Services were rendered and only after the Designated Paying Agent has determined that a claim is a Clean Claim. Neither Agent nor Provider shall seek payment from Enrollees for claims for Designated Covered Services submitted to the Designated Paying Agent except with respect to the applicable Copayment amount. Forms used in submitting claims shall be in a format approved by the Designated Paying Agent (generally HCFA 1500 and UB-92 forms are in an approved format). Claims shall include, at a minimum, the following information if applicable: date of service, patient name, Enrollee identification number, Provider Panel identification number, Referring Primary Care Physician's name and identification number, number of service units, diagnosis, billed dollar amount, Copayment amount (if applicable), CPT codes and procedure description.

2.20 Legal and Professional Responsibility. Provider shall perform all of Provider's duties and obligations under this Agreement in accordance with all applicable laws, rules and regulations, including those made applicable by reason of any Payor Plan or Applicable Policies and Procedures. To the extent Provider is an individual practitioner, Provider agrees that he/she has an independent professional responsibility to his/her patient/Enrollee, and no action by agent, THP or Payor pursuant to this Agreement, any Payor Plan or Master Agreement or Applicable Policies and Procedures shall in any way absolve Provider or any Provide Affiliate from, or in any way restrict or inhibit his/her performance of, professional duties and obligations due a patient/Enrollee.

2.21 Transfer. If Provider is an individual practitioner, then, if after reasonable efforts a satisfactory Provider-patient relationship is not established and maintained between Provider and any Enrollee, either Provider, Agent, such Enrollee, THP or the Payor may request that the Enrollee's care be transferred to another THP Panel Provider. No such change shall be effective, however, without prior express approval of THP or Payor which shall not be unreasonable delayed or withheld. An individual Provider shall not be required to accept or continue treatment of an Enrollee with whom the provider cannot, after reasonable efforts, establish or maintain a professional relationship.

2.22 Confidentiality and Return of Proprietary Information. Agent and Provider covenant to maintain the confidentiality of any information and documents relating to or prepared pursuant to this Agreement, any Master Agreement or any Payor Plan and all information or documents supplied to Provider by THP or Payors pursuant to this Agreement, including, without limitation, Applicable Policies and Procedures, and shall not copy such documents or use such information or documents for any purpose other than discharging Provider's duties under this Agreement. Agent and Provider shall take reasonable precautions to prevent the unauthorized disclosure of all such information and documents. THP consents to such disclosure to Provider Affiliates as is necessary for Provider to arrange coverage by or otherwise engage Provider Affiliates to provide Designated Covered Services in accordance with this Agreement. Agent and Provider agree to promptly return any THP or Payor provider manual and any other THP or Payor proprietary documents or material upon termination of this Agreement, including any copies thereof, in Provider's or any Provider Affiliates possession or control.

2.23 Referrals. Consistent with sound medical practice and in accordance with accepted community professional standards within the Service Area, to the extent required by the Payor Plan, Master Agreement or Applicable Policies and Procedures, Provider shall Refer Enrollees only to other Panel Providers. Provider shall comply with all requirements of each Payor Plan, Master Agreement and Applicable Policies and Procedures for notification of THP or the Primary Care Provider with respect to Referrals for Emergency Care or other Covered Services to a health care provider that is not a Panel Provider.

2.24 No Right to Refuse Designated Covered Services. Except as provided below and in Subsection 2.7.3 and Section 2.21, Provider shall not refuse to provide Medically Necessary Designated Covered Services to any Enrollee provided the Enrollee has been certified by THP or Payor as eligible to receive such Designated Covered Services and THP or Payor has given its prior authorization for the provision of such Designated Covered Services when required under the terms of the Payor Plan, Master Agreement or Applicable Policies and Procedures. Provider shall not refuse to provide Designated Covered Services to an Enrollee for nonmedical reasons other than failure to pay any applicable Copayment.

2.25 Marketing. THP and Payor may include references to Agent, Provider, Provider Affiliates and their business addresses and telephone numbers in any Payor Plan material provided to Enrollees in any marketing or solicitation campaigns initiated by THP or Payor and in any materials used by THP or Payor in informing other Panel Providers of panel affiliations. All marketing, advertising and publicity relative to the solicitation of Payor Plans will be conducted by THP or the appropriate Payor.

2.26 Addenda. To the extent any of the obligations, responsibilities or rights of THP, Agent, Provider or any Provider Affiliate shall be expanded, limited or otherwise affected by the terms of any Addendum, then the terms of such Addendum shall control, and, in the event any of the provisions or terms of an Addendum shall conflict with or be inconsistent with the terms and conditions of this Agreement, the terms and provisions of such Addendum shall control.

2.27 Compliance with Payor Plans. Provider and Provider Affiliates will comply with all requirements imposed on providers under Payor Plans and will not implement any policy or practice designed or intended to circumvent the obligation of any Enrollee to pay any Copayment.

2.28 Credentialing Information. It may be necessary for THP to perform Credentialing of Provider and Provider Affiliates, and each individual Provider and Provider Affiliate that THP elects to Credential shall be required to execute the Agreement Release and Immunity authorizing THP to obtain Credentialing information from third parties in the form of Exhibit 3 attached to this Agreement.

2.29 Agent Authorization. Provider shall appoint Agent as Provider's agent and attorney-in-fact and shall enter into an appropriate provider agreement with Agent pursuant to which Agent shall be authorized to exercise, waive and represent the rights and interest of Provider under this Agreement to the extent specified in Section 5.4. Each Provider shall be required to execute the Agreement, Release and Immunity attached as Exhibit 3 confirming that Provider has so authorized Agent and shall execute and deliver to THP such further documents or instruments confirming such authorization as may be requested from THP from time to time during the term of this Agreement.

ARTICLE III

Duties and Obligations of Agent

3.1 Maintenance of Network. Throughout the term of this Agreement, Agent shall be responsible for including and maintaining in Agent's THP Network that number of Providers sufficient for meeting all requirements for the provision of Designated Covered Services to Enrollees under the terms of this Agreement including, without limitation, range and scope of Designated Covered Services and geographic coverage in the Service Area meeting THP requirements. Subject to the preceding requirements, Agents shall have the right and authority to add or delete Providers from Agent's THP Network subject to the prior approval of THP, which shall not be unreasonably withheld. Agent and Providers recognize that the addition or deletion of Providers to the Network may require the reassignment of Enrollees to one or more other Providers and that the terminated

Provider shall be required to continue to provide Designated Covered Services to Enrollees subsequent to termination from Agent's THP Network to the extent required by the terms of this Agreement. Any new Providers added to Agent's THP Network from and after the date of this Agreement must be approved in writing by THP and must be Credentialed and otherwise authorized to provide Designated Covered Services to Enrollees under this Agreement in advance and in writing by THP. Exhibit 4 shall be amended to reflect the addition or deletion of
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Providers from Agent's THP Network. In any instance where the Agent's THP Network is considered an exclusive network by geography or service, Agent's THP Network shall include a sufficient number of Providers to accommodate the number of Enrollees to be assigned. Such defermentation shall be at the sole judgment of THP. THP reserves the right to recruit and credential other providers should Agent's THP Network be deemed insufficient.

3.2 Administrative Responsibilities. In addition to its other duties, obligations and responsibilities under this Agreement, Agent shall perform and be responsible for those other administrative and ministerial responsibilities described in Exhibit 5 attached to this Agreement.

3.3 Administrative Compliance. Agent will perform on a timely basis all administrative and ministerial duties required under this Agreement and Applicable Policies and Procedures in order to ensure compliance by Agent and all Providers with all administrative requirements imposed on Agent and Providers under this Agreement. Agent will, from time to time and without notice, permit THP, its employees and agents, to inspect Agent's premises and records in order to ensure compliance by Agent and Providers with all administrative requirements under this Agreement. Agent will participate in and abide by decisions effected by THP in resolution of Provider and Enrollee grievances as specified in Applicable Policies and Procedures. Agent will provide THP on a timely basis, at Agent's sole cost and expense, with all data and information required to be furnished by Provider to THP under the terms of this Agreement to the extend not furnished on a timely basis by Provider for complying with the requirements of this Agreement imposed on Providers and Agent.

3.4 Provider Contracts. Agent shall be responsible for entering into a binding legal agreement with each Provider pursuant to which Provider agrees to become a member of Agent's THP Network and authorizes Agent to serve as the agent and attorney-in-fact for such Provider and to enter into, execute and exercise all rights of Provider under rights of Provider under this Agreement on behalf of Provider and to bind Provider to all terms, conditions and obligations imposed on Provider under the terms of this Agreement. All provider agreements shall conform in form and content to the requirements of this Agreement and each Payor Plan covered by this Agreement. A true and accurate copy of Agent's form of provider agreement shall be submitted by Agent to THP for review and approval and Agent will furnish copies of its executed provider agreements for Agent's THP Network to THP upon request.

3.5 Representations and Warranties of Agent. Agent hereby represents and warrants to THP as follows:

3.5.1 Agent has the legal right, power and authority to execute and deliver this Agreement on behalf of each Provider listed on Exhibit 4 and
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to legally bind such Provider to the terms, conditions and obligations of the Agreement as the authorized agent and attorney-in-fact for such Provider to the same extent as if this Agreement had been executed and delivered by such Provider.

3.5.2 If Agent is designated as Payee, under the terms of its agreement with each Provider listed on Exhibit 4, Agent is authorized to receive payment from the Designated Paying Agent for all Designated Covered Services provided by such Provider to Enrollees, and Agent shall indemnify and hold the Designated Paying Agent, THP and the appropriate Payor, and each of their officers, employees and agents harmless from and against any claims made by Provider for payment for services rendered pursuant to this Agreement.

3.5.3 Each Provider listed on Exhibit 4 has such licenses, certifications and other qualifications as are necessary to meet THP's Credentialing requirements and will maintain all such licenses, certifications, and qualifications for so long as such Provider is a member of Agent's THP Network and is providing Designated Covered Services under the terms of this Agreement.

3.5.4 Each Provider listed on Exhibit 4 has appointed Agent as its agent and attorney-in-fact to exercise, waive and represent the rights and interests of such Provider under this Agreement, including, without limitations, exercising the following rights on behalf of each Provider:

(i) if Agent is designated as Payee, to receive and disburse payments for furnishing of Designated Covered Services and agree to the Fee Schedule as provided in Section 14.3;

(ii) to pursue grievance procedures;

(iii) to accept and execute Addenda adding Payor Plans or amending this Agreement;

(iv) to pursue arbitration remedies; and

(v) to exercise rights of extension or termination of this Agreement.

3.5.5 To the extent Agent shall add a Provider to Agent's THP Network from and after the date of this Agreement, all representations and warranties of Agents contained in this Section 3.5, shall be applicable to such Provider and to Agent's rights, powers and authorities under its agreement with such Provider.

3.5.6 Risk Assumption. Agent has the legal right and all licenses or certificates required by law to assume all risks imposed on Agent under this Agreement and its arrangements with Providers.

3.5.7 Compliance. Agent shall at all times comply with all federal, State, and local laws, rules and regulations applicable to Agent's activities and responsibilities under this Agreement and under its agreements with Providers.

ARTICLE IV

Provider Compensation

4.1 Compensation to Provider. In consideration for the Designated Covered Services which any Provider or any Provider Affiliate renders to Enrollees pursuant to this Agreement, the Designated Paying Agent shall reimburse Payee on behalf of Providers and Provider Affiliates in accordance with the following provisions and all Addenda. The Master Agreement shall specify whether THP or Payor shall be the Designated Paying

Agent. Where any Addendum sets forth a compensation arrangement which is inconsistent with the following provisions, the terms of the addendum shall govern.

4.1.1 Method and Amount of Compensation. Payee shall accept as payment in full for Designated Covered Services rendered by any Provider or any Provider Affiliate of Enrollees under a Payor Plan and Master Agreement based upon and in accordance with the method and amounts payable set forth in the Addendum referencing such Payor Plan and Master Agreement, plus Copayments payable solely by Enrollees in accordance with such Payor Plan. Each Addendum shall provide for payments from the Designated Paying Agent based on the Fee Schedule or shall set forth such other method of compensation as shall be applicable to the Payor Plan described in such Addendum.

4.1.2 No payment for Excluded Services. Except as provided in Section 2.5, neither an Enrollee, the Payor under the Payor Plan, not THP shall be liable for Payment for (1) any Designated Covered Service determined by THP to be not Medically Necessary, (2) any Designatee Covered Service for which Prior Authorization and/or Referral is required under the applicable Payor Plan as a prerequisite of coverage but which is not obtained or (3) any Excluded Services.

4.1.3 Time Requirements for Payment of Claims by THP. To the extent an Addendum shall require that THP, as the Designated Paying Agent, compensate Provider on a fee for service or other basis requiring the submission of claims as a condition to payment, THP shall process and reimburse Provider's claims for Designated Covered Services to Enrollees consistent with Applicable Policies and Procedures and in accordance with terms of the pertinent Master Agreement. THP shall pay ninety-five (95%) of Clean Claims within 30 calendar days of receipt of such claim by THP and will pay the remaining five percent (5%) of Clean Claims within forty (40) calendar days of receipt by THP. THP shall process within sixty (60) days of receipt all claims submitted by Agent or Provider. The term "process" means that THP will make a determination as to whether the submitted claim is a Clean Claim or advise Agent or Provider that a submitted claim is (i) a denial claim and specify all reasons for denial or (ii) not a "Clean Claim" due to insufficient information and/or documentation that is needed from the Agent or Provider in order to allow or deny the claim. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing and payment under this Subsection 3.1.3. The denial of a
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claim or the determination that a claim is not a Clean Claim shall not affect the timing of payment of any other claim determined to be a Clean Claim.

4.1.4 Time Requirements for Payment of Fixed Amount Payment by THP. To the extent an Addendum shall require that the Designated Paying Agent compensate Payee on a monthly fixed fee basis or any other basis that does not require the submission of a claim as a condition to payment, the Designated Paying Agent shall make such payment to Provider by no later than (i) the tenth (10/th/) day of the calendar month or (ii) if THP is the Designated Paying Agent within five (5) business days after receipt of the capitation payment or other fixed compensation payment by THP from the Payor. If an Enrollee becomes eligible for coverage under a Payor Plan on or before the fifteenth (15) day of a month, a full month's payment will be made retroactively during the subsequent month. There will be no retroactive payment for any Enrollee who becomes eligible after the fifteenth day of a month. If an Enrollee is disenrolled after the fifteenth day of a month, a full month's payment will be made with no retroactive adjustment. If an Enrollee is disenrolled on or before the fifteenth day of a month, a retroactive adjustment to the total monthly amount payable to Provider will be made during the subsequent month.

4.1.5 Payments by Payor as Designated Paying Agent. The time requirements for processing and payment of claims and of other amounts due Payee from a Payor, as the Designated Paying Agent, shall be determined by the Payor Plan and shall be set forth in the Addendum referencing such Payor Plan.

4.1.6 Payment of Providers and Provider Affiliates. All payments due Providers and all Provider Affiliates under this Agreement from the Designated Paying Agent shall be made directly to Payee, and Payee shall be solely responsible for paying or otherwise compensating all Providers and Payee or Provider shall be solely responsible for paying or otherwise compensating Provider Affiliates, as provided in Subsection 2.3.2.

4.1.7 Payment by Another THP Provider. Notwithstanding any other provision of Section 4.1 (or any of its subsections) to the contrary, when
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the Designated Paying Agent compensates another THP Provider on an all inclusive per diem, program or monthly fixed amount basis that makes such other THP Provider responsible for the payment of Designated Covered Services rendered to an Enrollee by Provider or any Provider Affiliate, Agent and Provider shall look solely to such other THP Provider for payment and shall not be entitled to payment from THP or the Payor Plan under this

Section 4.1 with respect to such services.

4.1.8 Appeal Rights. Agent shall have the right to grieve and appeal claims for payment of services furnished by Provider that are denied by THP through those Applicable Policies and Procedures related to THP Provider appeals.

4.1.9 Other Payment Requirements. Other billing and claims submission requirements may be included in the provider manual referenced in

Subsection 5.1.5 or in the appropriate Addendum.

4.2 Monitor Quality Management. THP shall monitor Agent's and Provider's quality management activities and compliance with THP's quality management policies and procedures. THP shall also monitor Agent's and Provider's compliance with its Credentialing and disciplinary policies and procedures. Agent, Provider and Provider Affiliates shall comply with any corrective action plans implemented by THP.

4.3 Enrollee Grievances. THP or the Payor, as determined by the terms of the Master Agreement, shall have primary and final responsibility for administering Enrollee grievance procedures.

ARTICLE V

Duties and Obligations of THP

5.1 Functions

5.1.1 Plan Administration. THP shall perform such administrative and management functions related to or required by the Payor Plan as are delegated to THP under the terms of any Master Agreement or Payor Plan, including, without limitation, claims payment and adjudication, Prior Authorization, utilization review, Credentialing, contracting and network administration, Provider and Enrollee grievances and appeals, and data collection and reporting. Administrative and management functions that are not delegated to THP shall be performed by Payor or is designee.

5.1.2 Contracting. THP intends to form and market a provider network consisting of THP Providers to Payors. THP shall enter into a Master Agreement with each Payor with respect to each Payor Plan, the Enrollees of which will be provided Covered Services by Panel Providers.

5.1.3 Selection of Provider Panels. THP shall assign those THP Providers selected by THP and approved by Payor to each Provider Panel that provides Covered Services to Enrollees under a Payor Plan. The determination of those THP Providers to serve on a Provider Panel shall be made by THP and/or Payor based solely upon criteria determined to be relevant or appropriate by THP or Payor, including ,without limitation, the Provider Panel's need for Designated Covered Services, the applicable Service Area and all Payor Plan requirements. THP may assign one or more Providers to a Provider Panel without assigning all Providers to such Provider Panel.

5.1.4 Removal from a Provider Panel. In the event a Provider is assigned to a Provider Panel, THP shall have the right to remove Provider from such Provider Panel (with or without cause) at any time after such assignment and such removal shall not be deemed to be a violation of this Agreement, nor shall such removal require any amendment to this Agreement; provided, however, any removal without cause shall require at least sixty (60) days advance notice to Agent and the Provider. Such removal shall be accomplished by THP sending Agent and Provider a written notice of Provider's removal from the Provider Panel with a brief explanation for the reasons for such removal. If a Provider has been assigned to a Provider Panel by reason of an Addendum to this Agreement, the removal of such Provider from the Provider Panel shall terminate such Addendum, and its provisions shall no longer be applicable to Provider from and after the date of such removal. THP may remove a Provider from a Payor Panel for cause (i) if directed to do so by Payor based on Payor's reasonable determination that such action may be necessary to protect the health or safety of Enrollee or (ii) for any other reason constituting cause for termination of a Provider under Section 7.2. THP may elect to remove a
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Provider from one or more Provider Panels without affecting Provider's status as a member of one or more other Provider Panels.

5.1.5 Provider Documents. THP shall furnish each Panel Provider with a provider manual that contains those Applicable Policies and Procedures that must be readily accessible to Provider in order to carry out Provider's responsibilities under the Agreement, together with a summary of the terms and conditions of each Master Agreement and Payor Plan that will include compensation rates and terms, identification of the Designated Paying Agent, payment terms, utilization review requirements, quality requirements, claims filing procedures and appeal and grievance procedures.

5.1.6 Enrollee Identification. THP or Payor will furnish Enrollees with appropriate identification cards indicating their participation in the appropriate Payor Plan and will provide an appropriate list of Enrollees in the Payor Plan to Panel Provides who are primary care case managers or when Payee is compensated on a monthly fixed fee basis or other method that does not require the submission of a claim as a condition to payment. THP or Payor will assist Agent and Provider in identifying Enrollees who are to receive Designated Covered Services under a Payor Plan.

5.1.7 Enrollee Eligibility Information. Agent and Provider acknowledge that Payor information furnished to THP, Agent or Provider regarding Enrollee eligibility may be inaccurate at the time Designated Covered Services are provided. In the event Enrollee eligibility information furnished by THP or Payor to Provider is inaccurate and a person THP or Payor identifies to be an Enrollee was not in fact an Enrollee at the time of such identification, THP or Payor shall notify either Agent of the Provider of such fact and the Designated Paying Agent shall not be responsible for payment for Designated Covered Services provided to such person. Neither THP nor Payor shall be responsible for payment of any services provided to an Enrollee from after the date such Enrollee is disenrolled from

the Payor Plan. Agent or Provider may bill disenrolled persons for services received after their

disenrollement date. THP or Payor shall have the right to retroactively disenroll an individual who may have been identified as an eligible Enrollee prior to the time of the rendering of a Designated Covered Service.

5.1.8 Determination of Designated Covered Services. The determination of whether a health care service is included in the definition of a Designed Covered Service shall be made by THP or Payor, subject to appropriate grievance and appeal rights. If Payee is compensated on a monthly fixed fee basis or any other method that does not require the filing of a claim as a condition to payment, the cost of all Designated Covered Services to be reimbursed on such basis shall be covered by such amount. Following the provision of the service, if Agent or Provider wishes to dispute the inclusion of the cost of the service and the medical costs to be paid out of such amount (whether on the basis that the service is not a Designated Covered Service or should be reimbursed on a fee for service basis), Agent shall so notify THP or Payor, as appropriate, in writing within thirty (30) days of the provision of the service. The parties shall make a good faith effort to negotiate mutually agreeable settlement. If the parties are unable to resolve the dispute by agreement within thirty (30) days thereafter, Agent may pursue grievance and appeal rights on behalf of Provider under Applicable Policies and Procedures. The provider manual shall contain a summary description of grievance and appeal rights including the manner in which such rights may be exercised and pursued by Agent.

5.2 Limitations on Master Agreements. No Master Agreement entered into by THP and a Payor shall contain any obligation of Agent or Provider other than those set forth in this Agreement, unless separately agreed to by Agent pursuant to an Addendum to this Agreement.

5.3 Utilization Management and Quality Improvement. THP shall provide Agent with written information concerning the utilization management and quality improvement programs administered by THP or Payor with respect to each Payor Plan for which a Provider is a Panel Provider and any modifications thereto. Agent shall be responsible for furnishing such information to Providers. THP will develop and market to Payors a utilization management and quality improvement plan for adoption as part of Payor Plans, based on the utilization management and quality improvements developed by THP, but THP shall have no obligation to require that such programs be included in a Payor Plan, such determination to be made by Payor.

5.4 Marketing. THP shall be responsible for marketing and promoting the provider network developed by THP to Payors and shall list and arrange for Payors to list the Provider as a Panel Provider in marketing and information developed and distributed by THP and Payor with respect to those Payor Plans for which the Provider is a Panel Provider. It a Provider is removed from a Provider Panel for any reason, THP shall be responsible for notifying the Payor, Enrollees and other Panel Providers of such removal.

5.5 Contractual Authority. THP shall have the authority to enter into Master Agreements with Payors to serve or establish Payor Plans. Agent and Providers agree that THP has the right to bind Agent and Provider to Payor Plans whose compensation schedule is equal to or greater than the Fee Schedule agreed upon by Agent and THP pursuant to Section 14.3 in effect at such time. THP will
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notify Agent not less than twenty (20) days in advance of the effective date of the execution of each Master Agreement if any Provider is to be assigned to the Provider Panel for the Payor Plan covered by such Master Agreement and will provide Agent with the summary of the terms and conditions of the Payor Plan described in Section 5.1.5.

5.6 Software. From time to time during the term of this Agreement, THP, at its option, may make available to Agent or Provider software and other information reporting systems owned or licensed by THP that are used by THP in the administration, reporting and processing of information, services and claims under this Agreement and under each Master Agreement. During the term of this Agreement, Agent or Provider shall have

the right to utilize such software and other proprietary information owned or licensed by THP without charge; provided, however, that Agent's and Provider's rights to use such software or other proprietary information shall terminate as of the time of termination of this Agreement. All software and proprietary information made available to Agent or Provider by THP under the terms of this Section 5.6 shall remain the sole and exclusive property of THP and nothing in this Agreement shall be construed as granting to Agent or Provider any rights of ownership or use to such software and proprietary information except as expressly provided in this Section 5.6. To the extent any hardware is necessary for the operation of any software of THP and such hardware is not owned by Agent or Provider, THP, at its sole option, may elect to make such hardware available to Agent or Provider during the term of this Agreement without charge. Upon termination of such Agreement, such hardware shall be returned by Provider to THP. THP shall have access to Agent's and Provider's premises during normal business hours in order to install, maintain and remove any such hardware or software.

5.7 Confidentiality of Medical Records. THP shall maintain the confidentiality of the medical records and information that either (i) are generated and developed by THP and are required to be kept confidential pursuant to the laws of the State, including TENN.CODE ANN (S) 63-6-219 or (ii) that are furnished to THP by Provider subject to confidentiality restrictions imposed by the laws of the State. THP shall not disclose such confidential information to third parties without advance written consent from the appropriate party or as required by law. This restriction on disclosure of medical information shall not apply to any proprietary or other information developed, maintained or owned by THP that THP is not required to keep confidential under the applicable laws of the State.

ARTICLE VI

Term

This Agreement will have an initial term of one (1) year and will renew automatically for successive one-year terms, unless earlier terminated as provided in Article VII.

ARTICLE VII

Termination Provisions

7.1 Termination by Either Party Without Cause. This Agreement may be terminated without cause by either party at any time upon ninety (90) calendar days' prior written notice to the other party.

7.2 Immediate Termination. This Agreement shall terminate upon THP's notice to Agent in the event of the occurrence of any of the following:

7.2.1 violation by Agent, any Provider or any Provider Affiliate of any law, rule or regulation pertinent to this Agreement;

7.2.2 any act or conduct for which any of a Provider's license or certifications to provide Designated Covered Services may be revoked or suspended or for which Provider's or any Provider Affiliate's ability to provide Designated Covered Services in accordance with this Agreement is otherwise materially impaired;

7.2.3 failure by a Provider or any Provider Affiliate to comply with THP's quality management policies, utilization management policies, Credentialing criteria or Applicable Policies and Procedures:

7.2.4 any misrepresentation or fraud by Agent, any Provider, or any Provider Affiliate;

7.25 any action by a provider or, any Provider Affiliate which, in the reasonable judgment of THP, constitutes professional misconduct;

7.2.6 failure by Agent or Provider to maintain (or require a Provider Affiliate to maintain) professional liability insurance in accordance with this Agreement; or

7.2.7 THP shall determine, in its reasonable judgment, that a Provider's continue participation as a THP Provider may jeopardize the health or safety of Enrollees.

Notwithstanding the preceding, THP may request that Agent remove the Provider responsible for any occurrence giving rise to a right of termination of this Agreement from Agent's THP Network, instead of electing to terminate this Agreement in its entirety. Such request shall be made in writing to Agent, such notice to set forth in summary form THP's basis for such request. Upon receipt of such notice, Agent shall remove such Provider from Agent's THP Network. If a Provider Affiliate is responsible for an occurrence giving rise to a right of termination of this Agreement, THP may elect to terminate the right of such Provider Affiliate to provide Designated Covered Services under this Agreement instead of terminating this Agreement in its entirety. If THP terminates the rights of a Provider Affiliate, Agent will cause the appropriate Provider to notify such Provider Affiliate that he/she may no longer serve as a Provider Affiliate under this Agreement. Removal of a Provider from Agent's THP Network or termination of a Provider Affiliate shall occur within thirty (30) days after the date of the request for or the taking of such action by THP, as appropriate. Agent shall be solely responsible for removal of a Provider and Provider shall be solely responsible for the termination of a Provider Affiliate and each shall indemnify and hold THP harmless from and against any claim by the Provider or Provider Affiliate, as appropriate, arising from or based upon such action.

7.3 Termination Due to Lack of Accommodation. If THP and Agent are unable to reach an acceptable accommodation to Provider's duties under this Agreement pursuant to Subsection 2.7.3, then THP may request that Agent remove the
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Provider from Agent's THP Network and Agent will remove the Provider from Agent's THP Network in the same manner as provided under Section 7.2.

7.4 Termination by Either Party Due to Material Breach of Agreement. This Agreement may be terminated by either party upon thirty (30) days' prior written notice to the other party if the party to whom notice is given is in material breach of any provisions of this Agreement. The party claiming the right to terminate will set forth in the notice of intended termination the facts underlying the claim that the other is in breach of this Agreement. Remedy of the breach to the satisfaction of the party giving notice, within 30 days of receipt of notice, will nullify the intended termination notice.

7.5 Termination by Change in Law or Regulation. This Agreement may be terminated by a change in law or regulation or a judicial interpretation thereof, which renders any material term or provisions of this Agreement illegal, invalid or unenforceable. Termination under this section shall be effective on the effective date of the change in law or regulation, or judicial interpretation thereof.

7.6 Termination by THP on Rejection of Amendment. If Agent rejects an amendment submitted to Agent by THP pursuant to Article XIV of this Agreement,
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THP may elect, in its discretion, to terminate this Agreement upon written notice to Agent setting forth the date of termination.

7.7 No Further Force or Effect after Termination. Except as otherwise specified within this Agreement, following the effective date of termination, this Agreement will be of no further force or effect.

7.8 Continuation of Certain Services. If any Enrollees are receiving Designated Covered Services from a Provider as part of a course of treatment as of the date of termination of this Agreement or the date a Provider for any reason ceases to be a member of Agent's THP Network authorized to provide Designated Covered Services under this Agreement, Provider will continue to provide such Designated Covered Serves to those Enrollees in accordance with the terms of this Agreement until THP or Payor arranges for alternative care or treatment, which will be arranged as soon as practicable, but in no event, beyond the termination date of the Enrollee's coverage under the applicable Payor Plan. The Designated Paying Agent shall continue to compensate Payee for such services in accordance with the terms of this Agreement until the Enrollee is transferred to another Panel Provider or other health care provider.

7.9 Transfer of Enrollees. Upon termination of this Agreement or upon Provider(s) for any reason ceasing to be authorized to provide Designated Covered Services under this Agreement, Agent and Provider(s) shall cooperate in an orderly transfer of Enrollees to other Panel Provider(s) or other THP Providers to protect and meet the health care needs of Enrollees in the transfer.

7.10 Survivability. Notwithstanding any other provisions of this Agreement to the contrary, upon termination of this Agreement for any reason, each party will remain liable for any obligation or liabilities arising from activities occurring prior to the effective date of termination. The covenants and obligations of the parties set forth in Articles IX, XI and XXI, Sections 2.11, 2.12, 2.18, 2.20, 2.22, 2.27, 7.8, 7.9 and Subsection 2.13.1, and all other covenants or obligations which may by their terms or by implication are intended by the parties to continue in effect after termination of this Agreement, shall survive termination and shall remain in effect and enforceable by the parties.

ARTICLE VIII

Audit Rights

8.1 Audit and Inspection. THP, any Payor and State and federal regulatory agencies with regulatory jurisdiction have the right to conduct, or have conducted by a third party, medical , financial and other audits, inspections and evaluations of Agent's and Provider's records and facilities with respect to Designated Covered Services provided to Enrollees under this Agreement including quality appropriateness and timeliness of services. Audits and inspections by the State or federal agencies may be announced or unannounced, but other audits or inspections shall be at reasonable times, upon reasonable advance notice. Any such party or entity shall be allowed access to Agent's and Provider's place of business and to all appropriate records during normal business hours, except under special circumstances (as determined by State and federal regulatory agencies) when after hour admission shall be allowed. Such audit rights shall not apply to confidential corporate information of Agent and Provider that is unrelated to this Agreement or the provision of Designated Covered Services. In conducting any medical audit, neither THP nor the Payor shall be entitled to examine medical or health records of patients who are not Enrollees. Agent and Provider shall cooperate fully with the auditing or inspecting party and furnish copies of medical and health records, when requested by THP, the Payor or any State or federal regulatory agency for the purpose of an audit, inspection or evaluation at no charge. THP or the Payor, as appropriate, shall be responsible for providing Agent with copies of all releases or consents from Enrollees necessary for THP or Payor to have access to such records.

8.2 Monitoring. THP, any Payor and State and federal regulatory agencies with regulatory jurisdiction shall have the right to monitor, whether on an announced or unannounced basis, all services rendered to Enrollees by Provider.

ARTICLE IX

Dispute Resolution and Arbitration

9.1 Disputes. Except as provided in Section 9.3, if any dispute arises between Agent and THP involving a contention by one party that the other or a Provider or Provider Affiliate has failed to perform its/his/her obligations and responsibilities under this Agreement, then the party making such contention shall promptly give written notice to the other party pursuant to Article XVII. Such notice shall set forth in detail the basis for the party's contention. The other party shall, within thirty (30) calendar days after receipt of this notice, provide a written response seeking to satisfy the party that gave notice regarding the matter as to which notice was given. Following such response, or the failure of the second party to respond to the complaint of the first party within thirty (30) calendar days, if the party that gave notice of dissatisfaction remains dissatisfied, then that party shall so notify the other party and the matter shall be promptly submitted to binding arbitration. The Agent shall represent the rights and interests of Providers and Provider Affiliates in all arbitration proceedings.

9.2 Arbitration. Except as provided in Section 9.3, all claims, disputes, and other matters in question arising out of or relating to this Agreement or any breach of this Agreement shall be decided by arbitration in accordance with the rules of the American Arbitration Association, then obtaining, unless the parties mutually agree otherwise in writing. This agreement to arbitrate shall be specifically enforceable pursuant to the Tennessee Uniform Arbitration Act as codified in TENN. CODE ANN. (S)(S) 29-5-301, et seq. The award rendered by the arbitrator shall be final and a judgment may be entered upon it in accordance with the applicable State law. The responsibility for any legal fees and/or costs incurred by such action shall be borne by the party designated by the arbitrator.

9.3 Applicable Policies and Procedures. The provisions of Section 8.1 and 8.2 shall not apply to (i) any determination made by THP or Payor pursuant to Applicable Policies and Procedures that are subject to appeal by Agent or Provider under appeal or grievance procedures contained in Applicable Policies and Procedures or (ii) any decision made by Payor or THP that may be made at the discretion of such party by the terms of this Agreement. Such appeal or grievance procedures shall be the sole remedy of Agent and Provider in such instance, and the determination resulting from such appeal or grievance procedures shall be binding on Agent and Provider and shall not be subject to further appeal.

ARTICLE X

Relationships of Parties

THP on the one hand and Agent and Provider on the other hand are independent contractors in relation to one another and no joint venture, partnership, employment, agency or other relationship is intended or created by this Agreement. No such independent contractor is authorized to represent or bind the other for any purposes and none of their respective officers, agents or employees, shall be construed to be the officer, agent or employee of any other party.

ARTICLE XI

Coordination of Benefits

Coordination of Benefits shall be administered in accordance with the requirements of the applicable Payor Plan and/or Master Agreement. Rights of subrogation and to the proceeds or savings derived from Coordination of Benefits shall be governed by the terms of the applicable Payor Plan and/or Master Agreement. If a Payor Plan or Master Agreement fail to address Coordination of Benefits or any issue related thereto, the Designated Paying Agent shall administer Coordination of Benefits in compliance with applicable laws and/or industry standards. If the Designated Paying Agent has paid Payee for Designated Covered Services that are subject to Coordination of Benefits, all proceeds and savings derived from Coordination of Benefits shall be the exclusive property of the Designated Paying Agent and Agent and Provider hereby assign to the Designated Paying Agent all of Agent's and Provider's rights to any other benefits payable in respect to Enrollee. Agent and Provider will use their best efforts to assist the Designated Paying Agent in determining the availability of other benefits and obtaining any documentation required to facilitate the Designated Paying Agent's collection of such other benefits. If the Designated Paying Agent has not paid Payee for such services, as to all proceeds and savings derived from Coordination of Benefits, Agent and Provider shall be entitled to receive from such amount the lesser of (i) the entire amount or (ii) the amount Agent and Provider would have received under the Payor Plan for providing such services. If Agent or Provider should receive any payment from a Payor that should have been paid to THP or any other Payor under the Coordination of Benefits requirements of Payor Plan, Master Agreement or this Article XI, such recipient shall, without demand, promptly pay over such
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amount to THP or such Payor, as appropriate.

ARTICLE XII

No Third Party Beneficiary

Except as provided below, nothing in this Agreement is intended to be construed or deemed to create any rights or remedies in any third party beneficiary, including an Enrollee or Payor. Notwithstanding the preceding, a Master Agreement may, by its express terms, grant a Payor rights to enforce the terms of this Agreement and other third party beneficiary rights with respect to those Payor Plans adopted, sponsored, maintained or administered by such Payor.

ARTICLE XIII

Governing Law and Venue

This Agreement shall be governed by the laws of the State of Tennessee, without regard to conflict of laws principles, except where otherwise required by federal law or by the laws of any State in which Provider provides Designated Covered Services to Enrollees. Any arbitration proceeding instituted under this Agreement shall be in Knox County, Tennessee, and each party hereby waives any other right of venue such party may have.

ARTICLE XIV

Amendments

14.1 Right of Approval and Effective Date.

14.1.1. Amendments Proposed by Agent. All amendments to this Agreement proposed by Agent must be agreed to in writing by THP before they shall become effective. THP reserves the right to reject any proposed amendment in its absolute discretion.

14.1.2 Amendments Requiring Agent Consent. Except as provided in Subsection 14.1.3. any amendment to this Agreement proposed by THP must be proposed in the form of an Addendum forwarded to Agent in the manner specified in Section 14.2 and will be deemed effective upon the expiration of thirty (30) calendar days after receipt of such Addendum by Agent (determined under Article XVII) unless, within such 30-day period, Agent notifies THP in writing of Provider's rejection of the requested amendment.

14.1.3 Amendments Not Requiring Provider Consent. Notwithstanding Subsection 14.1.2, THP may unilaterally amend this Agreement by sending an Addendum to Agent, without the consent of Agent or any Provider, if such amendment (i) merely serves to add a Payor Plan to the List of Addenda and Payee is to be compensated under such Payor Plan at rates equal to or better than the then current Fee Schedule and Provider is to provide Designated Covered Services to Enrollees of such Payor Plan under terms that are substantially similar in all material respects to the terms of this Agreement or (ii) is required because of legislative, regulatory or legal requirements. Such amendment shall become effective on the date of the Addendum is received by Agent (determined under Article XVII).

14.2 Addenda. In the event THP desires to amend this Agreement for any reason, including, without limitation, adding an additional Payor Plan and Master Agreement not listed on the List of Addenda, such amendment shall be submitted by THP to Agent in the form of a written Addendum which shall be sent to Agent in accordance with the provisions of Article XVII, and such amendment shall become effective as provided in Section 14.1. Addenda that do not require the consent of the Agent pursuant to Subsection 14.1.3 need not be executed by the parties. In the event Agent rejects a proposed amendment described in Subsection 14.1.2 within the thirty (30) day period described by Subsection 14.1.2, THP shall have the right, exercisable in its option, to terminate this Agreement as provided in Section 7.6 or to continue this Agreement in effect without such Addendum. If such Addendum does not become effective and this Agreement is continued, the Agent shall not be required to comply with the Addendum and no Provider shall be required to serve on the Provider Panel described in the Addendum.

14.3 Fee Schedule. Subsequent to the execution of this Agreement by the parties, THP may elect to submit a proposed Fee Schedule to Payee in the form of a proposed Addendum this Agreement. If Payee accepts such proposed Fee Schedule, the parties will execute the Addendum, and it shall become a part of this Agreement. Thereafter, THP shall have the right to amend this Agreement to include additional Payor Plans without the consent of Agent or any Provider in accordance with Subsection 14.1.3(i). THP may not exercise rights under Subsection 14.1.3(i) until a Fee Schedule has been agreed upon by THP and Payee and has been added to this Agreement in the form of a fully executed Addendum.

ARTICLE XV

Entire Agreement

This Agreement supersedes any and all other agreements, either oral or written, between the parties with respect to the subject matter hereof, and no other agreement, statement or promise relating to the subject matter of this Agreement will be valid or binding.

ARTICLE XVI

Assignment

The services provided under this Agreement by Agent and Provider are unique, and neither Agent nor any Provider may assign this Agreement or any of its rights hereunder, or delegate or subcontract any duties, responsibilities or obligations under this Agreement, to any other person or entity without the prior written consent of THP. The consent of THP to one assignment shall not constitute a waiver of the requirement for consent of any subsequent assignment. The assigned party shall not be released or relieved from any of its obligations under this Agreement by reason of such assignment. THP shall have the unrestricted right to assign its rights and delegate its duties and responsibilities under this Agreement.

ARTICLE XVII

Notices

Any notice or other communication required under this Agreement will be given in writing and sent by certified mail, return receipt requested, by overnight courier or by facsimile transmission, and will be deemed received either three (3) business days after being deposited in the United State mail, or one (1) day after delivery to any overnight courier addressed to the applicable address appearing on the signature page of this Agreement or on the date of facsimile transmission to the facsimile number set forth on such signature page. Any changes to these addresses shall be designated by notice given in accordance with this Article XVII.

ARTICLE XVIII

Severability

The provisions of this Agreement are severable. If any provision of this Agreement is held to be invalid, illegal or otherwise unenforceable in any jurisdiction, the holding shall not affect the remaining provisions of this Agreement and shall not affect such provision in any other jurisdiction, unless the effect of the severance would be to alter the obligations of a party in any material respect, in which case, this Agreement may be immediately terminated by the affected party pursuant to Section 7.5.

ARTICLE XIX

Waiver of Breach

Any waiver of any provision or right by a party must be in writing. The waiver of any breach of this Agreement by either party hereto will not constitute a continuing waiver or a waiver of any subsequent breach of either the same or any other provision of this Agreement.

ARTICLE XX

Non-Inducement Warranty

20.1 Agent and Provider Warranty. Agent and each Provider warrants and covenants he/she/it has not paid and shall not pay, either directly or indirectly, any compensation to any officer or employee of the State, or any employee or member of a federal agency, as wages, compensation, or gifts in exchange for action as an officer, agent, employee, subcontractor or consultant to Agent or Provider in connection with any work contemplated or performed in connection with this Agreement.

20.2 THP Warranty. THP warrants and covenants it has not paid and shall not pay, either directly or indirectly, any compensation to any officer or employee of the State, or any employee or member of a federal agency, as wages, compensation, or gifts in exchange for action as officer, agent, employee, subcontractor or consultant to THP in connection with any work contemplated or performed in connection with this Agreement.

ARTICLE XXI

Legal Responsibilities

21.1 Legal Defense. The defense of any legal action instituted on a claim of malpractice against Agent, Provider or any Provider Affiliate relating to services provided pursuant to this Agreement shall not be an obligation of THP. THP shall not be responsible for any legal expenses including, without limitation, reasonable attorney's fees, costs and necessary disbursements, in connection with any such legal action against Agent or Provider. THP shall, however, fully cooperate with Agent and Provider by furnishing such material or information as it has available in connection with the defense of any such action.

21.2 Indemnification. If any party is without fault and is held liable for the acts or omissions of another party, its employees or agents, the party not at fault shall have such rights of indemnity or contribution against the party at fault as are provided by the applicable laws of the State.

ARTICLE XXII

Non-Exclusive Agreement

22.1 Agent and Provider Rights. Nothing contained in this Agreement shall preclude Agent or Provider from participating in or contracting with any other Payor or other person, group or entity, whether before, during or subsequent to the term of this Agreement, with regard to the provision of any health care services.

22.2 Rights of THP. Nothing contained in this Agreement shall preclude THP from contracting with one or more other health care providers for services under any other contracts, agreements or arrangements, or any other business operations of THP. Nothing in this Agreement shall be construed as imposing any duty on or otherwise requiring THP to assign Provider to any Provider Panel, the determination of such assignments to be made solely in the discretion of THP and/or the applicable Payor.

ARTICLE XXIII

Effective Date

This Agreement shall become effective on the date of execution of this Agreement by the last party to execute this Agreement.

IN WITNESS WHEREOF the parties have executed this Agreement in multiple counterparts (including the use of counterpart signature pages if necessary) as of the dates set forth below each party's signature.

ADDRESS:

220 Fort Sanders West Boulevard
Suite 302
Knoxville, Tennessee 37922

Phone: (423) 531-5551
Fax: (423) 531-5299

THP:

TENNESSEE HEALTH PARTNERSHIP

By: /s/ Rocky Davis

Its: CEO

Date: 2/26/96

ADDRESS:
1226 17/th/ Avenue South
Nashville, TN 37212

Phone: (615) 320-9445
Fax: (615) 320-1928

AGENT:

RxCARE
Name of Agent

By: /s/ Gary W. Cripps

Its: CEO

Date: 2/23/96

EXHIBIT 1

DESIGNATED COVERED SERVICES

The following health care services are Designated Covered Services under the Provider Agreement between Tennessee Health Partnership ("THP") and RxCare ("Agent") dated January , 1996. This Exhibit 1 is effective from and after January 31, 1996.

During the term of the Agreement, unless otherwise provided in an Addendum, each Provider will provide Enrollees with all services that are Designated Covered Services that Provider offers to other Provider patients and will make available to its other patients. Provider may not elect to limit or discontinue any Designated Covered Service after the date of execution of this Agreement by Provider without the prior written consent of THP which shall not be unreasonably withheld. In any event, Agent and Provider shall give THP at least ninety (90) days prior written notice of a Provider's intent to limit or discontinue a Designated Covered Service. The determination of whether any service is a Designated Covered Service shall be made by THP or Payor pursuant to Subsection 5.1.8, subject to Agent's grievance and appeal rights described in such Subsection.

RxCare/Pro-Mark
Prescription Drug Benefits
Closed Formulary/Mandated Generics
RxCare/TennCare LTC

Group Name: Tennessee Health Partnership
Group Number:

Covered	NonCovered	Classification	Definition
x		Federal Legend	"Caution:Federal law prohibits dispensing without a prescription"
x		OTC drugs	Drugs which do not require a prescription by law
	x	DESI	Drugs labeled as DESI or LTE by the FDA (Class 5 and 6)
	x	Investigational	Drugs used for investigational purposes without FDA approval
x		Compound Drugs	One ingredient of the compound must be a Formulary Drug
x		Insulin	Insulin
bb		Needles/Syringes	Insulin needle/syringe only
bb		Diabetics Products	Glucose Monitoring Supplies, e.g. urine/blood glucose test strips, lances, swabs, meters
x		Oral Contraceptives	
	x	Diaphragms	
	x	Anorexics	Anorexics classified as Federal Legend drugs
x		Dependency Drugs	Disulfiram ONLY
	x	Multivitamins	Multivitamins classified as Federal Legend Drugs excluding Prenatals
x		Prenatal Vitamins	Prenatal vitamins classified as Federal Legend Drugs
	x	Fertility Agents	Oral agents classified as Federal Legend Drugs
x,bb		Injectable Products	For in-home use if self-administered, injectable antipsychotics, and Depo-Provera (see attached listing)
x		Growth Hormones	For in-house use if self-administered
	x	Immunization	Neither vaccinations nor immunizations are covered
	x	Biologicals	
bb		Blood Products	
	x	Smoking Deterrents	Smoking cessation products
	x	Medical Supplies	Supplies/devices regardless of Federal Legend Status
	x	DME	Durable Medical Equipment, e.g. canes, walkers, commodes
x		Diagnostic Aids	Orally administered bowel evacuants ONLY(i.e. Colyte(R) and Telepague(R)
	x	Dietary Supplements	Liquid nutritional supplements, e.g. Ensure (R) and Telepagne (R)
	x	Cosmetic Drugs	i.e. Rogaine (R)
	x	Acne Products	Topical & oral products, RetinA(R) up to 21st birthday
	x	Cough/Cold	Only those products labeled as Federal Legend Drugs
	x	Non-ambulatory services	Medication administered while a patient in a nursing home, rest home, home care program, hospital or similar program
	x	Worker's Comp.	Any claims for Worker's Compensation cases

Notes:
"X" in NonCovered column indicates an absolute exclusion - NO products in this classification are covered. The NonCovered column takes priority over the Covered column- For example, while Legend Vitamins are on the Formulary, OTC Vitamins are not.

"X" in Covered column indicates items from within this classification are available on the formulary and covered proposed capitation rates.
Please refer to the formulary document for coverage of specific

"bb" indicates a bill back to benefit sponsor at proposed Fee-for-Service

Benefit Parameter: Mandatory Generic Substitutes (Brand Override)
Closed Formulary

EXHIBIT 1

RxCare/Pro-Mark
Prescription Drug
Closed Formulary / Mandatory Generics
RxCare / TennCare Ambulatory Formulary

Group Name: Tennessee Health Partnership
Group Number:

Injectables included in Capitation Rates

Antipsychotics (injectable)

Beta-Interferon (Betaseron) Non-Formulary-Medical Necessity Claims ONLY

Calcitonin (P)

Depo-Provera(R)

Epinephrine (Epi-Pen(R))

Epoetin Alfa (Procrit(R)) (P)

Filgrastim (Neupogen(R)) (P)

Glucagon

Growth Hormone (Humatrope(R)) (P)

Heparin, sub-cutaneous Non-Formulary-Medical Necessity Claims ONLY

Insulin

Octreotide (Sandostatin(R)) (P)

Sumatriptan (Imitrex(R)) (P)

Vitamin B-12 (cyancobalamin) (P)

NOTES: Other self-administered injectable products may be administered by Pro-Mark and billed back to the client at an appropriate Fee-for-Service rate. This bill back arrangement applies for all other self-administered injectable medications.

EXHIBIT 2

LIST OF ADDENDA

The following Addenda describe and refer to Payor Plans and Master Agreements that are covered under the Agreement and the effective date of such Addenda:

Addendum No. 1:

Payor Plan: Contractor Risk Agreement of October 1, 1995, between Volunteer State Health Plan and the State of Tennessee, as amended from time to time.

Master Agreement: Tennessee Health Partnership Definitive Agreement between Boue Cross and Blue Shield of Tennessee and THP.

Effective Date: See Addendum No. 1.

EXHIBIT 3

AGREEMENT, RELEASE AND IMMUNITY

The undersigned hereby agrees to comply with, observe and be bound by all the terms and conditions imposed upon Providers under that certain Provider Network Agreement ("Agreement") between Tennessee Health Partnership and RxCare ("Agent") to the same extent as if the undersigned had executed the Agreement as a Provider. If the undersigned is a Provider listed on Exhibit 4 of this Agreement, the undersigned hereby certifies to Tennessee Health Partnership that it/he/she has appointed Agent as his/her/its agent and attorney-in-fact for the purpose of executing and delivering the Agreement on behalf of Provider and for the purpose of granting Agent the absolute and unrestricted right to exercise, waive and represent the rights and interests of the undersigned under the Agreement, including, without limitation, exercising the following rights on behalf of the undersigned:

(i) if Agent is designated as Payee below, to collect and disburse all payments for Designated Covered Services and agree to the Fee Schedule as provided in Section 14.3 of the Agreement;

(ii) to pursue grievance procedures on behalf of the Undersigned;

(iii) to accept and execute Addenda adding Payor Plans or amending the Agreement;

(iv) to pursue arbitration remedies; and

(v) to exercise all rights of extension or termination of the Agreement.

The undersigned hereby authorizes Tennessee Health Partnership to rely on all statements, representations and warranties made by Agent to THP in, under or pursuant to the Agreement and to rely on all statements, acts and omissions of Agent in dealing with THP pursuant to the terms of the Agreement.

The undersigned hereby authorizes Tennessee Health Partnership and its authorized representatives to consult with any third party who may have information, including otherwise privileged or confidential information, bearing on my professional qualifications, Credentials, clinical competence, character, ethics, behavior or any other matter that may be relevant that relates to my professional qualifications. This authorization includes the right to inspect or obtain copies of any and all documents, recommendation, reports, statements, letters or disclosures relating to such questions. The undersigned also expressly authorizes said third parties to release this information to Tennessee Health Partnership and its authorized representatives upon request.

The undersigned hereby extends absolute immunity to, and releases from any and all liability, and agrees not sue any facility, its authorized representatives or any third parties for any actions, recommendations, reports, statements, communications or disclosures involving me (including otherwise privileged or confidential information) which are performed, made, taken or received by any facility, its authorized representatives or any third party relating to my professional qualifications or my activities as a member of the medical staff or other professional staff of such facility.

Check one: [X] I hereby acknowledge that I have appointed Agent as Payee for all purposes under the Agreement

[_] I have not appointed Agent as Payee, and the undersigned shall be the Payee.

Date: January 5, 1996

Gary W. Cripps
Type Name

/s/ Gary W. Cripps
Signature

EXHIBIT 4

LIST OF PROVIDERS

The attached pharmacy providers are providers in Agent's THP Network and constitute Providers under the Provider Network Agreement between Tennessee Health Partnership ("THP") and RxCare ("Agent") dated January 5, 1996, unless otherwise provided in an Addendum.

EXHIBIT 5

ADMINISTRATIVE DUTIES OF AGENT

The Agent shall perform and be responsible for the following administrative and ministerial duties under the Provider Network Agreement between Tennessee Health Partnership ("THP") and RxCare ("Agent") dated January 5, 1996, including those duties and responsibilities set forth in the body of the Agreement, unless otherwise provided in an Addendum.

. Drug Utilization Review

. Formulary Maintenance

. Claims Payment

. Provide Copies of Formulary to THP Providers (including pharmacies, hospitals and physician providers)

. Reports to THP including but not limited to:
  a) Number of prescriptions by physicians per member per month
  b) Prescriptions by physician by drug class
  c) Standard reports already developed by RxCare
  d) Reasonable customized reporting as requested by THP

. Encounter data reporting as required by TennCare

ADDENDUM NO. 1

Tennessee Health Partnership
Provider Agreement

Payor Plan: Contractor Risk Agreement of October 1, 1995, between Volunteer State Health Plan and the State of Tennessee, as amended from time to time.

Master Agreeement: Tennessee Health Partnership Definitive Agreement between THP and Blue Cross and Blue Shield of Tennessee.

Effective Date: This Addendum shall become effective as of the later of (i) the date the Master Agreement between Blue Cross and Blue Shield of Tennessee and THP referenced above becomes effective or (ii) the date this Addendum No. 1 is executed by the parties.

Enrollees Covered: All Enrollees covered under the Payor Plan residing in the following Tennessee counties:

Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Knox, Loudon, Monroe, Morgan, Roane, Scott, Sevier and Union.

Designated Paying Agent: THP.

Designated Covered Services:

All services described in Exhibit 1 to the Agreement.

Prior Authorization Requirements: All Designated Covered Services require Prior Authorization with the exception of (1) Emergency Care, (2) services delivered by a Primary Care Provider to his/her assigned Enrollees that are reimbursed on a fixed monthly fee or other method of reimbursement that does not require the filing of a claim as a condition to payment and (3) those Designated Covered Services listed as not requiring Prior Authorization in THP's provider manual. Emergency Care is not subject to Prior Authorization; however, Provider is required to give notice to THP within twenty-four (24) hours after the provision of Emergency Care or any Referral for Emergency Care. Once the Enrollee has been stabilized, any subsequent care is subject to Prior Authorization requirements.

Compensation: The Fee Schedule (to be agreed upon pursuant to Section 14.3) shall not be applicable to Designated Covered Services provided under this Addendum. THP shall compensate Agent for Provider's providing Designated Covered Services to Enrollees of the above-referenced plan as follows:

See Attachment I to this Addendum.

Payee: RxCare

Copayment: As described in an permitted by TennCare pursuant to Section 2-3.h and Attachment V of the Payor Plan. The provider manual will set forth Copayment policies and procedures.

Special Terms, Conditions or Obligations: The following terms, conditions, covenants and obligations shall apply to THP, Agent or Provider, as appropriate, notwithstanding any terms or conditions of the Agreement to the contrary:

1. Definitions. To the extent the Payor Plan or Master Agreeement contains definitions of terms identical, similar or comparable to the terms defined in Article I of the Agreement, the definitions in the Master Agreement shall control the meaning of such terms. The following definitions are included in the above-referenced Payor Plan:

(a) "Emergency Care" means a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in: a) permanently placing an Enrollee's health in jeopardy; b) causing other serious medical consequences; c) causing impairments to body functions; or d) causing serious or permanent dysfunction of any body organ or part.

(b) "Medically Necessary" or "Medical Necessity" means services or supplies provided by an institution, physician or other provider that are required to identify or treat a TennCare Enrollee's illness or injury and which are: a) consistent with the symptoms or diagnosis and treatment of the Enrollee's condition, disease, ailment or injury; b) appropriate with regard to standards of good medical practice; c) not solely for the convenience of an Enrollee, physician, institution or other providers; and d) the most appropriate supply or level of services which can safely be provided to the Enrollee. When applied to the care of an inpatient, it further means that services for the Enrollee's medical symptoms or condition require that the services cannot be safely provided to the Enrollee as an outpatient.

(c) "State" means the State of Tennessee and any entity authorized by statute or otherwise to act on behalf of the State of Tennessee in administering and/or enforcing the terms of the Payor Plan described in this Addendum. Such entities may include, but are not limited to, the TennCare Bureau, the Department of Finance and Administration and the TennCare Division of the Tennessee Department of Commerce and Insurance.

2. Third Party Beneficiary. Enrollees are the intended third party beneficiary of the Master Agreement and this Agreement and, as such, are entitled to remedies accorded to third party beneficiaries under the laws of the State.

3. Laboratory Testing. If Provider is to provide laboratory testing as a Designated Covered Service, all laboratory testing sites utilized to provide such services must have either a Clinical Laboratory Improvement Act (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA identification number. Those laboratories with a Certificate of Waiver may provide only the types of tests permitted under the terms of the waiver.

4. Coordination of Benefits. THP shall be the Payor of last resort for Designated Covered Services. THP shall be entitled to full subrogation rights and shall be responsible for determining the legal liability of third parties to pay for Designated Covered Services and to recover any such amounts from the third party. If THP has determined that third party liability exists for part or all of Designated Covered Services provided to an Enrollee, and the third party will make payment to Agent or Provider in a reasonable time, THP may pay Payee only the amount, if any, by which the Clean Claim exceeds the amount of third party liability, or THP may pay the full amount due Payee under this Agreement and assume full responsibility for collection from such third party. THP shall not withhold payment to Payee if third party liability or the amount of liability cannot be determined or payment will not be made to Agent or Provider within a reasonable time. Agent and Provider shall make such assignments and pay over such amounts to THP as shall be required by this paragraph or Applicable Policies and Procedures.

5. Agent and Provider Warranties. Agent and each Provider warrants that such Provider has not been excluded from participation in the Medicare or Medicaid programs pursuant to Sections 1128 or 1156 of the Social Security Act and is in good standing with TennCare.

6. Maintenance of Records. Medical health and records of Enrollees and all related administrative records shall be maintained under Section 2.12.2 of the Agreement for five (5) years after termination of the Agreement and further if the records are under review or audit until the review or audit is complete. Prior approval for the disposition of records must be requested from the State.

7. Claims Submission. The time period for the submission of claims under Section 2.19 of the Agreement shall be 120 calendar days from the date of rendering services rather than ninety (90) days.

8. Compliance with Laws. THP and Provider agree to recognize and abide by all State and federal laws, regulations and guidelines applicable to TennCare and the Master Agreement.

9. Incorporation of Legal or Contract Requirement. The parties hereby incorporate by reference all applicable federal and State laws or regulations and agree that revisions of such laws or regulations shall automatically be incorporated into this Addendum as they become effective. In the event the changes in this Agreement or this Addendum as a result of revision in applicable federal and State laws materially affect the position of either party, THP and Provider agree to negotiate such further amendments as may be necessary to correct any inequities.

10. Special Termination Provisions.

(a) In the event of a termination of the parties' obligations pursuant to Article VI with respect to this Addendum, Provider shall immediately make available to the State, or its designated representative, in usable form, any or all records, whether medical or financial, related to the Provider's activities undertaken pursuant to this Agreement with respect to this Addendum No. 1. Provision of such records shall be at no expense to the State.

(b) THP may immediately terminate this Addendum and remove Provider from the Provider Panel serving Enrollees covered by the Payor Plan, if the Payor directs THP to take such action and represents to THP that such demand was based upon the exercise of Payor's reasonable judgment that Provider's continued participation as a Panel Provider under this Addendum may jeopardize the health or safety of Enrollees.

11. Other Contracts. Provider is required to accept compensation for Designated Covered Services provided under this Agreement as set forth above, but shall not be required to accept TennCare reimbursement amounts for services to Enrollees who are covered under any other Master Agreement.

12. Quality Compliance. In addition to all other requirements of this Agreement, Agent and each Provider must adhere to the quality of care monitors required by the terms of the Payor Plan and Master Agreement, including without limitation Attachment IV to the Payor Plan described in this Addendum, a copy of which is attached to this Addendum as Attachment II.

13. Arbitration. The State shall have not involvement in arbitration under Section 8.2 of the Agreement except to (i) enforce Section 8.2, (ii) approve the arbitration procedure proposed by THP and (iii) to voluntarily intervene if the State deems intervention to be in the best interest of TennCare; provided, however, that the State shall not be bound by said arbitration. If at any time the State decides that a particular dispute should be in a court of competent jurisdiction, the State shall notify the parties to the dispute of its decision to

refer the dispute to a court of competent jurisdiction and said arbitration process shall cease and the dispute shall be heard in said court. The only exception to the arbitration process shall be resolution of the cost of emergency medical services. The cost of establishing any arbitration procedure shall be borne by THP. If a dispute between the parties involving a claim submitted by Payee to THP is not resolved prior to entry of a final decision by the arbitrator(s), then the prevailing party at the arbitration shall be entitled to award of reasonable attorneys' fees and expenses from the non-prevailing party. Reasonable attorneys' fees means the number of hours reasonably expended on the dispute multiplied by a reasonable hourly rate but shall not exceed ten percent (10%) of the total monetary amount in dispute or $500.00, whichever amount is greater.

14. Coordination of Health Care Services. To the extent and in the manner required by the terms of the Master Agreement, Provider will cooperate with each behavioral health organization (BHO) and the primary care providers under contract with or employed by such BHO who provide medical services to Enrollees in an effort to (i) coordinate and integrate health care services provided to each Enrollee by such providers and Provider, (ii) help ensure the appropriateness of all health care services provided to Enrollee and (iii) help ensure that such health care services are provided in a manner that allows the most efficient use of resources and the achievement of quality health outcomes.

15. Assignment to State. THP shall have the right to assign to the State its rights and delegate its duties and responsibilities under this Agreement with respect to the Payor Plan and Master Agreement described in this Addendum No. 1 to the State to the extent required by the terms of the Master Agreement.

16. Limitation on Assigned Enrollees for Primary Care Providers. Agent's THP Network includes Primary Care Providers as of the execution of this Agreement by Agent. Each such Primary Care Provider may be designated a primary care health manager by THP and such Providers, in the aggregate, will serve as primary care health managers for no less than a total of Enrollees under the Payor Plan described in this Addendum No. 1. The assignment of Enrollees to each primary care health manager shall be made by THP or Payor, subject to the approval of Agent, which shall not be unreasonably withheld. Providers designated as primary care health managers shall not be required to serve as primary care health manager for more than the above total number of Enrollees unless otherwise agreed to in writing by Agent.

17. Failure to Pay Copayment. Notwithstanding Section 2.24 to the contrary, Provider may not refuse to provide Designated Covered Services to an Enrollee for failure to pay any applicable Copayment.

18. Hold Harmless. In no event, including but not limited to nonpayment of Payee by the Designated Paying Agent or nonpayment of Provider by Payee, shall any Enrollee, or any other person, group or entity other than Designated Paying Agent ("other party") be liable for any amounts owed to Provider for any Designated Covered Service provided by Provider to Enrollee under this Agreement, except to the extent Provider shall be permitted to bill for and collect a Copayment from the Enrollee pursuant to the Payor Plan. Provider shall not maintain any action at law or take any action against any Enrollee or other party (other than the Designated Paying Agent) to collect sums owed or allegedly owed to Provider by the Designated Paying Agent with respect to any Designated Covered Service. Provider shall not charge, collect or seek to collect from any Enrollee any surcharge or other amount for Designated Covered Services other than applicable Copayments, nor shall Provider solicit or accept any surety or guarantee or payment from Enrollee in excess of the amount of such Copayments. The term Enrollee, as used in this Paragraph 18, includes the patient and the parent(s), guardian, spouse or any other person legally responsible for the patient.

19. Indemnification. The State as well as its officers, agents and employees shall be entitled to be indemnified by THP, Agent and Provider to the same extent as any party to this Agreement pursuant to the terms of Section 21.2 of the Agreement.

IN WITNESS WHEREOF the parties have executed this Addendum No. 1 in multiple counterparts (including the use of counterpart signature pages if necessary) as of the dates set forth below each party's signature.

THP:

TENNESSEE HEALTH PARTNERSHIP

By: /s/ Rocky Davis

Title: CEO

Date: 2/26/96

AGENT:

_____
Name of Entity

By: /s/ Gary W. Cripps

Title: CEO

Date: 2/23/96

ATTACHMENT 1

Capitated PBM Fees. The following utilization-based capitated PBM Fees are payable to Manager per member per month ("PMPM")

Utilization Rxs PMPM*	Capitation Rate**
Less than.. 0.90***	[*]
At least... 0.90 but less than 0.95	[*]
At least... 0.95 but less than 1.00	[*]
At least... 1.00 but less than 1.05	[*]
At least... 1.05 but less than 1.10	[*]
At least... 1.10 but less than 1.15	[*]
At least... 1.15 but less than 1.20	[*]
At least... 1.20 but less than 1.25	[*]
At least... 1.25 but less than 1.30	[*]
At least... 1.30***	[*]

* Calculated independently for each calendar service month, and equal to the number of Rx claims with a service date during the month (the month's "Claims") divided by the average number of enrolled Members during the month.

** The listed capitation rates are the ultimate capitation rates, which vary with utilization rates as listed above. Since the actual utilization rate for a month will not be known when the capitation payment for that month is due, the initial capitation payment for each month will be made using the capitation rate which corresponds to the parties' mutually-agreed best projection of that month's ultimate utilization rate. (Until experience under this Agreement allows the parties to better estimate monthly utilization rates, the parties will use the [*] PMPM capitation rate for such initial capitation payments). Each month, (i) Manager will provide MCO with then-available utilization data regarding each of the eight immediately proceeding service months and (ii) an adjustment payment will be made by MCO to Manager (or by Manager to MCO) with regard to each of said preceeding months equal to the amount by which the capitation rate corresponding to the then-currently-known utilization rate for said preceeding month exceeds (or is exceeded by) total net capitation payments previously made to Manager with respect to said preceeding month.

*** For these two utilization brackets only, Manager and MCO will share [*] in Manager's "Profit or Loss" during each calendar service month, defined as the difference between total capitated

PBM Fees ultimately due Manager for said month and the following: total Manager payments due pharmacies for said month's Claims plus and administrative overhead allowance equal to [*]% of total Manager payments due pharmacies for said month's claims minus total pharmaceutical manufacturer rebates received by Manager at any time for brand products dispensed in connection with the month's Claims. The Profit or Loss payment for a given service month will be made within 30 days after the last adjustment of the month's capitation payment per the last sentence of note ** above.

Fee-for-Service PBM Fees. The following fee-for-service PBM Fees are payable to Manager per fill or refill, net of Deductibles and Co-Payments:

Brand drug: [*] Generic Drug: [*]

Other Benefit Design Parameters:

- Dispensing Limits
- Emergency Coverage
- Mandatory Generic Substitution
- Non-Formulary Coverage
- OTC Product Restrictions
- Override PBM Fees
- Prior Authorization

Exhibit 10.11

[canceled]

PROMISSORY NOTE

$99,000 Peace Dale, Rhode Island March 21, 1996

FOR VALUE RECEIVED, MIM Holdings, LLC, a Rhode Island limited liability company, with a registered office at One Richmond Square, Providence, Rhode Island 02906, Attention: Robert C. Bruns ("Borrower") promises to pay to the order of MIM Strategic Marketing, LLC, a Rhode Island limited liability company, with offices at 25 North Road, P.O. Box 3689, Peace Dale, Rhode Island 02883 ("Lender"), the principal sum of Ninety-Nine Thousand Dollars ($99,000.00), without interest, on September 30, 1996.

Borrower may prepay all or any portion of the unpaid principal balance at any time, and from time to time, without penalty.

Principal is payable in lawful money of the United States of America and in immediately available funds at the address of Lender shown above or at such other address as the Lender or other holder of this Note may designate in writing.

Borrower will pay all costs and expenses, including reasonable attorney's fees, incurred by the holder in collecting this Note or foreclosing on the security for this Note, even if no legal proceeding is filed.

Borrower waives presentment, notice of dishonor and protest.

This Note will be construed and enforced in accordance with the laws of the State of Rhode Island, without resort to its conflict of laws rules.

IN WITNESS WHEREOF, the undersigned Borrower has caused this Note to be executed by its duly authorized representative on the date first above written.

Witness: MIM Holdings, LLC

/s/ Douglas C. Leonard
- ----------

/s/ E. David Corvese

E. David Corvese, Manager

Exhibit 10.12

PROMISSORY NOTE

$86,000 Peace Dale, Rhode Island December 31, 1996

FOR VALUE RECEIVED, MIM Holdings, LLC, a Rhode Island limited liability company with offices at 25 North Road, P.O. Box 3689, Peace Dale, Rhode Island 02883 ("Borrower"), promises to pay to the order of MIM Corporation, a Delaware corporation with offices at One Blue Hill Plaza, Pearl River, New York 10965-8670 ("Lender"), the principal sum of Eighty-Six Thousand Dollars ($86,000), together with interest at the rate of ten percent (10%) per annum on the unpaid balance of principal from September 30, 1996 until this Note is paid in full.

The entire unpaid principal balance of this Note and all interest due under this Note shall be due and payable in full on September 30, 1997.

Borrower may prepay all or any portion of the unpaid principal balance at any time, and from time to time, without penalty. A prepayment of principal will not postpone the due date of any subsequent payment of interest or principal under this Note. All payments on this Note will be applied first to interest accrued as of the date of payment and then to principal.

Both principal and interest are payable in lawful money of the United States of America and in immediately available funds at the address of Lender shown above or at such other address as the Lender or other holder of this Note may designate in writing.

Borrower will pay all costs and expenses, including reasonable attorney's fees, incurred by the holder in collecting this Note or foreclosing on the security for this Note, even if no legal proceeding is filed. Borrower waives presentment, notice of dishonor and protest.

This Note will be construed and enforced in accordance with the laws of the State of Rhode Island, without resort to its conflict of laws rules.

IN WITNESS WHEREOF, the undersigned Borrower has executed this Note as of the date first above written.

MIM Holdings, LLC

By: /s/ E. David Corvese

Its: Manager

Witness: /s/ Mary Sampson

Exhibit 10.14

PROMISSORY NOTE

$456,000 Peace Dale, Rhode Island December 31, 1996

FOR VALUE RECEIVED, MIM Holdings, LLC, a Rhode Island limited liability company with offices at 25 North Road, P.O. Box 3689, Peace Dale, Rhode Island 02883 ("Borrower"), promises to pay to the order of MIM Corporation, a Delaware corporation with offices at One Blue Hill Plaza, Pearl River, New York 10965-8670 ("Lender"), the principal sum of Four Hundred Fifty-Six Thousand Dollars ($456,000), together with interest on the unpaid balance of principal from January 1, 1996 until this Note is paid in full at the rate of ten percent (10%) per annum.

All accrued interest from January 1, 1996 through September 30, 1997 shall be due on September 30, 1997. Thereafter, interest shall be paid on a quarterly basis, in arrears, until March 31, 2001, at which time the entire unpaid principal balance of this Note and all interest due under this Note shall be due and payable in full.

Borrower may prepay all or any portion of the unpaid principal balance at any time, and from time to time, without penalty. A prepayment of principal will not postpone the due date of any subsequent payment of interest or principal under this Note. All payments on this Note will be applied first to interest accrued as of the date of payment and then to principal.

Both principal and interest are payable in lawful money of the United States of America and in immediately available funds at the address of Lender shown above or at such other address as the Lender or other holder of this Note may designate in writing.

Borrower will pay all costs and expenses, including reasonable attorney's fees, incurred by the holder in collecting this Note or foreclosing on the security for this Note, even if no legal proceeding is filed. Borrower waives presentment, notice of dishonor and protest.

This Note will be construed and enforced in accordance with the laws of the State of Rhode Island, without resort to its conflict of laws rules.

IN WITNESS WHEREOF, the undersigned Borrower has executed this Note as of the date first above written.

MIM Holdings, LLC

By: /s/ E. David Corvese

Witness: /s/ Mary Sampson

Exhibit 10.32

MIM CORPORATION
1996 STOCK INCENTIVE PLAN

As Amended and Restated

TABLE OF CONTENTS

MIM CORPORATION
1996 STOCK INCENTIVE PLAN

SECTION 1 - Purpose

This MIM CORPORATION 1996 STOCK INCENTIVE PLAN (the "Plan") is intended to provide a means whereby MIM Corporation, a Delaware corporation (the "Company"), and any Subsidiary or other Affiliate of the Company (as hereinafter defined) may, through the grant of incentive stock options and non-qualified stock options (collectively "Options") to Employees and Key Contractors (as defined in Section 3), attract and retain such Employees and Key Contractors and motivate them to exercise their best efforts on behalf of the Company and of any Subsidiary or other Affiliate.

As used in the Plan, the following terms shall have the following meanings:

"Affiliate" means any corporation, limited liability company, partnership or other entity, including Subsidiaries, which is controlled by or under common control with the Company;

"incentive stock options" ("ISOs") means Options which qualify as incentive stock options within the meaning of section 422 of the Internal Revenue Code of 1986, as amended from time to time (the "Code"), at the time they are granted and which are either designated as ISOs in the Option Agreements (as hereinafter defined) covering such Options or which are designated as ISOs by the Committee (as defined in Section 2 hereof) at the time of grant;

"non-qualified stock options" ("NQSOs") means all Options granted under the Plan other than ISOs; and

"Subsidiary" means any corporation (whether or not in existence at the time the Plan is adopted) which, at the time an Option is granted, is a subsidiary of the Company under the definition of "subsidiary corporation" contained in section 424(f) of the Code or any similar provision hereafter enacted.

SECTION 2 - Administration

The Plan shall be administered by the Company's Compensation Committee (the "Committee"), which shall consist of not less than two (2) non-employee directors (within the meaning of Rule 16b-3(b)(3) under the Securities Exchange Act of 1934 (the "Exchange Act"), or any successor thereto) who are also outside directors (within the meaning of Treas. Reg. (S) 1.162-27(e)(3), or any successor thereto) of the Company who shall be appointed by, and shall serve at the pleasure of, the Company's Board of Directors (the "Board"). Each member of such Committee, while serving as such, shall be deemed to be acting in his or her capacity as a director of the Company.

The Committee shall have full and final authority in its absolute discretion, subject to the terms of the Plan, to select the persons ("Awardees") to be granted ISOs and NQSOs (collectively "Awards") under the Plan, to grant Awards on behalf of the Company, and to set the date of grant and the other terms of such Awards. The Committee may correct any defect, supply any omission and reconcile any inconsistency in the Plan and in any

Award granted hereunder in the manner and to the extent it shall deem desirable. The Committee also shall have the authority to establish such rules and regulations, not inconsistent with the provisions of the Plan, for the proper administration of the Plan, and to amend, modify or rescind any such rules and regulations, and to make such determinations and interpretations under, or in connection with, the Plan, as it deems necessary or advisable. All such rules, regulations, determinations and interpretations shall be binding and conclusive upon the Company, its shareholders and all officers and employees and former officers and employees, and upon their respective legal representatives, beneficiaries, successors and assigns and upon all other persons claiming under or through any of them.

No member of the Board or the Committee shall be liable for any action or determination made in good faith with respect to the Plan or any Award granted hereunder.

SECTION 3 - Eligibility

The class of persons who shall be eligible to receive Awards under the Plan shall be (i) the employees (including any directors and officers who also are employees) of the Company and/or of a Subsidiary or other Affiliate ("Employees") and (ii) contractors of the Company and/or of a Subsidiary or other Affiliate who the Committee believes have the capacity to contribute to the success of the Company and/or a Subsidiary or other Affiliate ("Key Contractors"), provided that ISOs shall be granted only to employees of the Company or of a Subsidiary. More than one Award may be granted to an Employee or Key Contractor under the Plan.

SECTION 4 - Stock

The number of shares of the Company's $.0001 par value per share Common Stock ("Common Shares") that may be subject to Awards under the Plan shall be 4,372,718 shares, subject to adjustment as hereinafter provided: provided, however, that no Awardee shall receive Options for more than 1,500,000 shares. Shares issuable under the Plan may be authorized but unissued shares or reacquired shares, as the Company may determine from time to time.

Any Common Shares subject to an Option which expires or otherwise terminates for any reason whatever (including, without limitation, the surrender thereof by the Awardee) without having been exercised shall continue to be available for the granting of Awards under the Plan; provided, however, that (a) if an Option is canceled, the Common Shares covered by the canceled Option shall be counted against the maximum number of shares specified in Section 4 for which Options may be granted to a single Awardee, and (b) if the exercise price of an Option is reduced after the date of grant, the transaction shall be treated as a cancellation of the original Option and the grant of a new Option for purposes of counting the maximum number of shares for which Options may be granted to a single Awardee.

SECTION 5 - Annual Limit

(a) ISOs. The aggregate Fair Market Value (determined as of the date the ISO is granted) of the Common Shares with respect to which ISOs become exercisable for the first time by an Awardee during any calendar year (under this Plan and any other ISO plan of the Company or any parent corporation (within the meaning of section 424(e) of the Code ("Parent")) or Subsidiary) shall not exceed $100,000. The term "Fair Market Value" shall mean the value of the Common Shares arrived at by a good faith determination of the Committee and shall be:

(1) the mean between the highest and lowest quoted selling price, if there is a market for the Common Shares on a registered securities exchange or in an over the counter market, on the date specified;

(2) the weighted average of the means between the highest and lowest sales on the nearest date before and the nearest date after the specified date, if there are no such sales on the specified date but there are such sales on dates within a reasonable period both before and after the specified date;

(3) the mean between the bid and asked prices, as reported by the National Quotation Bureau on the specified date, if actual sales are not available during a reasonable period beginning before and ending after the specified date; or

(4) such other method of determining Fair Market Value as shall be authorized by the Code, or the rules or regulations thereunder, and adopted by the Committee.

Where the Fair Market Value of Common Shares is determined under (2) above, the average of the means between the highest and lowest sales on the nearest date before and the nearest date after the specified date shall be weighted inversely by the respective numbers of trading days between the dates of reported sales and the specified date (i.e., the valuation date), in accordance with Treas. Reg. (S) 20.2031-2(b)(1), or any successor thereto.

(b) Options Over Annual Limit. If an Option intended as an ISO is granted to an Awardee and such Option may not be treated in whole or in part as an ISO pursuant to the limitation in (a) above, such Option shall be treated as an ISO to the extent it may be so treated under such limitation and as a NQSO as to the remainder. For purposes of determining whether an ISO would cause such limitation to be exceeded, ISOs shall be taken into account in the order granted.

(c) NQSOs. The annual limit set forth above for ISOs shall not apply to NQSOs.

SECTION 6 - Options

(a) Granting of Options. From time to time until the expiration or earlier suspension or discontinuance of the Plan, the Committee may, on behalf of the Company, grant to Awardees under the Plan such Options as it determines are warranted, subject to the limitations of the Plan; provided, however, that grants of ISOs and NQSOs shall be separate and not in tandem. The granting of an Option

under the Plan shall not be deemed either to entitle the Awardee receiving the Option to, or to disqualify the Awardee from, any participation in any other grant of Awards under the Plan. In making any determination as to whether an Awardee shall be granted an Option and as to the number of shares to be covered by such Option, the Committee shall take into account the duties of the Awardee, the Committee's views as to his or her present and potential contributions to the success of the Company or a Subsidiary or other Affiliate, and such other factors as the Committee shall deem relevant in accomplishing the purposes of the Plan. Moreover, the Committee may determine that the Option Agreement (as defined below) shall provide that said Option may be exercised only if certain conditions, as determined by the Committee, are fulfilled.

(b) Terms and Conditions of Options. The Options granted pursuant to the Plan shall expressly specify whether they are ISOs or NQSOs; however, if the Option is not designated in the Option Agreement as an ISO or NQSO, the Option shall constitute an ISO if it complies with the terms of section 422 of the Code, and otherwise, it shall constitute an NQSO. In addition, the Options granted pursuant to the Plan shall include expressly or by reference the following terms and conditions, as well as such other provisions not inconsistent with the provisions of this Plan as the Committee shall deem desirable, and for ISOs granted under this Plan, the provisions of section 422(b) of the Code:

(1) Number of Shares. A statement of the number of Common Shares to which the Option pertains (or, except in the case of an ISO, of a formula or other method by which such number shall be then or thereafter objectively determinable).

(2) Price. A statement of the Option exercise price (or, except in the case of an ISO, of a formula or method by which the exercise price shall be then or thereafter objectively determinable) which shall be determined and fixed by the Committee in its discretion at the time of grant, provided that, in the case of an ISO, the exercise price shall not be less than 100% of the Fair Market Value of the optioned Common Shares on the date the ISO is granted (or 110%, if the ISO is granted to a more than 10% shareholder per (9) below).

(3) Term.

(A) ISOs. Subject to earlier termination as provided in Subsections (5), (6) and (7) below, the term of each ISO shall be not more than 10 years (5 years in the case of a more than 10% shareholder as provided in (9) below) from the date of grant.

(B) NQSOs. The term of each NQSO shall be not more than 15 years from the date of grant.

(4) Exercise.

(A) General. Options shall be exercisable in such installments and on such dates, commencing not less than 6 months and 1 day from the date of grant (but, in the case of ISOs, not less than 12 months

from the date of grant), as the Committee may specify, provided that:

(i) in the case of new Options granted to an Awardee in replacement for options (whether granted under the Plan or otherwise) held by the Awardee, the new Options may be made exercisable, if so determined by the Committee, in its discretion, at the earliest date the replaced options were exercisable; and

(ii) the Committee may accelerate the exercise date of any outstanding Options in its discretion, if it deems such acceleration to be desirable.

Any Common Shares, the right to the purchase of which has accrued under an Option, may be purchased at any time up to the expiration or termination of the Option. Exercisable Options may be exercised, in whole or in part, from time to time by giving written notice of exercise to the Company at its principal office, specifying the number of Common Shares to be purchased and accompanied by payment in full of the aggregate Option exercise price for such shares. Only full shares shall be issued under the Plan and, if any fractional share would otherwise be issuable upon the exercise of an Option granted hereunder, the number of Common Shares issuable upon such exercise shall be rounded to the nearest whole share and the unexercised portion of such Option adjusted accordingly provided that in no event shall the total number of Common Shares issuable upon the full exercise of an Option exceed the number so specified for such Option under Section 6(b)(1) hereof.

(B) Manner of Payment. The Option price shall be payable:

(i) in cash or its equivalent;

(ii) in the case of an ISO, if the Committee in its discretion causes the Option Agreement so to provide and, in the case of a NQSO, if the Committee in its discretion so determines at or prior to the time of exercise, in Common Shares previously acquired by the Awardee, provided that if such shares were acquired through the exercise of an ISO and are used to pay the Option exercise price of an ISO, such shares have been held by the Awardee for a period of not less than the holding period described in section 422(a)(1) of the Code on the date of exercise, or if such Common Shares were acquired through exercise of an NQSO or of an option under a similar plan or through exercise of an ISO and are used to pay the Option exercise price of an NQSO, such shares have been held by the Awardee for a period of more than 12 months on the date of exercise; or

(iii) in the discretion of the Committee, in any combination of (i) and (ii) above.

In the event such Option exercise price is paid, in whole or in part, with Common Shares, the portion of the Option exercise price so paid shall equal the Fair Market Value on the date of exercise of the Option of the Common Shares surrendered in payment of such Option exercise price.

(5) Termination of Employment. If an Awardee's employment as an Employee or Key Contractor by the Company and Subsidiaries and, except in the case of ISOs, other Affiliates ("Employment") is terminated by either party prior to the expiration date fixed for his or her Option for any reason other than death or disability, such Option may be exercised, to the extent of the number of shares with respect to which the Awardee could have exercised it on the date of such termination, or to any greater extent permitted by the Committee, by the Awardee at any time prior to the earlier of:

(A) the expiration date specified in such Option; or

(B) in the case of an ISO, three months after the date of termination of the Awardee's Employment.

(6) Exercise upon Disability of Awardee. If an Awardee shall become disabled (within the meaning of Section 22(e)(3) of the Code) during his or her Employment and, prior to the expiration date fixed for his or her Option, such Employment is terminated as a consequence of such disability, such Option may be exercised, to the extent of the number of shares with respect to which the Awardee could have exercised it on the date of such termination, or to any greater extent permitted by the Committee, by the Awardee at any time prior to the earlier of:

(A) the expiration date specified in such Option; or

(B) in the case of an ISO, one year after the date of termination of Awardee's Employment.

In the event of the Awardee's legal disability, such Option may be so exercised by the Awardee's legal representative.

(7) Exercise upon Death of Awardee. If an Awardee shall die during his or her Employment and prior to the expiration date fixed for his or her Option, or if an Awardee whose Employment is terminated for any reason shall die following his or her termination of Employment but prior to the earliest of:

(A) the expiration date fixed for his or her Option;

(B) the expiration of the period determined under Subsections (5) and (6) above; or

(C) in the case of an ISO, three months following termination of Employment,

such Option may be exercised, to the extent of the number of shares with respect to which the Awardee could have exercised it on the date of his or her death, or to any greater extent permitted by the Committee, by the Awardee's estate, personal representative or beneficiary who acquired the right to exercise such Option by bequest or inheritance or by reason of the death of the Awardee, at any time prior to the earlier of:

(i) the expiration date specified in such Option; or

(ii) in the case of an ISO, one year after the date of death.

(8) Rights as a Shareholder. An Awardee shall have no rights as a shareholder with respect to any shares covered by his or her Option until the issuance of a stock certificate to him or her for such shares.

(9) Ten Percent Shareholder. If an Awardee owns more than 10% of the total combined voting power of all shares of stock of the Company or of a Subsidiary or Parent at the time an ISO is granted to such Awardee, the Option exercise price for the ISO shall be not less than 110% of the Fair Market Value of the optioned Common Shares on the date the ISO is granted, and such ISO, by its terms, shall not be exercisable after the expiration of five years after the date the ISO is granted. The conditions set forth in this Subsection (9) shall not apply to NQSOs.

(c) Option Agreements. Options granted under the Plan shall be evidenced by written documents ("Option Agreements") in such form as the Committee shall, from time to time, approve, which Option Agreements shall contain such provisions, not inconsistent with the provisions of the Plan and, in the case of an ISO, Section 422(b) of the Code, as the Committee shall deem advisable, and which Option Agreements shall specify whether the Option is an ISO or NQSO; provided, however, if the Option is not designated in the Option Agreement as an ISO or NQSO, the Option shall constitute an ISO if it complies with the terms of section 422 of the Code, and otherwise, it shall constitute an NQSO. Each Awardee shall enter into, and be bound by, the terms of the Option Agreement.

SECTION 7 - Capital Adjustments

The number of shares which may be issued under the Plan as stated in Section 4 hereof, and the number of shares issuable upon exercise of outstanding Options under the Plan (as well as the Option exercise price per share under such outstanding Options) shall, subject to the provisions of section 424(a) of the Code, be adjusted, as may be deemed appropriate by the Committee, to reflect any stock dividend, stock split, share combination, or similar change in the capitalization of the Company.

In the event of a corporate transaction as that term is described in Section 424(a) of the Code and the Treasury Regulations issued thereunder (a "Corporate Transaction") (as, for example, a merger, consolidation, acquisition of property or stock, separation, reorganization, or liquidation), each outstanding Award shall be assumed by the surviving or successor corporation; provided, however, that, in the event of a proposed Corporate

Transaction, the Committee may terminate all or a portion of the outstanding Options if it determines that such termination is in the best interests of the Company. If the Committee decides to terminate outstanding Options, the Committee shall give each Awardee holding an Option to be terminated not less than ten days' notice prior to any such termination by reason of such a Corporate Transaction, and any such Option which is to be so terminated may be exercised (if and only to the extent that it is then exercisable) up to and including the date immediately preceding such termination. Further, as provided in Section 6(b)(4)(A)(ii) hereof, the Committee, in its discretion, may accelerate, in whole or in part, the date on which any or all Options become exercisable.

The Committee also may, in its discretion, change the terms of any outstanding Award to reflect any such Corporate Transaction, provided that, in the case of ISOs, such change is excluded from the definition of a "modification" under section 424(h) of the Code.

SECTION 8 - Change in Control

All Options shall become fully vested and exercisable upon a Change in Control of the Company occurring after June 30, 1996. A "Change in Control" shall be deemed to have taken place if and only if either (i) any Person (as defined hereinbelow), together with all affiliates and associates thereof (as defined in Rule 12b-2 under the Exchange Act), shall become the beneficial owner (as such term is used under Section 13(d) of the Exchange Act and the rules and regulations promulgated thereunder) of shares of the Company having more than 50% of the total number of votes that may be cast for the election of directors of the Company, or (ii) there occurs any cash tender or exchange offer for shares of the Company, merger or other business combination, or sale of assets, or any combination of the foregoing transactions, and as a result of or in connection with any such event persons who are directors of the Company before the event shall cease to constitute a majority of the board of directors of the Company or of any successor to the Company. The Company shall give appropriate advance notice to all Awardees of Options under the Plan of a pending Change in Control so as to permit such Awardees the opportunity to exercise such Options prior to the Change in Control.

As used in clause (i) of this Section 8, a "Person" means any person, group or entity other than the following: the Company; any employee benefit plan of the Company or of any affiliates or associates thereof (each as defined in Rule 12b-2 under the Exchange Act); any person or entity organized, appointed or established by the Company for or pursuant to the terms of any such employee benefit plan; any stockholder of the Company as of June 30, 1996; or any stockholder, member or other owner of a stockholder of the Company as of June 30, 1996.

SECTION 9 - Amendment or Discontinuance of the Plan

At any time and from time to time, the Board may suspend or terminate the Plan or amend it, and the Committee may amend any outstanding Awards, in any respect whatsoever, except that the following amendments shall require the approval by the affirmative votes of holders of at least a majority of the shares present, or represented, and entitled to vote at a duly held meeting of stockholders of the Company:

(a) with respect to ISOs, any amendment which would:

(1) change the class of employees eligible to participate in the Plan;

(2) except as permitted under Section 7 hereof, increase the maximum number of Common Shares with respect to which ISOs may be granted under the Plan; or

(3) extend the duration of the Plan under Section 10 hereof with respect to any ISOs granted hereunder; and

(b) any amendment which would require shareholder approval pursuant to Treas. Reg. (S) 1.162-27(e)(4)(vi), or any successor thereto.

The foregoing notwithstanding, no such suspension, discontinuance or amendment shall materially impair the rights of any holder of an outstanding Award without the consent of such holder.

SECTION 10 - Termination of Plan

Unless earlier terminated as provided in the Plan, the Plan and all authority granted hereunder shall terminate absolutely at 12:00 midnight on May 22, 2006, which date is the day immediately prior to 10 years after the date the Plan was adopted by the Board, and no Awards hereunder shall be granted thereafter. Nothing contained in this Section 10, however, shall terminate or affect the continued existence of rights created under Awards issued hereunder and outstanding on May 22, 2006 which by their terms extend beyond such date.

SECTION 11 - Shareholder Approval

This Plan became effective on May 23, 1996.

SECTION 12 - Miscellaneous

(a) Governing Law. The Plan, and the Option Agreements entered into, and the Awards granted thereunder, shall be governed by the applicable Code provisions. Otherwise, the operation of, and the rights of Awardees under, the Plan, the Option Agreements, and the Awards shall be governed by applicable federal law and otherwise by the laws of the State of Delaware.

(b) Rights. Neither the adoption of the Plan nor any action of the Board or the Committee shall be deemed to give any individual any right to be granted an Award, or any other right hereunder, unless and until the Committee shall have granted such individual an Award, and then his or her rights shall be only such as are provided by the Plan and the Award Agreement.

Any Option under the Plan shall not entitle the holder thereof to any rights as a shareholder of the Company prior to the exercise of such Option and the issuance of the shares pursuant thereto. Further, no provision of the Plan or any Option Agreement with an Awardee shall limit the Company's right, in its discretion, to retire such person at any time pursuant to its retirement rules or otherwise to terminate his or her Employment at any time for any reason whatsoever.

(c) No Obligation to Exercise Option. The granting of an Option shall impose no obligation upon the Awardee to exercise such Option.

(d) Non-Transferability. No Award shall be assignable or transferable by the Awardee otherwise than by will or by the laws of descent and distribution, and during the lifetime of such person, any Options shall be exercisable only by him or her or by his or her guardian or legal representative. If an Awardee is married at the time of exercise of an Option and if the Awardee so requests at the time of exercise, the certificate or certificates issued shall be registered in the name of the Awardee and the Awardee's spouse, jointly, with right of survivorship.

(e) Withholding and Use of Shares to Satisfy Tax Obligations. The obligation of the Company to deliver Common Shares or pay cash to an Awardee pursuant to any Award under the Plan shall be subject to applicable federal, state and local tax withholding requirements.

In connection with an Award in the form of Common Shares subject to the withholding requirements of applicable federal tax laws, the Committee, in its discretion (and subject to such withholding rules ("Withholding Rules") as shall be adopted by the Committee), may permit the Awardee to satisfy the minimum required federal, state and local withholding tax, in whole or in part, by electing to have the Company withhold (or by returning to the Company) Common Shares, which shares shall be valued, for this purpose, at their Fair Market Value on the date of exercise of the Option (or if later, the date on which the Awardee recognizes ordinary income with respect to such exercise) (the "Determination Date"). An election to use Common Shares to satisfy tax withholding requirements must be made in compliance with and subject to the Withholding Rules. The Company may not withhold shares in excess of the number necessary to satisfy the minimum required federal, state and local income tax withholding requirements. In the event Common Shares acquired under the exercise of an ISO are used to satisfy such withholding requirement, such Common Shares must have been held by the Awardee for a period of not less than the holding period described in section 422(a)(1) of the Code on the Determination Date, or if such Common Shares were acquired through exercise of an NQSO or of an option under a similar plan, such option must have been granted to the Awardee at least six months prior to the Determination Date.

(f) Listing and Registration of Shares. Each Award shall be subject to the requirement that, if at any time the Committee shall determine, in its discretion, that the listing, registration or qualification of the shares covered thereby upon any securities exchange or under any state or federal law, or the consent or approval of any governmental regulatory body, is necessary or desirable as a condition of, or in connection with, the granting of such Award or the purchase or vesting of shares thereunder, or that action by the Company or by the Awardee should be taken in order to obtain an exemption from any such requirement, no such Option may be exercised, in whole or in part, unless and until such listing, registration, qualification, consent, approval, or action shall have been effected, obtained, or taken under conditions acceptable to the Committee. Without limiting the generality of the foregoing, each Awardee or his or her legal representative or beneficiary may also be required to give satisfactory assurance that

shares purchased upon exercise of an Option are being purchased for investment and not with a view to distribution, and certificates representing such shares may be legended accordingly.

IN WITNESS WHEREOF, MIM Corporation has caused these presents to be duly executed, under seal, this 19th day of March, 1997.

MIM Corporation

By: /s/ E. David Corvese

E. David Corvese, Vice Chairman

Exhibit 10.42

Guaranty

For good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the undersigned unconditionally guarantees the full payment to MIM Corporation of the obligation set forth in the Promissory Note of MIM Holdings, LLC to MIM Corporation dated December 31, 1996, a copy of which is attached hereto as Exhibit A, upon the default of MIM Holdings, LLC.

I hereby waive presentment, demand, protest, notice of dishonor, and notice of acceptance of this guaranty. I also waive, to the extent permitted by law, all notices, all defenses and claims that the borrower, MIM Holdings, LLC, could assert, any right to require you to pursue any remedy or seek payment from any other person before seeking payment under this agreement, all other defenses to the debt, except payment in full. If any payments on the debt are set aside, recovered, or required to be returned in the event of the insolvency, bankruptcy or reorganization of the borrower, my obligations under this agreement will continue as if such payments had never been made.

This Guarantee will be construed and enforced in accordance with the laws of the State of Rhode Island, without resort to its conflict of laws rules.

Dated as of December 31, 1996.

/s/ E. David Corvese

E. David Corvese

Witness: /s/ Mary Sampson

EXHIBIT A.

PROMISSORY NOTE

$456,000 Peace Dale, Rhode Island December 31, 1996

FOR VALUE RECEIVED, MIM Holdings, LLC, a Rhode Island limited liability company with offices at 25 North Road, P.O. Box 3689, Peace Dale, Rhode Island 02883 ("Borrower"), promises to pay to the order of MIM Corporation, a Delaware corporation with offices at One Blue Hill Plaza, Pearl River, New York 10965-8670 ("Lender"), the principal sum of Four Hundred Fifty-Six Thousand Dollars ($456,000), together with interest on the unpaid balance of principal from January 1, 1996 until this Note is paid in full at the rate of ten percent (10%) per annum.

All accrued interest from January 1, 1996 through September 30, 1997 shall be due on September 30, 1997. Thereafter, interest shall be paid on a quarterly basis, in arrears, until March 31, 2001, at which time the entire unpaid principal balance of this Note and all interest due under this Note shall be due and payable in full.

Borrower may prepay all or any portion of the unpaid principal balance at any time, and from time to time, without penalty. A prepayment of principal will not postpone the due date of any subsequent payment of interest or principal under this Note. All payments on this Note will be applied first to interest accrued as of the date of payment and then to principal.

Both principal and interest are payable in lawful money of the United States of America and in immediately available funds at the address of Lender shown above or at such other address as the Lender or other holder of this Note may designate in writing.

Borrower will pay all costs and expenses, including reasonable attorney's fees, incurred by the holder in collecting this Note or foreclosing on the security for this Note, even if no legal proceeding is filed. Borrower waives presentment, notice of dishonor and protest.

This Note will be construed and enforced in accordance with the laws of the State of Rhode Island, without resort to its conflict of laws rules.

IN WITNESS WHEREOF, the undersigned Borrower has executed this Note as of the date first above written.

MIM Holdings, LLC

By: /s/ E. David Corvese

Witness: /s/ Mary Sampson

Exhibit 10.43

ASSIGNMENT

MIM Holdings, LLC hereby assigns to MIM Corporation as security for the repayment to MIM Corporation of that indebtedness represented by the Promissory Note of MIM Holdings, LLC dated December 31, 1996, the following Promissory Notes of MIM Holdings, LLC:

(i) Promissory Note of Michael R. Ryan in the amount of $100,000 dated March 31, 1996; and

(ii) Promissory Note of Todd Palmieri in the amount of $356,000 dated March 31, 1996.

MIM Holdings, LLC agrees that MIM Corporation is entitled to notify the issuers of the assigned promissory notes to make payments of amounts due directly to MIM Corporation in the event MIM Holdings, LLC defaults on its debt owed to MIM Corporation.

Dated as of December 31, 1996.

MIM Holdings, LLC

By /s/ E. David Corvese

YEAR	
	DEC-31-1996
	JAN-01-1996
	DEC-31-1996
	1,834
	37,038
	19,734
	1,088
	0
	49,722
	3,664
	1,241
	61,800
	30,153
	0
	0
	0
	1
	30,142
	61,800
	283,159
	283,159
	278,068
	278,068
	38,259
	928
	0
	(31,754)
	0
	(31,754)
	0
	0
	0
	(31,754)
	(3.32)
	(3.32)