Independent Medical Systems

06/22/2011

(NTENT) North Texas Ear, Nose & Throat Associates
Attn: Cindy Ranson
1000 Texan Trail, Ste # 210
Grapevine, TX 76051

Re: Delegated Group Agreement

Dear NTENT:

Welcome to IMS! We are excited to have you join the Independent Medical Systems PPO network, effective 6-15-2011. Enclosed for your file, please find the original executed delegated group agreement between yourself and Independent Medical Systems.

Please do not hesitate to contact me with questions or concerns at 1-800-853-7003, extension 1220 or pdalcour@imsppo.com. I look forward to a mutually beneficial and prosperous relationship!

Sincerely,

Paulette Dalcour
Provider Relations Representative
Independent Medical Systems, Ltd

PROVIDER PARTICIPATION AGREEMENT

(Delegated Group)

This Provider Participation Agreement ("Agreement") is made and entered into as of the Effective Date set forth on the signature page of this Agreement by and between Independent Medical Systems, Ltd. ("Network"), an organization licensed under the laws of the State of Texas and **NORTH TEXAS EAR, NOSE & THROAT ASSOCIATES (NTENT)**("Provider"), an organization of healthcare providers licensed to practice in the State(s) of Texa

RECITALS

WHEREAS, Network has contracts with physicians, non-physician providers and health care facilities; and

WHEREAS, Network may from time to time enter into contractual arrangements with certain insurers, HMOs, Associations, Taft Hartley Trusts, workers compensations, automobile liability, and other Payers for the purpose of providing or arranging for the delivery of health care services to Beneficiaries of such Payers by Participating Providers; and

WHEREAS, Provider and its Members desire to participate as Participating Providers in the Network to provide health care services coordinated and arranged by Network and its Payers pursuant to this Agreement.

NOW, THEREFORE, in consideration of the premises and mutual covenants contained herein, the receipt and adequacy of which are acknowledged, it is agreed as follows:

I. DEFINITIONS

For the purposes of this Agreement, certain terms are defined as follows:

1.1 Beneficiary means any person who is eligible to receive Covered Services paid for by a Payer or whom a Payer is legally obligated to indemnify for the cost of such Covered Services, and who has enrolled in Network Program.

1.2 Billed Charges means the fees for health care services which Provider charges all patients regardless of payment source.

1.3 Clean Claim means a request for payment for Covered Services submitted by a Participating Provider or his/her designee on a UB-04 or CMS 1500 (or successor forms), or the electronic equivalent of this form when billing claims electronically, that contains all of the elements as required pursuant to the Department of Insurance regulations of the state the practice resides in.

1.4 Complementary Care Professional means a non-physician provider licensed under a recognized state licensing authority including, but not limited to, acupuncturists, chiropractors, physical therapists, etc. who may be contracted by Network to provide Covered Services as required by a Payer or Health Benefit Plan.

1.5 Covered Services means health care services rendered to a Beneficiary by a Participating Provider that are authorized for payment under the Health Benefit Plan sponsored by Payer.

1.6 Credentialing Criteria means the criteria established by Network for credentialing and re-credentialing Participating Providers. Network's Credentialing Criteria pertaining to Provider which may be amended from time to time in accordance with Sec. 2.3 below is set forth in Exhibit B.

1.7 Health Benefit Plan means a Payer's medical benefits and hospitalization plan whereby the Payer agrees to make payments to Participating Providers for Covered Services on behalf of Beneficiaries as defined in such Health Benefit Plan.

1.8 Member means the individual healthcare providers included under this Agreement, incorporated herein as part of "Provider", listed in Exhibit C, and who have returned to Network a signed Letter of Agreement Exhibit F.

1.9 Network Program means the program developed by the Network for the purpose of soliciting Payers and Providers to enter into Network agreements: entering into agreements with such Payers and Providers and; performing or arranging for the performance of health care services pursuant to the Network agreements.

1.10 Participating Hospital means a hospital provider that has entered into an agreement with Network to provide inpatient and outpatient services to Beneficiaries.

1.11 Participating Physician means any credentialed physician who is licensed to practice medicine in the state in which they practice and who has agreed to participate in the Network by entering into either a group practice Network agreement or an individual provider Network agreement.

1.12 Participating Provider means Participating Hospitals, Participating Physicians, Complimentary Care Professionals, and other licensed health professionals, institutions, or facilities which have entered into a written agreement with Network.

1.13 Payer means any government program, trust fund, insurance carrier, non-profit hospital service plan, managed care plan, union, employer or employee group which has contracted with Network to utilize the panel of Participating Providers established by Network, and to be responsible for the payment of Covered Services under this Agreement.

1.14 Payer Agreement means the separate agreement between Network and Payer defining the terms and conditions under which Participating Providers provide and are paid for Covered Services furnished to Beneficiaries under the Payer's Health Benefit Plan.

1.15 Primary Physician or Primary Care Physician means a Participating Physician selected by a Beneficiary to render first contact medical care and to provide primary care services. Primary Physician or Primary Care Physician may include, as determined by Payer, internists, pediatricians, family practice and general practice.

1.16 Supplemental Charges means a co-payment or deductible or that portion of the charge for Covered Services which shall be collected from a Beneficiary in addition to any other payment to which Provider is entitled to receive based on the applicable Health Benefit Plan, or which is approved by the applicable state and federal regulatory authority, and is disclosed and provided for in the Beneficiary's certificate of coverage and for which the Beneficiary is solely liable.

1.17 Utilization Management Program means a program established by a Payer which is designed to oversee and manage the utilization of Covered Services based on appropriate medical necessity criteria.

II. DUTIES OF NETWORK

2.1 Confidentiality and Security of Medical Information. Medical or health records of Beneficiaries for whom medical or health services are provided by Provider/Members shall be subject to all laws and regulations regarding confidentiality of patient records.

2.2 Marketing Materials. Network will use its best efforts to arrange for Payers to list Provider/Members, and other Participating Providers in provider directories and other marketing and informational materials developed and distributed by Payers.

2.3 Credentialing and Re-credentialing. Provider shall be responsible for obtaining the credentialing and re-credentialing information from Members and providing such materials to Network. Network may delegate the verification of such information to a qualified credentials verification vendor. Network may also delegate credentialing of Members to Provider upon agreement under Exhibit D, if applicable. Network shall provide to Provider its credentialing and re-credentialing criteria for participation through Network. Each Member will meet any changes to Exh. B or additional criteria required by Network or Payers, which shall be disclosed in advance. The current criteria applicable to Provider's Members are included as Exhibit B to this Agreement. Network shall maintain all credentialing and re-credentialing information in confidence and consistent with applicable state and federal laws. Provider agrees to furnish all information and documentation as requested in the credentialing and re-credentialing application. Provider understands and agrees that failure to cooperate with credentialing procedures or

furnishing inaccurate information will be sufficient grounds for denial or termination of participation of Provider or individual Members.

2.4 Beneficiary Eligibility Verification. Network's duties are limited to those specifically set forth herein. Network does not determine eligibility or benefit availability for Beneficiaries under Payers' Health Benefit Plans. Network is not liable for reimbursement to Provider/Members for services rendered pursuant to this Agreement, and does not exercise any control with respect to Payers' Health Benefit Plan assets, policies, practices, procedures, or payment of claims.

2.5 Identification of Network Program. Payer Agreements shall require the identification of Network or affiliated entities through identification cards, directories, explanations of benefits, and/or other documents presented to Provider/Members by Payers or Beneficiaries.

III. DUTIES OF PROVIDER

3.1 Representations and Warranties. Provider's Members shall at all times be licensed and in good standing, and as such, represents and warrants to Network:

A. That Members are and, at all times during this Agreement, shall be eligible to participate as Participating Providers consistent with the Credentialing Criteria as defined in Exhibit B.

B. Provider shall notify Network of any claim made or actions filed by Beneficiaries or Payers arising out of, or relating to, services performed by Member to any Beneficiary, within seven (7) days of Member's receipt of notification or becoming aware of such claim or action.

3.2 Professional Liability Insurance. Provider's Members, at their expense, agree to maintain professional liability insurance coverage at a level determined to be acceptable by Network for their state. Provider's Members also agree during the term of this Agreement to maintain professional liability coverage for each professional provider employed by Members. At the request of Network, Provider shall provide evidence of Members' coverage required by this Agreement. Provider's Members shall also maintain other insurance as shall be necessary to insure Members and their employees against any event or loss which would impair the ability of Members to carry out the terms of this Agreement. If a Member becomes uninsured at any time while this Agreement is in effect, Provider shall notify Network in writing promptly, but not more than seven (7) days after the date Member becomes aware of lapse in coverage or date insurance expires, whichever is earlier.

3.3 Compliance with Law and Ethical Standards. Provider/Members shall comply, at all times during the term of this Agreement, with all applicable federal, state or municipal statutes or ordinances, all applicable rules and regulations of the State Board of Medical Examiners, Medical Society, or other similar body and the ethical standards of the American and State Medical Associations. Provider agrees to immediately notify Network if a Member's staff membership or privileges are suspended, limited or revoked at any hospital, if any hospital initiates any adverse peer review action against a Member, or if a Member voluntarily or involuntarily relinquishes his/her staff privileges. Provider agrees to notify Network within seven (7) days of the occurrence of any disciplinary proceedings against a Member of sufficient gravity to be reported to or initiated by the State Board of Medical Examiners, Medical Society, or other similar body or any action which may be brought against him/her by any medical society or hospital, any action taken against him/her by any governmental agency, or any other material adverse change to a Member's ability to perform under this Agreement. Such notice shall include copies of any complaints, petitions, lawsuits or other documents filed or prepared in connection with such proceeding.

3.4 Nondiscrimination. Provider/Members agree to:

A. Not differentiate or discriminate in their provision of professional services to Beneficiaries because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, handicap (except to the extent that different treatment is medically appropriate because of the Beneficiary's medical condition), or age; and

B. Render professional services to Beneficiaries in the same manner, in accordance with the same standards, and within the same time availability as offered to non-Health Benefit Plan patients consistent with existing medical, ethical, and legal requirements for providing continuity of care to any patient.

3.5 Cooperation with Network's Medical Directors. Provider understands that Network shall place certain obligations upon Members regarding the quality of care received by Beneficiaries and that the Network's Quality Assurance Committee in certain instances shall have the right to review the quality of care administered to Beneficiaries. Provider/Members agree to cooperate with Network's medical directors in the review of the quality of care administered to Beneficiaries.

3.6 Hospital Privileges. During the entire term of this Agreement, Provider's Members shall be and remain members in good standing of the medical staff of a Participating Hospital. If a Member loses his/her medical staff membership or has his/her privileges at a Participating Hospital impaired, suspended or reduced, then Network, at Network's sole discretion, may immediately remove Member from further performing any Covered Services pursuant to this Agreement.

3.7 Compliance with State and Federal Statutes. Provider/Members shall cooperate with Network so that Network may meet any requirements imposed on Network by state and federal law, and all regulations issued pursuant thereto.

3.8 Provision of Care. Subject to Provider's/Members' available facilities and service capability, Provider/ Members shall provide Covered Services to Beneficiaries promptly and in the same manner as services are provided to all patients. In providing services to Beneficiaries under worker's compensation programs, Provider/Members agree to cooperate with Payers to expedite the Beneficiaries' return to work, consistent with the Provider's/Members' professional judgment.

3.9 Maintenance of and Access to Records. Provider/Members agrees to maintain such records and provide such information to Network or its designee as may be necessary to comply with the law and this Agreement. Such records shall be retained by Provider/Members for at least two (2) years from the date the record is created. This obligation shall continue after the termination of the Agreement. Network or its designee shall have access at reasonable times and upon reasonable notice to the books, records, and papers of Provider/Members as they relate to the health care services provided to Beneficiaries, subject to applicable laws. Provider/Members further agree that Network may inspect Provider's/Members' office(s) during normal business hours upon giving Provider/Members five business days' written advance notice.

3.10 Utilization Management Program. Provider/Members agree to cooperate with the Utilization Management Program for each Health Benefit Plan. Network will use best efforts to request Payers to provide material changes to the Utilization Management Program to Provider in writing at least ninety (90) days prior to the change.

3.11 Managed Care Efforts. Provider/Members agree to the appropriate utilization of such managed care methods and practices as are consistent with sound health care practice and in accordance with accepted community standards of quality care.

3.12 Beneficiary Services Program. Provider/Members shall cooperate with Network in a grievance and complaint program designed to process and consider questions, complaints, and other matters, as appropriate, raised by Beneficiaries with respect to the access to and quality of Covered Services provided to them by Members.

3.13 Reporting Changes of Provider/Member Information. Provider will use reasonable efforts to notify Network in writing, at least thirty (30) calendar days prior to any change in Provider's/Members' business addresses, business telephone numbers, office hours, tax identification numbers, insurance carriers or coverage, state license numbers, pharmacy or DEA registration numbers as applicable, or accreditation or certification status. Provider shall notify Network in advance of any change in ownership or control.

3.14 Closing of Practice to New Beneficiaries. Provider may submit a request that a Member does not wish to accept additional patients (excluding persons already in Member's practice who are covered by a Health Benefit Plan as a Beneficiary) by giving Network written notice of such intent sixty (60) days in advance of the effective date of such closure.

3.15 Disciplinary Action. Provider agrees to notify Network in writing within seven (7) days of the date that Provider/Member becomes aware of 1) any disciplinary proceedings which warrant formal investigation by the State Licensing Board, DEA or other government regulatory agency; or 2) any civil complaints

brought against a Member as a result of Member's medical or health service practice; or 3) any criminal charges filed against a Member for any reason; or 4) any changes in a Member's health status that would impact Member's ability to practice at the highest level. If Provider fails to notify Network, or if any disciplinary action or judgment results in suspension of license or curtailment of surgical privileges or otherwise limits a Member's ability to render services by this Agreement, then Network may terminate that Member immediately in accordance with Section 6.5 of this Agreement.

3.16 Referrals. Consistent with sound medical practice and in accordance with accepted community professional standards for rendering quality medical care, Provider/Members agrees to make referrals of Beneficiaries to Participating Providers in the Payer Health Benefit Plans. Provider/Members should refer a Beneficiary to a provider who is not a Participating Provider only if the Beneficiary requires medical services not available through a Participating Provider. Provider/Members agree to make reasonable efforts to notify Beneficiary that a lower reimbursement may apply to service from non-Participating Providers.

3.17 Professional Services. Provider/Members will provide professional service to Beneficiaries in accordance with the terms set forth in the relevant Payer Agreement in the same manner, in accordance with the same standards, and within the same time availability as provided to their other patients. Provider/Members shall not be obligated to accept an individual Beneficiary as a patient; provided, however, that Provider/Members shall not refuse to accept any Beneficiary as patient on the basis of race, color, religion, sex, age, national origin, Payer Health Benefit Plan or health status or medical condition of such patient. Provider/Members shall assist the Network in monitoring accessibility of care for Beneficiaries, including scheduling of appointments and waiting times. Provider/Members shall provide only those services that are customarily and usually provided to their other patients.

3.18 Coordination and Delivery of Professional Services. If applicable, Primary Physician shall be responsible for the continuity and coordination of the care of those Beneficiaries who have selected such Participating Provider as their Primary Physician. If Primary Physician must be accessible to such Beneficiaries on a twenty-four hour per day, seven day per week basis, then he/she shall provide for comparable accessibility through his/her designated on-call Participating Provider(s), who shall also be Primary Physician(s).

3.19 Inquiries. Provider/Members agree to respond to any written inquiry from Network regarding services rendered to a Beneficiary within ten (10) days of receipt of the inquiry by Provider/Members. Provider/Members also agree to respond promptly to any Payer or Beneficiary who makes an inquiry to Provider/Members regarding services rendered to the Beneficiary.

3.20 Notice to Beneficiaries. In the event of termination of this Agreement, Provider/Members agree to use best efforts to notify Beneficiaries prior to providing any Covered Services that Provider/Member is no longer contracted with Network and to transfer the care of beneficiaries to another Participating Physician as soon as is practical. The parties agree that nothing in this Agreement shall be construed to authorize Provider/Member to abandon any Beneficiary who is a patient as of the effective date of the termination of this Agreement. Services rendered to Beneficiaries not properly informed of Provider's/Members' termination will be subject to the Network rates then in force.

IV. PAYMENTS AND TERMS

4.1 Standard Payment Methodology – General Provisions.

A. Except as provided in subsections (C) and (D) below, Provider/Members will look solely to Payer for payment for Covered Services rendered pursuant to the terms of this Agreement. Provider/Members shall not balance bill or attempt to collect compensation from Beneficiaries except for applicable co-payments, deductibles, and co-insurance or as otherwise may be expressly permitted by law. Provider/Members shall accept from Payers as payment in full for each Covered Service rendered pursuant to this Agreement the least of the following, less any applicable co-payment, co-insurance and/or deductible:

1) Amount specified on the appropriate reimbursement schedule, which is attached and incorporated by this reference, as Exhibit A, if applicable; and
2) Provider's/Members' usual and customary charge.

B. Provider/Members shall submit Clean Claims to Payers for processing claims for Covered Services to Beneficiaries as described in Section 4.4.

C. Provider/Members shall directly bill a Beneficiary only for Supplemental Charges that are related to Covered Services and that are deemed medically necessary by the Payer in accordance with the applicable Health Benefit Plan and Payer Agreement unless the Beneficiary has been advised by Provider/Members and has expressly agreed in writing to receive the non-Covered Services in advance of receiving non-Covered Services.

D. Upon notification by the Payer that a health care service rendered to a Beneficiary is a non-Covered Service, Provider/Members may bill the Beneficiary directly for such health care services at usual and customary charges.

4.2 Reasonable Assurances. Network shall make best efforts to negotiate Payer Agreements that obligate the Payer to:

A. Make payments to Provider/Members for Covered Services provided by Provider/Members to Beneficiaries:

B. Make payments for Covered Services on the basis of the applicable payment methodology as agreed to by Provider/Members;

C. Make payments to Provider within forty-five (45) days after receipt of a Clean Non-electronic Claim and within thirty (30)days of receipt of a Clean Electronic Claim, unless otherwise agreed;

D. Agree that in the event payment is denied, to provide Provider/Members with notice thereof and an opportunity to substantiate the right to payment as provided by law;

E. Provide an identification system for Provider/Members to assist in identification of Beneficiaries and the scope of Covered Services applicable to Beneficiaries.

4.3 Provider Reimbursement. Provider/Members agrees to accept the reimbursement amounts specified in Exhibit A, if applicable, as payment in full for Covered Services rendered to Beneficiaries. In no case shall reimbursement exceed Provider's/Members' Billed Charges. Provider/Members further agrees that when Covered Services are provided to a Beneficiary, the Beneficiary shall be liable only for the Supplemental Charges as determined by the Payer in accordance with the Payer's Health Benefit Plan.

4.4 Claims Administration.

A. Claim Forms. Provider/Members shall submit claim forms to the Payer, on a UB-04, CMS 1500 or other successor form as appropriate for processing claims for Covered Services rendered to a Beneficiary. Each claim shall include the Provider's/Members' Federal Tax Identification Number (FTIN). Provider/Members understands that, in order to avoid delays in processing of Provider's/Members' bills, any changes in the FTIN must be submitted to Network in advance, and that failure to do so may result in the return of bills to Provider/Members unpaid.

B. Actual Charges. Bills shall show Provider's/Members' actual charges for the services rendered.

C. Claim Submission. Best efforts shall be made to submit bills within ninety-five (95) days following the date of service. Provider/Members agree that their failure to submit Clean Claims within the time required by the Health Benefit Plan may result in disallowance of payment.

D. Reimbursement and Claim Procedures. Provider/Members agree to comply with reasonable reimbursement and billing procedures as required by Payer. Provider/Members agree to cooperate in completing Clean Claims and not to charge for this service, except where coordination of benefits or other special reports are required by Payer if not the primary carrier. Nothing herein shall be deemed to affect Provider's/Members' rights and obligations with respect to third party payers other than Payer.

E. Coordination of Benefits. Upon request by Network or Payer, Provider/Members shall authorize and assist Payer in coordinating benefits with other entities when Covered Services are provided by Provider/Members to a Beneficiary. Where, pursuant to applicable coordination of benefits law, Payer is primary, the Payer shall be required to pay the amounts due under this Agreement. Where the Payer is other than primary, the Payer shall be required to pay only

those amounts which, when added to amounts owed to Provider/Members from other sources, equal one hundred percent of the amount required under this Agreement. However, nothing herein shall be construed to preclude Provider/Members from seeking and obtaining payment from sources of payment other than Payer and Beneficiary.

F. Resolution of Disputes with Payers. Network shall act as mediator in resolving disputes between the Provider/Members and Payers relative to reimbursement for Covered Services.

4.5 Supplemental Charges. Provider/Members are entitled to bill and have the responsibility to collect from a Beneficiary any applicable Supplemental Charges for Covered Services according to the terms of the applicable Health Benefit Plan. Provider/Members understand and agree that the Payer has no responsibility to pay any amount except as described in Section 4.3 above and Provider/Members shall bill and collect Supplemental Charges that are the Beneficiary's responsibility. For services not covered by this Agreement and for so long as not prohibited by Payer, Provider/Members may bill Beneficiary or other responsible party at Provider/Member's normal Billed Charges for such services. Provider/Members agree to notify Beneficiary, in advance of providing any non-Covered Service that the service is not covered by the Health Benefit Plan and that Beneficiary will be responsible for all charges.

V. RELATIONSHIP OF PARTIES

5.1 Independent Contractors. This Agreement sets forth the understandings, rights and obligations of the parties for the purpose of providing preferred reimbursement rates for medical services for persons covered under various Payer plans. None of the provisions of this Agreement are intended to create, nor to be construed to create, any relationship between Network and Provider other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. None of the parties hereto nor any of their respective officers, agents or employees shall be construed to be the officer, agent or employee of the other. Network and Provider agree it is not the intent of either party that Beneficiaries to whom services are rendered under this Agreement occupy the position of intended third party beneficiaries of the obligations assumed by either party known to this Agreement and no such individual shall have the right to enforce any such obligation. Network acknowledges that it is not authorized to intervene in any way or manner with the rendering of professional services by Provider and further represents that its Payer Agreements contain a statement to the effect that all health care services and the results thereof are to be determined by Participating Provider.

5.2 No Guarantee of Utilization. Provider acknowledges that there is no warranty or guarantee that (1) every Participating Provider will be selected to participate as a member of any particular Health Benefit Plan, or (2) if selected, Participating Provider will be utilized by a Beneficiary or any number of Beneficiaries within the Health Benefit Plan.

VI. TERM AND TERMINATION

6.1 Term. This Agreement shall remain in full force and effect for a period of twelve (12) months from the effective date as set forth on the signature page of this Agreement ("Initial Term") unless terminated as provided for in this Agreement. To promote continuity of care and to prevent undue hardship to Beneficiaries under Provider's/Members' care upon termination of this Agreement, the parties agree that the terms of this Agreement shall continue to apply with regard to such Beneficiary for at least sixty (60) days after the effective date of termination.

6.2 Automatic Renewal. At the end of the Initial Term, this Agreement shall automatically renew for successive one (1) year periods thereafter unless terminated as provided for in this Agreement.

6.3 Optional Termination. In the event either party shall, with or without cause, at any time give to the other party advance written notice at least one-hundred twenty (120) days from the date notice is received by the other party, this Agreement shall terminate on the future date specified in such notice.

6.4 Termination for Specific Breach. This Agreement may be terminated by either party for the failure, by omission or commission in any substantial manner, of the other party to keep, observe or perform any covenant, agreement, term or provision of this Agreement ("Breach"). In the event of a Breach, the party claiming a Breach shall give written notice to the other party as specified in Sec. 7.8 of this Agreement. The notice shall specify the Breach with as much detail as possible. The party receiving the notice shall then have thirty (30) days to cure the Breach. If the Breach is not cured to the

satisfaction of the complaining party within thirty (30) days after the notice is received by the other party, this Agreement shall terminate at the end of the thirtieth (30^{th}) day.

6.5 Immediate Termination. In cases where Network determines in good faith that the health, safety or welfare of Beneficiaries is jeopardized by continuation of this Agreement, Network may terminate this Agreement immediately upon written notice to Provider. If Provider/Members furnishes false, incomplete or inaccurate information to Network in Provider's/Members' applications to participate in the Network PPO Plan or at any time during the term of this Agreement, or if Provider/Members suffer revocation, termination or suspension of Provider's/Members' professional licenses or medical staff privileges, or the ability of Provider/Members to perform the services covered by this Agreement are otherwise impaired, Network may terminate this Agreement, in whole, or in part by terminating individual Members only, immediately upon written notice to Provider.

6.6 Rights, Duties, and Obligations. Termination of this Agreement shall not affect the rights, duties, and obligations of the parties arising out of transactions occurring prior to the effective date of termination. No assignment of the rights, duties, and obligations of this Agreement shall be made by Provider without written approval by Network.

VII. MISCELLANEOUS

7.1 No Indemnity. The parties agree that any liability arising from this Agreement, except for Provider's responsibilities described in Exhibit D attached hereto, shall be borne by the responsible party. Each party shall be responsible for its own defense and resolution of any claim against that party.

7.2 Non-disclosure. Neither party shall disclose the terms of this Agreement or the Payer Agreement, including but not limited to the compensation arrangement, methodologies or other price-sensitive terms, without the prior written consent of the other party. Network, Provider, and Members shall hold all proprietary and confidential information in the strictest confidence and shall not voluntarily or involuntarily sell, transfer, publish, display, or otherwise make available to others any portion of the other party's proprietary and confidential information, except as provided for in this Agreement or as may be required by state and federal law. Notwithstanding anything contained herein to the contrary, nothing in this section shall be construed to conflict with state or federal laws related to patient protection and communication of medical information by Provider/Members.

7.3 Governing Law. This Agreement has been executed and delivered, and shall be interpreted, construed, and enforced pursuant to and in accordance with the laws of the State of Texas. All duties and obligations of the parties created hereunder are performable in all counties within Network. Dallas County, Texas shall be the sole and exclusive venue for any litigation, special proceeding, or other proceeding between the parties that may be brought or arise out of or in connection with or by reason of this Agreement.

7.4 Third-party Beneficiaries. There are no third-party beneficiaries of this Agreement, except as otherwise provided in this Agreement.

7.5 Assignment. Provider agrees to notify Network of any significant changes in the ownership of its business or a Member's practice within a reasonable period of time. Provider cannot assign this Agreement in whole or in part to another party without advance written authorization by Network.

7.6 Waiver of Breach. The waiver by either party of any breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach of the same or other provision hereof.

7.7 Force Majeure. Neither party shall be liable nor deemed to be in default for any delay or failure to perform under this Agreement deemed to result, directly or indirectly, from any cause beyond the reasonable control of either party, including without limitation, acts of God, civil or military authority, acts of public enemy, fires, floods, strikes or regulatory delay or restraint.

7.8 Notice. Any notice or other communication made or contemplated by this Agreement to be in writing shall be deemed to have been made three (3) days after it is deposited in the United States mail, postage prepaid, return receipt requested, and addressed as follows, or to such other address as shall have been given in writing by either party to the other.

To Provider: North Texas Ear, Nose & Throat Associates
1000 Texan Trail, Suite 210
Grapevine, Texas 76051

To Network: Independent Medical Systems, Ltd.
Attn: Jennifer Boone, Dir. of Network Development
12221 Merit Drive, Ste 1950
Dallas, Texas 75251

7.9 Severability. The invalidity or unenforceability of any term or provision hereof shall in no way affect the validity or enforceability of any other term or provision of this Agreement.

7.10 Entire Agreement. This Agreement and all Exhibits attached to this Agreement and expressly made a part hereof shall constitute the entire agreement relating to the subject matter between the parties. Each such party acknowledges that no representation, inducement, promise or agreement has been made, orally or otherwise, by the other party, or anyone acting on behalf of the other party, unless such representation, inducement, promise or agreement is embodied in this Agreement, expressly or by incorporation.

7.11 Remedies. Provider agrees that reinstatement to the Network shall be the sole remedy for a dispute relating to Provider's/Members' participation in Network's PPO Plan. Provider further agrees that the payment of claims and any applicable penalties for delay in payment for services rendered shall be the sole remedy for disputes with Payers involving nonpayment of said claims. Network shall not be liable for actual damages, liquidation damages, consequential damages, legal fees or other expenses incurred as a result of claim disputes with Payers.

7.12 Amendments and Execution of Agreement. For amendments required by state or federal law, statute or regulation, this Agreement may be amended at any time in writing by Network and such amendment shall automatically become effective thirty (30) days from the date the notice of the amendment is issued by Network to Provider. With the exception of a modification to Exhibit A as specified in Section 4.3 above, for all other amendments the amendment will become effective thirty (30) days after written acceptance by both parties unless formal written notice of non-acceptance of the amendment in its entirety is received by Network within thirty (30) days of the date the notice of amendment is issued by Network.

7.13 Dispute Resolution. Any controversy, dispute or disagreement arising out of or relating to this Agreement or the breach of this Agreement shall first be referred to mediation through the American Health Lawyers Association using the dispute resolution procedures of the applicable state Civil Remedies Code. Any issue or dispute remaining unresolved through mediation shall be submitted to binding arbitration, which shall be conducted in the State of Texas in the county selected by the respondent in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration, and judgment on the award rendered by the arbitrator shall be binding, and may be entered in any court having jurisdiction.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the applicable Effective Date set forth below.

Provider		**Independent Medical Systems, Ltd.**	
Signature:		Signature:	
Printed Name:	Antony Wax	Printed Name:	David A Rendall
Title:	Executive Director	Title:	CEO
Date:	June 10, 2011	Date:	6-17-2011

Effective Date: 6-15-2011
To be determined by Network

EXHIBIT A
REIMBURSEMENT SCHEDULE

Provider shall be reimbursed the lessor of 150% of the current Dallas County RBRVS Fee Schedule or 80% of the Providers usual billed charges for all services, unless otherwise defined below.
Codes in range V5008 through V5298 shall be reimbursed 80% of Provider's usual billed charges unless otherwise defined below.

- Multiple procedures shall be reimbursed at 100% for the 1st procedure, 50% for the 2nd and subsequent procedures.

Anesthesia services shall be reimbursed at $55.00 per unit.
Services without assigned relative values in the RBRVS schedule will be reimbursed at 80% of Provider's usual billed charges.

Agreed to as of the date executed by each party:

Provider		**Independent Medical Systems, Ltd.**	
Signature:		Signature:	
Printed Name:	Anthony Wax	Printed Name:	David A Rendall
Title:	Executive Director	Title:	CEO
Date:	June 10, 2011	Date:	6-17-2011

EXHIBIT B
CREDENTIALING CRITERIA SUMMARY

1. General Criteria for All Participating Physicians.

   A. The physician must be of sound moral character and must not have been convicted of or be under investigation with respect to any crime involving dishonesty, fraud, deceit, or misrepresentation and/or any offense related to his or her professional practice or which in any respect, in the opinion of Network, would reflect adversely on Network's reputation should the physician be associated with Network.

   B. The physician must not presently be suspended or excluded from participating in a Federal health care program or under investigation resulting from participation in such Federal health The physician care programs and must fully inform the Network about any prior suspensions, exclusions, or investigations either prior to or after becoming a Participating Provider in Network.

   C. The physician must not presently be subject to any probation or suspension of hospital staff privileges or hospital registration, as applicable, state licensure, DEA number, state license or state controlled substance certificate and must inform Network of any probation, suspension or loss of hospital staff privileges, state licensure, DEA number, state license or state controlled substance certificate.

   D. The physician's general area of practice or specialty must not, in the opinion of the Network, involve experimental or unproven modalities of treatment, or therapy not widely accepted in the local professional community. This prohibition, however, is not intended to extend to funded research conducted pursuant to an established protocol that complies with federal and state law.

2. Specific Criteria for All Participating Physicians.

   A. A valid and unrestricted license to practice medicine in the state of practice.

   B. All appropriate approvals to prescribe and dispense drugs under applicable federal and state laws.

   C. Twenty four hour coverage capability.

   D. Professional liability coverage:
      1) Providers retained as independent contractors must:
         (i) maintain professional liability coverage in amounts of one hundred thousand dollars ($100,000) per occurrence and three hundred thousand dollars ($300,000) in aggregate;
         (ii) provide the Network with evidence of such coverage, and notify Network of any change in such coverage.

   E. Current and continued satisfaction of minimum medical continuing education requirements of the applicable State Board of Medical Examiners.

   F. Accurately complete an Application for Appointment or Application for Reappointment, as applicable, including completion of the necessary attestation, release and waiver; submission to Provider of all required documents listed below under Credentialing Functions.

   G. Office standards: Office site surveys must be conducted in accordance with Provider's NCQA-compliant guidelines.

H. Comply with the Network Policies and Procedures as amended from time to time and as made available to Participating Providers upon request.

EXHIBIT C
MEMBER ROSTER

(List Member names and TIN's only UNLESS credentialing has been delegated to Provider. Delegated credentialing requires submission of an electronic roster with all key data elements, and a signed Letter of Agreement Exhibit F for each participating Member.)

EXHIBIT D
DELEGATION OF CREDENTIALING

RECITALS

A. Network maintains credentialing programs designed to periodically review and monitor the credentials of Participating Physicians and other Participating Providers who render Covered Services to Beneficiaries. Network has established policies and procedures for delegating certain of its administrative functions to Provider where Provider's credentialing and recredentialing standards are consistent with Network standards and the standards of the NCQA.

B. Provider desires to facilitate the credentialing review of Members by performing certain delegated functions on behalf of Network, and Network is willing to delegate such functions, on the terms and conditions set forth below:

NOW THEREFORE, in consideration of the premises and of the mutual covenants contained herein, the parties do hereby agree as follows:

1. (a) Capitalized terms used herein and not defined herein shall have the meanings ascribed to those terms in the Provider Participation Agreement (Delegated Group).

   (b) Except as modified below, the provisions of the Agreement shall remain in full force and effect.

2. Provider represents and warrants that (a) a copy of its credentialing policies and procedures is attached hereto as Exhibit E, (b) that such policies and procedures are based on current NCQA standards, (c) Provider has been organized and is operating in compliance with all applicable laws, and (d) Provider has the power and authority under applicable state law to accept the delegation of credentialing functions.

3. Network hereby delegates to Provider, and Provider hereby agrees to provide, the attached credentialing and recredentialing functions for all Provider's Members in accordance with Provider's credentialing and recredentialing policies and procedures, as these policies have been approved by Network.

4. Provider shall at all times (a) be accountable to Network for the credentialing functions delegated herein, (b) comply with the credentialing and recredentialing standards of Network and the NCQA, (c) abide and cause its Members to abide by, the results of any decision by Network's credentialing committee, and (d) take appropriate steps to implement corrective action if Network notifies Provider that it has failed to perform or comply with the terms of this Exhibit.

5. Network reserves the right, in its sole discretion, to disapprove any Member, regardless of the initial credentialing or recredentialing decision. Members who are disapproved by Network shall not provide services to Beneficiaries pursuant to this Agreement.

6. Upon request, Provider shall provide Network with a written report in a format reasonably acceptable to Network which addresses summary results of its credentialing activities. This report should summarize performance indicators, improvement activities, and status of credentialing and recredentialing activities.

7. Network may periodically review Provider's credentialing policies and criteria and shall, from time to time, be granted access to Provider's files, on a scheduled basis, with a minimum of five (5) working days notice, to ensure compliance by Provider with Network credentialing standards. This access by Network shall not be construed as and is not intended to be a waiver of any privileges that may attach to

such credentialing information. Network may review the greater of five percent (5%) or fifty (50) of Provider's credentialing files in connection with each such audit

8. If Provider receives a notice of non-compliance from Network, Provider agrees to:
   a) Submit to Network within thirty (30) days of the date of notice, a written corrective plan, including specific measures and timelines for restoring compliance with this Agreement.
   b) Allow Network's credentialing staff to conduct such on-site audits as network may deem necessary to evaluate or facilitate Provider's implementation of the corrective plan.
   c) Modify its procedures or the corrective plan as needed to correct any deficiencies identified during the on-site audit.
   d) Allow Network to maintain ongoing oversight of implementation of the corrective action plan.

   Network shall have the option of revoking its delegation of some or all of the function(s) delegated hereunder if:
   a) Provider does not show marked improvement after Network has identified non-compliance issues.
   b) The delegation jeopardizes Network's eligibility for NCQA accreditation.

   Any revocation made pursuant to these sections hereof shall be effective immediately upon Network notifying Provider. If Network revokes the delegation of any function, Network will resume performing that function.

9. In the event that any of Provider's Members cease to meet Network credentialing criteria, or is disapproved by Provider or Network, Provider shall immediately cease referrals of Beneficiaries to such Member and promptly notify Network, and if such Member is a Primary Care Physician and / or providing an active course of treatment to a Beneficiary, alternate arrangements for the provision of covered services shall be made.

10. Provider shall promptly notify Network if any information comes to its attention regarding any adverse action taken with respect to the licensure of any Member, suspension or termination (in whole or in part) of a Member's hospital staff privileges or clinical privileges, suspension or termination of Provider's or a Member's Medicare or Medicaid privileges, a lawsuit is filed against a Member alleging professional negligence, or any other information that adversely reflects on the ability or capacity of a Member to provide medically appropriate care consistent with appropriate standards of professional competence and conduct.

11. Provider agrees to require its Members to cooperate with and abide by the results of Network credentialing policies and procedures whether implemented through Provider or directly by Network.

12. Provider shall be responsible for all costs and expense related to the operation of its credentialing program.

13. Provider shall permit Network to conduct an initial due diligence audit to confirm that Provider is in compliance with each of the provisions of this Exhibit.

14. Provider shall comply with all state requirements (including applicable licensure) and requirements of other applicable regulatory authorities in the performance of the administrative functions delegated hereunder. Provider shall, upon written request, provide Network with documentation of the satisfaction of these requirements.

15. Provider and Network shall indemnify and hold harmless each other, each other's directors, officers, agents and employees against any and all claims, lawsuits, settlements, judgments, costs, penalties, and expenses, including without limitation, reasonable attorneys' fees, which result from any act or omission by Provider or any Members concerning its representations, duties and obligations under this Exhibit D.

Credentialing functions to be performed- Check all that apply:

_____ Verification of Board certification for any and all specialties in which each Member so represents he/she is certified

_____ Verification of completion of residency and reported performance

_____ Review of work history and confirmation that during the last five (5) years there are no unexplained gaps of more than six (6) months

_____ Verification of hospital privileges and good standing

_____ Verification of license from a primary source

_____ Verification of valid and current DEA certificate

_____ Verification of current malpractice insurance satisfying Network's standards and collection of documentation in support thereof

_____ Research regarding any malpractice claims

_____ Confirmation that provider's record is clear of any Medicare/Medicaid sanctions

_____ Confirmation that all credentialing questions on the application have been answered and that no one answer raises an issue

_____ Obtain affidavit from Member that he/she is fit to practice and has reviewed his/her application and verifies its correctness and completeness

_____ Verification of DPS certification (Texas only)

_____ Obtain all necessary attestations and releases with respect to information needed to perform credentialing

_____ Recredential each Member within a minimum of every three (3) years

Agreed to as of the date executed by each party:

Provider		**Independent Medical Systems, Ltd.**	
Signature:		Signature:	
Printed Name:	Anthony Wax	Printed Name:	David A Rendall
Title:	Executive Director	Title:	CEO
Date:	June 10, 2011	Date:	6/17/2011

CONTACT INFORMATION

Cindy Ranson Contact Name	Director of Operations Title
1000 Texan Trail, Suite 210 Mailing Address	Grapevine, Texas 76051 City/State/Zip

817-328-0500 Telephone	817-310-3349 Fax	cindyrntent@yahoo.com E-Mail Address

IMS PPO Network
Quick Reference Sheet

NOTE: IMS is a preferred provider network, and does not pay claims or determine benefits or eligibility.

Patient ID card

Claims submission: contact the Payor as shown on the ID card.

Eligibility and UM: contact the Payor for eligibility, benefits, deductible status; contact the UM vendor listed for pre-certifications/pre-authorizations and other UM requirements.

Patient Referrals

No authorizations are required, however referral to non-network providers may affect benefit levels and patient payments. To find a network provider, please log on to our website, www.imsppo.com and select Members, choose Provider Search and follow the prompts.

Provider Reference Manual

The Provider Reference Manual is available on our website: go to www.imsppo.com, select Providers, then click on Provider Reference Manual to print or download this document.

Provider Updates

To send us any changes in your Provider demographic/credentialing information (address, TIN etc.) please go to our website, www.imsppo.com and select Providers, then choose Update Your Information, and follow the instructions to input your new information and send to us.

NOTE: If you are a member of a group, IPA or PHO, this new information must be submitted to us by that organization.

In order to avoid delay or denial of claim payments, please submit these changes as far in advance as possible, noting the effective date of the change. Changes can also be mailed or faxed on your business letterhead to:

IMS PPO Network
12221 Merit Drive, Suite 1950
Dallas, TX 75251
Fax: 214-269-8401

Contact Information: Main Telephone Number – 1-800-566-5663

Claims Repricing – ext. 1201
Provider Relations – ext. 1220
Network Development/Contracting – ext. 1212 or 1221
General email: info@imsppo.com