



P.O. BOX 15688, AMARILLO, TEXAS 79105
800-687-1501 • 806-373-1580 • FAX 806-373-6646

January 25, 2005

Mr. Robert R. King, President
Southwest Medical IPA, PA
3803 22nd Street
Lubbock, Texas 79410

RE: OMNI NETWORKS, INC.

Dear Mr. King:

Enclosed is an executed copy of Amendment I to the Provider Organization Agreement between OMNI Networks, Inc. and Southwest Medical IPA, PA that will go into effect February 1, 2005.

If you have any questions, please let me know.

Best regards,

A handwritten signature in cursive script that reads "Joe Clark".

Joe C. Clark, President

JCC/nlh

Enclosure

cc: Cathy Kirkland
OMNI Networks, Inc.

Jan-17-2005 12:17pm

From-SOUTHWEST MEDICAL IPA

806-785-5488

T-249

P.001/004

F-821

SOUTHWEST MEDICAL I.P.A., P.A.

3803 22nd Street
Lubbock, Texas 79410
806-785-0590
FAX 806-785-5488

TO: Nancy Hunter @MNP

FAX #: 1-800-373-3621

FROM: Ann Apple

DATE: 1-17-05

NUMBER OF PAGES (including cover page): 4

**AMENDMENT I
TO
PROVIDER PARTICIPATION AGREEMENT
BETWEEN
OMNI NETWORKS, INC. [OMNI NETWORK]
AND
SOUTHWEST MEDICAL IPA, PA [PROVIDER]**

The above Agreement is hereby amended in accordance with Article I. of the Agreement as follows:

WHEREAS, OMNI Networks and Provider have entered into a Provider Participation Agreement, effective September 1, 2002; and

WHEREAS, OMNI Networks and Provider agree that the provisions of this Amendment shall be effective as of February 1, 2005.

WHEREAS, except as provided by this Amendment, the Existing Agreement shall remain in full force and effect.

THEREFORE, in consideration of the foregoing and mutual promises herein, the parties agree to amend only the sections specified herein as follows:

Exhibit A. Delegated Credentialing shall be added to this Agreement.

IN WITNESS WHEREOF, the Parties have executed this Delegated Credentialing Amendment as of the date indicated above in this Amendment. Signatures of a duly authorized representative of both Parties are incorporated below attesting to the execution of this Amendment on the date specified above.

Southwest Medical IPA, PA

By: [Signature]

Printed Name: Robert R. King, M.D.

Title: President

Date: 1-17-05

Federal Tax I.D. Number(s):

75-2122457

OMNI Networks, Inc.

By: [Signature]

Printed Name: JOE CLARK

Title: PRESIDENT

Date: JANUARY 24, 2005

**OMNI NETWORKS, INC
PROVIDER PARTICIPATION AGREEMENT**

EXHIBIT A

DELEGATED CREDENTIALING

OMNI Networks will delegate credentialing to Provider. Provider shall establish and provide OMNI Networks with Provider's credentialing criteria by which providers shall be required to meet all requirements prior to becoming a Provider. In the event, Provider fails to provide credentialing according to criteria set forth in this Exhibit A, Delegated Credentialing, OMNI Networks may suspend delegated credentialing until such time as Provider's Board of Directors can submit a written letter regarding proof of establishment and compliance with a formal review process or plan to correct any non-compliance with Provider's credentialing process.

Provider shall require that all credentialing information shall be reviewed and approved by Provider's credentialing committee and Board of Directors before an applicant is approved as a Provider. Provider shall review the credentials of every Provider at least every three (3) years to ensure that the quality of care is appropriate and that Provider is in compliance with Provider's credentialing standards.

OMNI Networks may perform a pre-delegation audit with Provider to ensure qualification of Delegated Credentialing status to include, but not limited to a comprehensive credentialing process that meet or exceeds industry standards for Credentialing and Recredentialing Policies and Procedures to assure quality health care delivery.

OMNI NETWORKS may review the Provider's credentialing files located in Provider's office at least annually, provided that OMNI Networks gives Provider written notification at least ten (10) working days before such a review will occur. Any such release of information shall be consistent with state and federal confidentiality laws and shall not jeopardize any available peer review privilege.

Provider shall have the opportunity to answer or correct any deficiencies within Provider's file noted by OMNI Networks within thirty (30) days of written notification of question or deficiency by OMNI Networks. OMNI Networks shall have the right to terminate this Exhibit A, Delegated Credentialing in the event Provider has significant continued noncompliance with Provider's credentialing criteria, or Provider fails to provide OMNI Networks with Provider Information as set forth in this Exhibit A.

PROVIDER INFORMATION

(a) Provider agrees to furnish to OMNI Networks prior to or with the signed Agreement, a record for each Provider containing the following information, which shall be incorporated into this Agreement by reference:

- (1) Full name
- (2) Medical degree designation (M.D., D.O., etc.)
- (3) Date of enrollment with Provider

- (4) Social Security Number
- (5) Federal Tax Identification Number(s)
- (6) Medicare Number
- (7) Hospital staff privileges list (including level and status)
- (8) Board certification status
- (9) Site locations
- (10) Site telephone numbers
- (11) Mailing address
- (12) Open or Closed practice

(b) Provider agrees to furnish OMNI Networks with updated information for each Provider and each new member of Provider. Such updated information shall include the following for each Provider:

- (1) Full name
- (2) Medical degree designation
- (3) Social Security Number
- (4) Reason for change (address, telephone, FTIN, etc.)
- (5) Old and New Federal Tax Identification Number(s) if changed
- (6) Old and New Medicare Number
- (7) Old Address and new address (for address change)
- (8) Old telephone number and new number (if changed)
- (9) Effective date of changed data
- (10) Effective date of disenrollment/termination (if no longer a member of Provider)
- (11) Open or Closed practice

OMNI NETWORKS

P.O. BOX 15688, AMARILLO, TEXAS 79105
800-687-1501 • 806-373-1580 • FAX 806-373-6646

August 29, 2002

Dr. W. C. Williams
Southwest Medical, I.P.A., P.A.
3803 22nd Street
Lubbock, Texas 79410

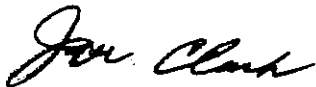
RE: OMNI NETWORKS, INC.

Dear Dr. Williams:

Enclosed is an executed original of the Provider Participation Agreement between Southwest Medical I.P.A, P.A. and OMNI Networks, Inc. which will go into effect September 1, 2002.

If you have any questions, please let me know.

Best regards,



Joe C. Clark, CLU

JCC/nlh

Enclosure

cc: Cathy Kirkland
IMS Marketing, Inc.

PROVIDER PARTICIPATION AGREEMENT

By this Provider Participation Agreement ("Agreement"), Southwest Medical IPA, P.A. ("Provider") accepts and understands the conditions for participation in OMNI Networks, Inc. a Texas for-profit corporation.

A. OMNI Network's Purpose. OMNI Networks is an organization of health care providers, which has as its purposes:

1. To function as a preferred provider organization with the goals of preparing to address the health care marketplace now and in the future;
2. To facilitate the provision of quality health care services in a cost effective manner;
3. To offer access through certain managed care programs to patients in the service area;
4. To develop a network arrangement through which to offer geographic and specialty coverage to areas of the community that currently do not receive them;
5. To meet the needs of the community with regard to improving access to managed care; and
6. To do such things as may be incident to, and necessary or appropriate to effect, any and all of such purposes.

B. Obligations of OMNI Networks

1. OMNI Networks intends to contract, affiliate or otherwise collaborate with certain insurance companies and third-party administrators ("Companies") in order to include OMNI Network's members, including Providers, in Companies' insured preferred provider organization products.
2. OMNI Networks agrees to use its best efforts to otherwise contract with potential third-party payors, including employers and health benefit and managed care plans ("Payors") in order to enable OMNI Networks to arrange for the delivery of professional health care services by its members, including Provider. OMNI Networks shall also meet such other criteria specific to fulfilling the purposes of the organization as the Board of Directors may from time to time determine.

3. OMNI Networks shall furnish Provider with a written summary of the terms and conditions of each executed Payor agreement proposed to utilize Provider at least thirty (30) days prior to the effective date of such agreement. If any Provider does not agree with the terms and conditions of the Payor agreement, Provider may decline participation without penalty.
 4. OMNI Networks shall contractually require Companies or Payors, as appropriate, to provide Provider with written information concerning any utilization management and quality improvement plan administered by OMNI Networks, Companies, or Payors and any modifications thereto at least thirty (30) days prior to the effective date of such plan or modification, as applicable.
 5. OMNI Networks shall, and shall require each Payor's agreement to, maintain any medical records, which it or Payor may obtain or have, access to under the Payor agreement in accordance with all applicable state and federal statutes and regulations regarding confidentiality of medical records.
 6. OMNI Networks shall arrange for Companies each to list their selected members, including Provider as applicable, as participating physicians in provider directories developed and distributed by those Payors whose contracts include Provider or which Provider has otherwise accepted pursuant to this Agreement. OMNI Networks and/or Payor shall provide a copy of this information at least quarterly.
 7. Assignment of Agreement. Neither party can assign this agreement without previous written consent of the other party.
- C. Conditions of Membership. Provider understands and agrees to comply with the following conditions of membership, which apply to all participating providers who are members of OMNI Networks:
1. To meet and comply with all the applicable participation criteria set forth in Attachment 1 to this Agreement;
 2. To recognize and agree to OMNI Networks authority on behalf of Provider to enter into agreements with Companies that match or exceed the reimbursement schedule that Provider has individually reviewed and approved at the time of application for membership in OMNI Networks and which is included as Attachment 2 to the Agreement, as it may from time to time be revised, and other terms or conditions of this Agreement. OMNI Networks shall afford Provider notice of such proposed revisions at least sixty (60) days prior to its effective date. Provider has the right to terminate this Agreement by providing written notice at least thirty (30) days prior to the effective date of any revisions to or amendments of the reimbursement schedule. Provider's failure to provide such notice to OMNI Networks will constitute acceptance of the amendment by Provider;

3. To participate in any and all managed care agreements with which OMNI Networks contracts through Companies that require Provider's participation and that fall within OMNI Networks contracting parameters that Provider has reviewed and approved, as set forth in Attachment 3 to this Agreement prior to such agreements being entered into by OMNI Networks (Provider recognizes and agrees that not all contracts may request or require that Provider be included in the panel of contracting providers and that if chosen, Provider may not be utilized by any guaranteed number of beneficiaries);
4. To recognize and allow the OMNI Networks to provide OMNI Networks membership or credentialing criteria upon request to Companies with whom OMNI Networks contracts;
5. To comply with criteria, policies and procedures of OMNI Networks as enacted by the Board of Directors. The Board of Directors shall advise all OMNI Networks members, including Provider, of such criteria, policies and procedures sixty (60) days but in no case later than thirty (30) days prior to the effective date of same;
6. To participate in and cooperate with any quality assurance and utilization review programs that OMNI Networks or Companies may develop, including agreeing to release to OMNI Networks and Companies information necessary to provide care under the signed agreements between OMNI Networks and Companies. The Board of Directors shall advise, and shall require Companies, as applicable, to advise, all OMNI Networks members, including Provider, of such criteria, policies and procedures at least thirty (30) days prior to the effective date of same;
7. To address all grievances arising out of or relating to this Agreement through the grievance process established by OMNI Networks, which is included as Attachment 4 to this Agreement, and to agree to settle any controversy or claim by arbitration in accordance with the Texas General Arbitration Act;
8. To comply with the membership renewal requirements and procedures utilized by OMNI Networks on periodic basis, which requirements and procedures shall be made available to all OMNI Networks members sixty (60) days prior to their effective date;
9. To advise OMNI Networks immediately upon the occurrence of any change or alteration in the information provided in the Provider's application for membership in OMNI Networks;
10. To recognize and agree that neither party shall disclose the terms of this Agreement or any Payor agreement, including but not limited to any fee schedule, without the prior written consent of the other party; and

11. To recognize and agree that the membership in OMNI Networks can be terminated for Provider's failure to materially comply with the terms and conditions of this Agreement, the application, and the Bylaws and Articles of Incorporation of OMNI Networks.

D. Effect of Membership in OMNI Networks. Provider understands and agrees that:

1. Membership in the OMNI Networks has no effect on or relationship to Medical Staff privileges at any hospital at which Provider has privileges, except that loss of staff membership results in termination of OMNI Networks membership;
2. Nothing shall prohibit Provider from providing on an individual basis any medical services not subject to a Payor agreement to any patient, or from providing medical services of any type to any patient who is not covered under any Payor agreement with the OMNI Networks. If, after reviewing a proposal for a Payor agreement, OMNI Networks elects not to enter into that Payor agreement, any OMNI Networks physician member including Provider may enter into a contract or contracts with or with respect to any or all such patients for the provision of medical or other services, on such terms as the parties to such contract or contracts shall see fit.

E. Termination of Membership. Provider understands that the following actions shall constitute Provider's termination or cause the Board of Directors to terminate Provider's membership in OMNI Networks;

1. This Agreement shall become effective as of the date on the signature page of this Agreement (the "Effective Date") and shall initially be for a period of one (1) year, unless sooner terminated by either party in accordance with this Agreement. Unless so terminated, thereafter this Agreement shall automatically renew for one (1) year periods on the anniversary of the Effective Date of this Agreement, subject, however, to termination by either party in accordance with this Agreement.
2. **This Agreement may be terminated by either party, with or without cause, by giving written notice thereof to the other party at least sixty (60) days in advance of such termination.**
3. Except for the termination capability set forth in Section C.2. regarding reimbursement revisions, Provider's voluntary termination of Provider's membership in the OMNI Networks requires written notice to the Board of Directors. Effective date of termination will be the earlier of sixty (60) days from the date of notice or until completion of the current course of treatment for a particular patient or until all patients being treated by Provider under an OMNI Networks contract have been transferred to another participating Provider. It shall be the responsibility of OMNI Networks or the Payor/Company to arrange for such transfers, and Payor agrees to reimburse any care provided after the completion of the course of treatment at

Provider's usual and customary rates.

4. Upon Provider's retirement from the active practice of medicine, Provider shall so notify the OMNI Networks, and Provider's membership in OMNI Networks shall be automatically terminated upon thirty (30) days after the notice is received;
 5. Provider's membership in OMNI Networks shall be terminated immediately upon OMNI Networks receipt of notice or other knowledge that Provider has ceased to be duly licensed to practice medicine in the State of Texas;
 6. Provider's membership shall be automatically terminated if Provider ceases for whatever reason to be on the Medical Staff at a Covenant Health System, System-affiliated facility or other approved hospital;
 7. Provider shall be notified by the OMNI Networks' Board in writing that his or her failure to comply with any OMNI Networks or Companies' programs, criteria, or policies and procedures. The OMNI Networks' Board or Companies, as applicable, shall state in the notice to Provider, within thirty (30) days to remedy such non-compliance. If Provider does not resolve such issues, Provider's membership shall be terminated effective on the date set forth in the notice. Provider shall have the opportunity to utilize the OMNI Networks grievance procedures as appropriate;
 8. The dissolution of bankruptcy of OMNI Networks.
- F. Confidentiality. Except as specifically provides for in this agreement, Provider and Payor/Network will consider all information provided by the other party as confidential and proprietary business information.
- G. Entire Agreement. This Agreement embodies the entire Agreement between OMNI Networks and Provider, and there are no agreements, representations, or warranties, oral or written between OMNI Networks and Provider other than those set forth as provided in this Agreement.
- H. Rights Under This Agreement. This Agreement shall bind, and inure to the benefit of, the parties hereto and their respective successors and assigns. Nothing contained in this Agreement is intended to confer upon any person, other than Provider and OMNI Networks and their respective successors and assigns, any rights, remedies, obligations or liabilities under or by reason of this Agreement.
- I. Amendment. This Agreement may be amended, modified or supplemented with respect to any of the terms contained herein with the written mutual consent of Provider and OMNI Networks.

I have read and understand this Provider Participation Agreement, and hereby accept participation as a member in the OMNI Networks. If Provider is a physician group, I warrant that I am executing this Provider Participation Agreement on behalf of each of the physicians listed in Attachment 5 hereto pursuant to the limited power of attorney each such physician has executed for such purpose. However, each physician and I understand that this Provider Participation Agreement shall be construed as a series of separate agreements, between the OMNI Networks and each respective physician, and further, that each such separate agreement may be terminated separately, either by the physician or by the OMNI Networks, in accordance with the terms herein.

W.C. Williams

(Signature)

W.C. Williams, M.D.

(Name)

Southwest Medical, I.P.A., P.A.

3803-22nd Street

(Address)

806-785-0590

(Telephone Number) Lubbock, Tx 79410

ACKNOWLEDGED AND ACCEPTED THIS 1st DAY OF September, 2002:
OMNI Networks

By: Joe Clark
Joe Clark

Title: President of OMNI Networks, Inc.



ATTACHMENT 1

Participation Criteria

OMNI NETWORKS

Provider Participation Criteria

- A. To be accepted for participation and to maintain status in the OMNI Networks Organization ("OMNI Networks"), every applicant must demonstrate that he or she fulfills at least the following criteria:
1. Graduation from a school of medicine, osteopathy, podiatry or dentistry recognized by the Medical Staff Bylaws of Covenant Health System or an affiliated facility as such is defined by the Board which is appropriately accredited.
 2. Maintenance of a level of clinical activity at Covenant Health System or an affiliated facility as such is defined by the Board, sufficient to evaluate applicant's clinical competency, quality of care and the efficiency of applicant's practice.
 3. Demonstration of active involvement in Covenant Health System's and/or an affiliated facility's health care community as evidenced by activities including, but not limited to, attendance at meetings, voluntary participation on committees and clinical activity at Covenant Health System or an affiliated facility as such is defined by the Board.
 4. Willingness to participate in OMNI Networks.
 5. Medical staff privileges at Covenant Health System or an affiliated facility as such is defined by the Board.
 6. Valid, current professional licensure for the State of Texas.
 7. Valid, current Drug Enforcement Administration (DEA) and Texas Department of Public Safety (DPS) registration, if applicable.
 8. Current professional liability insurance coverage in an amount and from carriers deemed appropriate by the Board.
 9. Willingness to participate in any and all contracts with Payors which meet the contract parameters of OMNI Networks (recognizing and agreeing to the fact that the OMNI Networks cannot guarantee that the applicant will be selected by every Payor to participate in, or be a member of every panel of contracting providers, or any minimum number of panels or plans, or that is selected, applicant will be utilized by any minimum number of patients, if at all).

10. Absence OR satisfactory resolution of the following:

- a. Involvement in a professional liability suit, arbitration, settlement or any legal or regulatory action in connection with applicant's professional practice.
 - b. Denial or cancellation of professional liability insurance.
 - c. Recognizing the requirements of the Americans with Disabilities Act, current physical or mental health problems, which may interfere with applicant's ability to practice medicine.
 - d. Professional disciplinary action or formal complaints by the State Board of Medical Examiners or any other regulatory body.
 - e. Involuntary termination of employment or contract as physician.
 - f. Felony criminal conviction (including a plea or verdict of guilty or a conviction following a plea of nolo contendere).
11. Maintenance of practice consistent with the goals of OMNI Networks and scrupulous observation of the highest professional level.
12. Willingness to report to OMNI Networks (and actual reporting thereof) to advise OMNI Networks of any changes in any of the above information within thirty (30) days after they occur.
13. Demonstration of cost effective utilization of health care resources will be based on criteria presented and described and made a part of the participation agreement.
14. Completion of an application form, submission of all supporting documentation, and absence of falsification on the application.
15. Execution of and agreement to abide by the terms of OMNI Networks' Participation Agreement.
16. Willingness to address all grievances through the grievance process established by OMNI Networks.

B. Acceptance as a participating providers is ultimately

dependent upon the geographic and specialty needs of the OMNI Networks at any given time, as established by the Board. New applications may be solicited from time to time by the Board in accordance with the needs of the OMNI Networks.

ATTACHMENT 2

Reimbursement



ATTACHMENT 3

Contract Parameters

CONTRACT PARAMETERS

OMNI Networks shall enter agreements with Companies which meet the following contract parameters:

1. OMNI Networks shall insure that agreements between OMNI Networks and Payors and Companies include the same or similar language addressing the specific points identified in these contract parameters, and that such further agreements do not conflict with various other provisions of the agreement between OMNI Networks and Provider.
2. The term and termination provisions will be clearly stated and will comply with paragraph E.3. above, to wit: except for the termination capability set forth in Section C.2. regarding reimbursement revisions, Provider's voluntary termination of Provider's membership in the OMNI Networks requires written notice to the Board of Directors. Effective date of termination will be the earlier of sixty (60) days from the date of notice or until completion of the current course of treatment for particular patient or until all patients being treated by Provider under an OMNI Networks contract have been transferred to another participating Provider. It shall be the responsibility of the Payor/Company to arrange for such transfers, and Payor agrees to reimburse any care provided after the effective date of termination of completion of a course of treatment at Provider's usual and customary rates.
3. No Assumption of Liability. Each party will use reasonable care and due diligence in performing this Agreement. Each party shall be responsible for any claims, actions, liabilities or damages arising under this Agreement out of their acts or omissions. Neither party assumes any liability for any actions or omissions of the other party of those of the other party's officers, employees, agents or representatives arising under this Agreement. Neither party shall be liable or assumes any responsibility for defending, or the expense of defending, the other party, its officers, employees, agents or representatives against any claim or legal action, or in any dispute resolution, administrative or regulatory proceeding arising under this Agreement out of such party's acts or omissions.
4. Specific provisions will be included to ensure the confidentiality of medical records and other proprietary information and identify responsibility for obtaining necessary authorization for release of information. Companies will be responsible for reasonable costs of records copying charges.
5. Ensure clearly defined billing and paying provisions, including prompt payment of clean claims, establishing responsibility of coordination of benefits and collection and payment procedures for third-party liability and subrogation claims. OMNI Networks will ensure that providers may bill and collect from enrollees any amounts not paid by companies, to include non-covered or denied services requested by and provided to patients. Companies will also be required to provide identification procedures for enrollees for the purpose of verifying eligibility for services.

6. Ensure clear and complete definition of Quality Assurance and Utilization Review procedures. OMNI Networks will ensure that there is a physician grievance or appeal process for Utilization Review decisions, as well as a patient grievance or problem resolution process.
7. Provisions will ensure that providers have a reasonable opportunity to review and comment upon any material changes in plans, procedures or reimbursement methods prior to implementation, with the opportunity to terminate from the plan without penalty if not in accord with such proposed changes.
8. Plans will provide a defined dispute and/or arbitration process, to include allowing a party to remedy problems with adequate notice and providing for notice to hearing procedures involving any provider termination from a plan.
9. Providers will have the right to manage the number of new patients to the practice and may upon adequate notice, suspend or terminate further acceptance of new patients within the network.
10. Provisions allowing a provider the right to refuse treatment if, in his/her sole discretion, there has been a failure to establish a satisfactory physician/patient relationship. In such instances, the provider shall be obligated to abide by applicable standards of medical ethics with respect to the transfer of responsibility of patient care.
11. In the event a participating provider agreement with OMNI Networks terminates, medical services shall continue to be provided to covered persons according to negotiated rates for a period of two (2) months.
12. In the event of termination of this contract, participating provider shall remain responsible for treating covered persons who began a course of treatment prior to termination until the course of treatment is completed or until other arrangements satisfactory to the covered person are made, for which service participating provider shall be promptly paid according to schedule hereto which is incorporated by reference herein.
13. Claims Processing.
 - 13.1 The term "clean claim" means a properly completed billing form UB 92 or HCFA 1500 (or its successor) with complete CPT-4 and ICD-9 coding, submitted in accordance with Payor's directions and that does not involve any investigations such as coordination of benefits, third party liability or subrogation. Clean claims will be paid by Payor within thirty (30) days of receipt.
 - 13.2 Claims may be submitted within ninety (90) days of the date services were provided with the provision that claims submitted later than the date will not be automatically rejected and provider may give reasonable explanation for the delay.

- 13.3 Provider may bill the enrollee for services provided that are non-covered services under the benefit plan or that are elective services requested by enrollee. Provider must notify enrollee that such services are not covered under the benefit plan prior to rendering such services.
- 13.4 Coordination of benefits. Each payor plan will specify which party is responsible for coordination of benefits. Group and Participating Providers will assist and cooperate with Payors in coordinating benefits for covered services with responsible Payors. Regardless, the Provider is entitled to collect reimbursement from all sources without limitation up to the usual and customary amount of charges. If the Payor is a secondary Payor for a Medicare beneficiary, nothing in this Agreement will be operate or be otherwise construed to prohibit a Provider from collecting co-payments or deductible amounts regardless of whether the secondary Payor is required to make any payment on a claim.
- 13.5 Subrogation. If Payor decides to exercise rights under subrogation, the Payor must make payment to provider in accordance with the contract provisions while pursuing those rights.
- 13.6 Closed claim. A claim will be considered to be closed after a period of one (1) years unless it can be demonstrated and documented in writing by Payor and/or Provider that a material reimbursement error was made, in any case a claim will be considered closed after three (3) years.
- 13.7 Overpayments and Underpayments.
- a. Requests for Adjustment of Payment. Either party shall be entitled to request an adjustment of payment if, within 180 days from the date of payment, it notifies the other party in writing of the overpayment or underpayment and provides documentation substantiating such claim.
 - b. Payment disputes. The parties shall work cooperatively and in good faith to attempt to resolve payment issues on an informal basis within 90 days of the first notification of a request for an adjustment of payment, pursuant to paragraph a above. If this is unsuccessful, then any dispute concerning claims of overpayment or underpayment shall be resolved in accordance with Plan's dispute resolution procedures.
 - c. Payments Final. Except for those payments that have been submitted to dispute resolution or arbitration in accordance with the foregoing, all payments shall be final.

- d. ~~Paying~~ Adjustments. If the parties determine that Plan has underpaid Provider, Plan shall pay the underpaid amount to Provider within 30 days of said determination. If the parties determine that Plan has overpaid Provider, Provider shall reimburse Plan for the overpayment within 30 days of said determination.
- e. No offsets or deductions without permission. In no event shall Plan offset overpayments against, or deduct overpayments from, any other payments it owes to Provider unless Provider expressly permits Plan to do so.

14. Confidentiality of Information.

- 14.1 Medical records are the property of the provider and Payor or OMNI Networks does not have automatic or unlimited access to records. Network or Payor will obtain necessary authorization from beneficiaries to release copies of medical records related to treatment provided to that patient under plan covered services. Network or Payor will be responsible for standard costs of copying records.
 - 14.2 Billing and claim information. Access to information will be reasonable and during normal business hours with adequate notice. Payor or network will be responsible for standard costs of copying records as necessary. Access will be limited to those services provided under the plan and not blanket access to all information.
 - 14.3 Plan shall conduct inspections pursuant to Paragraph 14.2 above only with thirty (30) days written notice and during Provider's normal business hours.
 - 14.4 Plan shall be responsible for obtaining written releases by Members authorizing the release of medical information by Provider, and shall, notwithstanding any other provision in this Agreement, indemnify and hold Provider harmless for any liability in connection with the requested release.
 - 14.5 Plan agrees to reimburse reasonable copy and shipping charges Provider incurs to furnish information the Plan requests.
15. Participating providers will not accept automatic deductions from future payments of claims for disputed or denied claims.

16. Pre-certification/identification of enrollees.

- 16.1 Payor shall supply Covered Persons with an identification card indicating coverage under their particular Benefit Agreement. Payor shall also identify on the card a toll-free number for eligibility and coverage questions and the address for submitting Provider's claims. Payor shall instruct its members to present this identification card when obtaining services from Provider. If Payor fails to furnish an identification card complying with this paragraph, Payor shall be obligated to pay Provider's usual and customary charges for any services rendered to members. If member does not present an identification card, Provider shall have the right to collect the full amount for services rendered at time of service up to the maximum amount allowed under OMNI Networks fee schedule.
- 16.2 All Payor contracts must include language that states if provider cannot obtain timely pre-certification of verification of coverage, that is, unreasonable delays in telephone access that delay treatment or appointments, that action will be taken to improve access. If Provider notifies Plan in writing of continued problems with unreasonable delays Provider may terminate participation with that specific Payor within ten (10) days.
- 16.3 Explanation of Benefit forms from Plans must identify membership in the network to obtain discounted fees. Providers have the right to rely on membership cards, member lists and telephone authorization to verify coverage and benefits for members. If a Provider obtains pre-certification for services, the Payor may not retroactively deny payment for services unless it can be shown that the Provider has actual knowledge of ineligibility for services.
17. Contracts must not contain any type of "gag" clause or similar restrictions, to include restrictions on discussing types of treatments available to the patient, plan provisions with third parties including hospitals, etc.
18. Payor contracts must contain language that states that OMNI Networks cannot be "bundled" or used as a "wrap-around" with any other Payor network without written permission from OMNI Networks and providers. OMNI Networks network may not be coupled with any other network and shall be exclusive for designated counties per this agreement.
19. Network will provide monthly list of Payors and by contract provision will assure that Payors provide similar lists of enrollees to providers.
20. No Indemnification. Each party will be responsible for its own acts or omissions that result in injury or damage to persons or property that arise as a consequence of the party's performance of this Agreement.
- 20.1 No Indemnification. OMNI Networks, Group and each Group Provider acknowledge and agree that this Agreement is not intended to indemnify or insure either party against any loss or liability and shall not be so deemed or construed. Each party shall, throughout the term of this contract, and as otherwise might be provided, maintain, at its sole cost and expense, policies of

insurance or self insurance as may be necessary to protect each party or party's employees, agents, or representatives in the discharge of its or their responsibilities and obligations under this agreement. Such policies will be made available for review by the other party upon request.

21. Liability Insurance. Each party, at its sole cost and expense, shall procure and maintain a policy of general liability insurance or maintain adequate resources to insure itself and its respective officers, agents and employees against any liability or claims or damages arising by reason of personal injuries or death, occasioned directly or indirectly by such party for its officers, agents or employees in connection with the performance of such party's responsibilities under this Agreement.
22. OMNI Networks will supply provider with a summary of all Payor contracts sixty (60) days prior to its effective date for review.

ATTACHMENT 4

Grievance Procedures

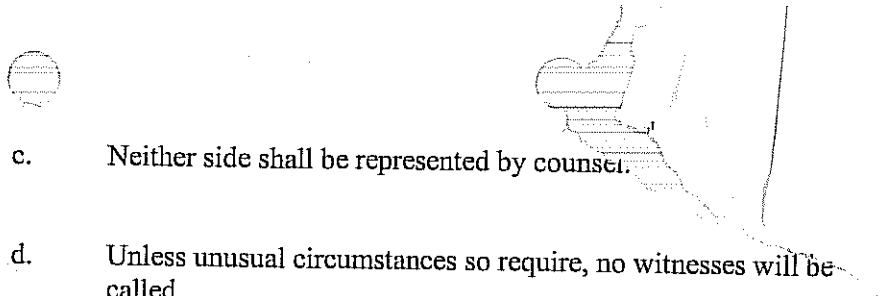
PROCEDURE FOR GRIEVANCES AND APPEALS OF ADVERSE DETERMINATION

The purpose of this procedure is to offer a fair opportunity to any Physician Member of the Preferred Physician Organization ("PPO") to air related grievances or complaints or to appeal a decision to terminate his or her membership in the PPO.

1. Applicability. Whenever:
 - a. A Physician member has a grievance or complaint regarding the operation of the PPO; or
 - b. The Board has under consideration a recommendation to terminate the membership of the Provider for one or more of the specific reasons set out in the Bylaws, participation criteria or policies and procedures of PPO;

the Board may offer the affected Physician Member the opportunity to discuss the matter prior to final action.

2. Written Request. Physician Members must submit a request to appeal a recommendation to terminate membership to the Board in writing within forty-five (45) days of receiving notification of the adverse decision. Physician Members who wish to air grievances or complaints must also submit a written request for review to the Board.
3. Review Panel. A special advisory committee appointed by the Board at its discretion, will discuss the matter with the Physician Member and will report its findings to the entire Board.
4. Procedure.
 - a. Because neither a review of a Physician Member's grievance or complaint regarding the PPO's operation nor the decision to terminate the Physician Member's membership in the PPO will affect the Physician Member's privileges at the Hospital or be reportable as a peer review action, the conduct of the interview will be informal in nature.
 - b. A record of his informal review is not required, although it may kept at Physician Member's request.

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- c. Neither side shall be represented by counsel.
 - d. Unless unusual circumstances so require, no witnesses will be called.
 - e. The discussion, whether for purposes of airing grievances and complaints or reviewing adverse membership determination, is intended to offer the Physician Member an opportunity to address any special circumstances that may apply, and to respond to questions and resolve any outstanding issues the Board or its specially designated committee may have.

5. Timing. Every attempt shall be made to conduct the review at a time that is convenient to the parties, and as soon as it practicable after the Board's receipt of the Physician Member's written request for review, but in no event more than thirty (30) days after the request is made.

6. Conclusion. The Board will consider the results of the review in making its decision, which shall be entirely in its discretion. Final notice will be provided to the Physician Member promptly in writing upon completion of the review when the Board reached its decision.