Instructions on completing Careington provider application to avoid delays in network participation.

****Please read thoroughly****

Application: Without using abbreviations complete all pertinent information. Page 1 must include providers DOB, specialty type, NPI, License number, and dental school graduation date in MM.YY format. The location page must be completed in it's entirety to include providers start date at that location, address, TIN, contact information, office hours, ADA compliance and ages treated.

Licensed Specialists: You must select your specialty, complete your specialty school attended, and provide a certificate if you are board certified.

Oral Surgeons will need to indicate whether they have hospital privileges. If you do not have hospital privileges a waiver will be provided for you to complete.

Anesthesia Portion of Page 1: Select whether you administer sedation. If you check yes please checkmark the type of sedation. If your sedation privileges fall under your state dental license please write your state dental license in the space provided and checkmark "No State-issued permit/license" If you have a sedation license separate from your dental license please write that license number in the space provided. Please sign and date Page 1 whether you have a separate state issued permit or not confirming you comply with all state requirements.

Attestation: ALL questions must be answered truthfully and a separate written explanation for any question checked "Yes" must be provided.

Documents to Include along with completed application in PDF format:

- **W-9**: TIN or Social Security number on W-9 MUST match what is listed on page 1 of the application. The W-9 must be signed and dated.

- **DEA**: A DEA must be provided for the state the provider is being credentialed in. If the provider does not have a DEA for the state we are credentialing them in a DEA waiver is required.

- **Malpractice or Liability Insurance**: Declaration page or face sheet must be provided with coverage amounts and policy dates. Binders and quotes will not be permitted as proof of liability coverage.

- **Work History**: You must provide work history for the last 5 years or dating back to providers dental school graduation date. You may provide a CV in lieu of completing the work history section, but ALL work history on the application or the CV must be in MM.YY format. Work history not in this format will not be accepted. You must also provide a written explanation for any gaps in work history over 6 months.

  For *Colorado* providers, work history dating back 10 years is required and we will need explanations for gaps over 30 days.

- **Dental School Diploma**: If provider attended dental school outside of the United States a copy of the diploma will need to be provided.

Careington
SOLUTIONS SIMPLIFIED

Supporting Credentialing Documents needed for the Careington Dental Network

The following checklist will need to be fully completed to avoid delays in enrollment eligibility.

- ☑ **Application:** 5 pages. Be sure to check off the plans on the plan pages
- ☑ **Service Agreement:** 7 pages – Please initial or sign/date where requested
- ☑ **W9:** Your office TIN or social security number on page one should match the W-9
- ☑ **DEA**
- ☑ **Liability Insurance:** Declaration page/face sheet – Must be effective through the end of the month

Note:

- ☑ Please provide your **work history** for the last 5 years with months and dates and an explanation for any gaps over 6 months
- ☑ Any **attestation questions** answered with a "yes" requires a written explanation
- ☑ A **DEA waiver** will be needed if you do not hold a DEA certificate
- ☑ We require a **CAQH** in the following states – KY, MD, NM, OH, VT
- ☐ We require a **State Agreement** in the following states – CO, LA, NV, OK, OR, and WV
- ☑ Copy of Provider's Diploma

*** no acronyms or abbreviations accepted. All dental schools must be spelled out

CA, HI,MN,MT,OH VA and foreign schooled applicants, please include a copy of diploma.

Careington SOLUTIONS SIMPLIFIED

Dental Network Provider Application & Agreement

THIS BOX FOR INTERNAL USE ONLY
Attention: Colton Jack
☐ Add Plan ☐ Add Location

Dentist Information

First Name: Jarrod Middle Initial: M Last Name: Lee

Other name used (e.g. maiden name, nick name)? ☐ Yes ☒ No

Name: _____ Dates used (mm/dd/yyyy) From: _____ To: _____

Name: _____ Dates used (mm/dd/yyyy) From: _____ To: _____

Degree (select one): ☑ D.D.S ☐ D.M.D Date of birth: 11/11/1994 Gender: ☐ Female ☑ Male

National Provider Identifier (Individual NPI): 1679209381 Social Security Number: 410-77-4720

Specialty (select one) ☑ General Dentist ☐ Licensed Specialist State Dental License #: DS0000012013

Dental School: Meharry Medical College City: Nashville Graduation Date (Month & Year): 06/2022
(no acronyms)

Language(s) of Provider: _____

The section below is for Licensed Specialists only

Area of Specialty (select one): ☐ Orthodontist ☐ Oral Surgeon ☐ Periodontist ☐ Prosthodontist ☐ Endodontist ☐ Pediatric Dentist

Specialty School: _____ City: _____ Month/Year completed: _____
(no acronyms)

American Board Certified (select one): ☐ Yes ☐ No Year: _____
If yes, please provide certificate

Hospital Privileges (select one): ☐ Yes ☑ No If No, you must include an explanation with who will admit on your behalf

Name of Hospital: _____ Current Status: ☐ Unrestricted ☐ Restricted

Type of Priveleges: ☐ Active ☐ Courtesy ☐ Temporary

Anesthesia

Do you administer any form of sedation and/or general anesthesia? ☐ Yes ☑ No

Please select the types of sedation you administer and provide the applicable permit/license information below:

☐ Deep Sedation/General anesthesia	Permit/License # _____	State _____	☐ No state-issued permit/license
☐ Moderate/Conscious Sedation (all types)	Permit/License # _____	State _____	☐ No state-issued permit/license
☐ Minimal Sedation (all types)	Permit/License # _____	State _____	☐ No state-issued permit/license
☐ Pediatric Moderately/Conscious Sedation (all types)	Permit/License # _____	State _____	☐ No state-issued permit/license
☐ Nitrous Oxide	Permit/License # _____	State _____	☐ No state-issued permit/license

Photocopy must be included be included for following states AL, AR, AZ, IL, LA, MA, MI, MD, NC, PR, SC, VA, VI, WV.

If no state-issued permit/license, please sign below: Please confirm that you comply with all State requirements in providing patients with any form or level of sedation, anesthesia, and/or nitrous oxide, including, but not limited to, those regarding equipment, supplies, and training.

Dentist Signature X _____ **Date** _____

Form **W-9**
(Rev. November 2017)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person** ►	**Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

Dentist's Practicing Locations

☑ *Check box if location is primary for provider listed*

Date started at location: 04/01/2024

Dental Office Name: Hintz and Oakley Family Dentistry

Address: 120 West Jackson Street

City: Cookeville County: Putnam

State: TN ZIP Code: 38501

Tel. No. 931-526-5460

Fax No. 931-526-5459

Email Intended for Patient Use: _____

Website URL: _____

Tax ID # (Required) 47-1611765

National Provider ID (Corporate/Group Type 2 if applicable): _____
1932351921

Office Manager Name: Kristi

Email Address: hintz.oakley@gmail.com

Credentialing Rep Name (i/a): Brandalynne Flemming

Email Address: brandalyn@plmhealth.com

Consultant Firm Name (i/a): _____

Email Address: _____

	OPEN		CLOSED	
Mon	8:00 A	am/pm	5:00 P	am/pm
Tues	7:30 A	am/pm	5:00 P	am/pm
Wed	7:30 A	am/pm	5:00 P	am/pm
Thurs	7:30 A	am/pm	5:00 P	am/pm
Fri	8:00 A	am/pm	5:00 P	am/pm
Sat		am/pm		am/pm
Sun		am/pm		am/pm

Ages Treated

☑ All

☐ Other (List Age Range)

Is this location compliant with the Americans with Disabilities Act? ☑ Yes ☐ No

Accepting new patients? ☑ Yes ☐ No

☐ *Check box if location is primary for provider listed*

Date started at location: _____

Dental Office Name: _____

Address: _____

City: _____ County: _____

State: _____ ZIP Code: _____

Tel. No. _____

Fax No. _____

Email Intended for Patient Use: _____

Website URL: _____

Tax ID # (Required) _____

National Provider ID (Corporate/Group if applicable): _____

_____

	OPEN		CLOSED	
Mon		am/pm		am/pm
Tues		am/pm		am/pm
Wed		am/pm		am/pm
Thurs		am/pm		am/pm
Fri		am/pm		am/pm
Sat		am/pm		am/pm
Sun		am/pm		am/pm

Ages Treated

☐ All

☐ Other (List Age Range)

Is this location compliant with the Americans with Disabilities Act? ☐ Yes ☐ No

Accepting new patients? ☐ Yes ☐ No

Language(s) Spoken at Location: _____

Billing Address

Address: 120 West Jackson Street

City: Cookeville State: TN ZIP Code: 38501

Tel. No. 931-526-5460 Fax No. _____

Plan Participation (Please check plan(s) in which Dentist will participate.)

☑ **Care Platinum PPO** - Care Platinum PPO works with payors and utilizes an assigned fee schedule for General Dentists and a discount for Specialists. Under this plan, the member could be responsible for a co-payment at the time of service, and any remaining balance will be filed with the member's designated Plan Administrator (i.e. Third Party Administrator, Insurance Company, etc.) for reimbursement.

☑ **Care Platinum POS** - Care Platinum POS is a fee for service plan that utilizes an assigned fee schedule for General Dentists and a discount for Specialists. You will collect all applicable fees from the member at the time of service. Since the fee is required at the time of service, there are no claims to be filed.

☑ **CarePPO** - CarePPO works with payors and utilizes an assigned fee schedule for General Dentists and a twenty percent (20%) discount for Specialists. Under this plan, the member could be responsible for a co-payment at the time of service, and any remaining balance will be filed with the member's designated Plan Administrator (i.e. Third Party Administrator, Insurance Company, etc.) for reimbursement.

☑ **CarePOS** – CarePOS is a fee for service plan that utilizes an assigned fee schedule for General Dentists and a twenty percent (20%) discount for Specialists. You will collect all applicable fees from the member at the time of service. Since the fee is required at the time of service, there are no claims to be filed.

☐ **500 Series** – 500 Series is a fee for service plan that utilizes an assigned fee schedule for General Dentists and a twenty percent (20%) discount for Specialists. You will collect all applicable fees from the member at the time of service. Since the fee is required at the time of service, there are no claims to be filed.

State Specific Plans

☐ **HIP VIP (applicable only in CA, CT, DC, FL, GA, MA, MD, MO, NC, NJ, NY, OH, PA, SC, VA, & WV)** - is a fee for service plan where General Dentists charge according to the assigned HIP fee schedule and Specialists give a 20% discount off UCR. You will collect all applicable fees from member at the time of service. Since the fee is required at the time of service, there are no claims to file.

☐ **Careington-Humana Plan (applicable only in FL)** - utilizes an assigned fee schedule for General Dentists and a twenty percent (20%) discount for Specialists. Members on this plan have some insured benefits. Contact the third party administrator for information on the insured benefits. Members are not charged lab and OSHA fees.

Signature

By signing below, Participating Provider agrees to participate with plan(s) selection above. Participating Provider may cancel participation in plan(s) at any time with notice.

X _____
Dentist Name (Please print)

X _____ _____
Dentist Signature **Date**

Credentialing Work History & Attestation

Work History (Last 5 years required) – Please include an explanation for any gap of employment (more than 6 months) within the last 5 years including residency. Dentist can provide Curriculum Vitae (CV) in lieu of completing the below Work History.

First Name: Jarrod Middle Initial: M Last Name: Lee

☑ I have included a Curriculum Vitae (CV) in lieu of completing the below Work History section (CV must provide last 5 years of work history with MM/YY format)

Residency/Location: (If residency, please provide a copy of your certificate of completion)

Location 1

Practice Name/Institution: Hintz and Oakley Family Dentistry From: 04/2024 To: _____ (MM/YY)

Address: 120 West Jackson Street City: Cookeville ZIP: 38501

☐ Residency or ☑ Dental Practice

Location 2

Practice Name/Institution: Open Door Dental From: 01/2024 To: _____ (MM/YY)

Address: 112 E 1st ST City: Crossville ZIP: 38555

☐ Residency or ☑ Dental Practice

Location 3

Practice Name/Institution: Dr. Darryl G. Smith, DDS From: 08/2022 To: 11/2023 (MM/YY)

Address: 805 Webb Ave City: Crossville ZIP: 38555

☐ Residency or ☑ Dental Practice

Attestation - Please check **"Yes" or "No" for each question listed below**. If you answer "Yes" to questions 2-9 please provide full written explanation on a separate document. **If any errors are made while filling out this portion, simply cross out the error and initial /date.**

1. Are you currently registered with the DEA or state agencies to prescribe medications including narcotics?
   - ☑ Yes (Please provide copy of DEA certificate)
   - ☐ No (Please provide a waiver or indicate who is prescribing on your behalf)

2. Has your professional liability insurance ever been suspended, canceled, or not renewed?
   - ☐ Yes If yes, please provide a written explanation in your own words
   - ☑ No

3. In the last 5 years have you been involved in or a party to any malpractice claim, action or suit in any way?
   - ☐ Yes If yes, please provide a written explanation in your own words
   - ☑ No

4. Do you have any physical or mental impairment that could cause you to be unable to perform the essential functions in your area of practice, without any threat to the health and safety of others?
   - ☐ Yes If yes, please provide a written explanation in your own words
   - ☑ No

Attestation - Continued on page 5

5. Are you suffering from any communicable health condition, which considering the essential functions of your practice could pose a health or safety risk to your patients?

☐ Yes If yes, please provide a written explanation in your own words

☑ No

6. Do you currently, or have you in the last 5 years, had any substance abuse, chemical dependency problems, engage in unlawful use of drugs, including prescription drugs, which might affect your ability to practice dentistry in your area of expertise in any way?

☐ Yes If yes, please provide a written explanation in your own words

☑ No

7. Have you ever been convicted of any felony convictions or crime of moral turpitude?

☐ Yes If yes, please provide a written explanation in your own words

☑ No

8. Have you ever had any of the following items revoked, denied, suspended, not renewed, limited or curtailed in anyway, or have you voluntarily relinquished any item in anticipation of such action?

☐ Yes If yes, please provide a written explanation in your own words

☑ No

If yes, check all that apply and explain

- ☐ State Dental License
- ☐ DEA Registration
- ☐ Hospital or any other health care facility privileges
- ☐ Participation in government programs. i.e. Medicaid/MediCare

9. Has any action or investigation been taken against you by any professional association, licensing board or ethics committee?

☐ Yes If yes, please provide a written explanation in your own words

☑ No

Signature

I attest that all of the information given in Credentialing Work History and Attestation section is complete and correct. I understand that failure to give complete and correct information could result in delayed or denied acceptance of this application. I authorize Careington International to consult with professional liability carriers, and other persons or entities to obtain information concerning my professional qualifications including competence, ethics and other qualifications. I understand that the intentional submission of false or misleading information or the withholding or relevant information is grounds for termination as a participating provider with the affiliated organization contracted with Careington International. The undersigned hereby agrees to notify Careington International of any changes in the above information.

X _____

Dentist Name (Please print)

X _____ _____

Dentist Signature **Date**

Terms & Conditions

This Agreement ("Agreement") is entered into between the undersigned dentist ("Participating Dentist") and Careington International Corporation, by and on behalf of itself and its subsidiaries and affiliates ("Careington").

I. **General Provisions**

A. Participating Dentist (General Dentist or Specialist) shall accept Covered Persons as new patients on the same basis as Participating Provider is accepting non-Covered Persons as new patients. Participating Dentist agrees to provide Dental Services without discrimination against any Covered Persons on the basis of participation in the Dental Benefit Plan, source of payment, age, sex, ethnicity, religion, sexual preference, health status or disability. A Participating Dental Specialist may only perform specialized procedures if they are board certified or board eligible to perform such procedures.

If a Participating Dentist performs oral surgery, such Participating Dentist agrees to obtain and maintain in full force and effect professional liability insurance, at its sole cost and expense, in coverage amounts of not less than $1,000,000 per occurrence and $3,000,000 annual aggregate, or such higher amounts as may be required under applicable law.

B. Participating Dentist represents and warrants that he or she is licensed to practice dentistry pursuant to the laws where he or she is practicing dentistry. Participating Dentist also represents and warrants that his or her license to practice dentistry and DEA registration, if applicable, are not suspended or revoked. Participating Dentist agrees that he or she will promptly notify Careington in writing should either such license or registration be revoked, restricted, suspended or otherwise subject to disciplinary action by any government agency. Participating dentist authorizes Careington to obtain information concerning my professional qualifications as well as to inquire within National Practitioner Data Bank about my practice.

C. For purposes of this Agreement, "Dental Services" means a dental service or supply for which a benefit may be payable under the terms of a Dental Benefit Plan. "Dental Benefit Plan" means a group or individual medical or dental Care program that is administered by a third party partner or offered by a Health Plan with a Medicare Contract. "Covered Person" means an individual entitled to benefits under a Dental Benefit Plan.

D. Careington may contract with persons or entities (including, without limitation, Careington subsidiary or affiliated organizations, self-administered or self-funded programs providing dental Care benefits, employers or insurers wishing to utilize the services of Careington's dental network) (collectively referred to as "Health Plans") incorporating the terms and conditions of this Agreement. It is agreed that the Health Plans will succeed to all of Careington's rights and obligations under this Agreement.

E. Participating Dentist agrees to comply with all applicable Medicare laws, rules and regulations, reporting requirements, CMS instructions, and applicable requirements of any Part C contract between a Health Plan and CMS (the "Medicare Contract") and with all other applicable state and federal laws and regulations, as may be amended from time to time, including, without limitation: (1) Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (section 1128B(b)) of the Act); and (2) the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") administrative simplification rules at 45 CFR parts 160, 162, and 164. To the extent Participating Dentist has agreed to furnish services under this Agreement to Covered Persons enrolled in a Health Plan with a Medicare Contract, Participating Dentist acknowledges that the Health Plan has delegated to Careington, which has in turn delegated to Participating Dentist, responsibility under the Medicare Contract to provide the services set forth in the Agreement. Participating Dentist agrees that Careington and the Health Plan may only delegate such responsibilities in a manner consistent with the standards set forth under 42 CFR §422.504(i)(3) and (4).

Participating Dentist shall provide or arrange for the provision of Dental Services in conformity with generally accepted dental practices in effect at the time of service. Participating Provider shall also ensure that ancillary dental personnel who provide Dental Services to Covered Persons are properly licensed.

Participating Dentist acknowledges and agrees that to the extent Careington, in its sole discretion, elects to delegate any administrative activities or functions to Participating Dentist, Participating Dentist understands and agrees that: (i) Participating Dentist may not delegate, transfer or assign any of Participating Dentist's obligations under the Agreement and/or any separate delegation agreement without Careington's prior written consent; and (ii) Participating Dentist must demonstrate, to Careington's satisfaction, Participating Dentist's ability to perform the activities to be delegated and the parties will set out in writing: (1) the specific activities or functions to be delegated

☐ ***Please initial that you have read the terms above***

and performed by Participating Dentist; (2) any reporting responsibilities and obligations pursuant to Careington or Health Plan's policies and procedures and/or the requirements of the Medicare Contract; (3) monitoring and oversight activities by Careington or Health Plan including without limitation review and approval by Careington or Health Plan of Participating Dentist's credentialing process, as applicable, and audit of such process on an ongoing basis; and (4) corrective action measures, up to and including termination or revocation of the delegated activities or functions and reporting responsibilities if CMS or Careington or Health Plan determines that such activities have not been performed satisfactorily. [42 C.F.R. § 422.504(i)(3)(iii); 422.504(i)(4)(i)-(v).] Moreover, to the extent Careington allows Participating Dentist to enter into subcontracts to provide services pursuant to this Agreement, Participating Provider agrees that any Health Plan with a Medicare Contract retains the right to approve, suspend, or terminate any such arrangement as it applies to their Medicare Contract.

F. Participating Dentist agrees to comply with all applicable state and federal laws, rules and regulations, Medicare program requirements, and/or requirements in the Medicare Contract regarding privacy, security, confidentiality, accuracy and/or disclosure of records (including, but not limited to, medical records), personally identifiable information and/or protected health information and enrollment information including, without limitation: (1) HIPAA and the rules and regulations promulgated thereunder, (2) 42 C.F.R. § 422.504(a)(13), and (3) 42 C.F.R. § 422.118; (iv) 42 C.F.R. § 422.516 and 42 C.F.R. § 422.310 regarding certain reporting obligations to CMS. Participating Dentist also agrees to release such information only in accordance with applicable state and/or federal law or pursuant to court orders or subpoenas.

G. Participating Dentist shall comply with all applicable policies and procedures of Careington and Health Plans including, without limitation, written standards for the following: (a) timeliness of access to care and member services; (b) policies and procedures that allow for individual medical necessity determinations (e.g., coverage rules, practice guidelines, payment policies); (c) Participating Dentist consideration of Covered Person input into Participating Dentist's proposed treatment plan; and (d) Health Plan's compliance program which encourages effective communication between Participating Dentist and Health Plan's Compliance Officer and participation by Participating Dentist in education and training programs regarding the prevention, correction and detection of fraud, waste and abuse and other initiatives identified by CMS. The aforementioned policies and procedures are identified in Careington and Health Plan Participating Dentist Manuals which are incorporated herein by reference and may be amended from time to time by Careington or Health Plan. [42 C.F.R. § 422.112; 422.504(i)(4)(v); 42 C.F.R. § 422.202(b); 42 C.F.R. § 422.504(a)(5); 42 C.F.R. § 422.503(b)(4)(vi)(C) & (D) & (G)(3).]

H. Participating Dentist shall comply with all provisions of any Addendum, Amendment or Appendix attached to this agreement.

I. Participating General Dentist on the Care Platinum PPO, Care Platinum POS, CarePPO, CarePOS, or 500 Series plans agrees to accept as payment in full for Dental Services
the amount shown in the attached assigned fee schedule (the "Reimbursement Amount"). Participating Dental Specialist on the Care Platinum PPO and Care Platinum POS plans will not use a fee schedule but agree to provide dental services at a fifteen percent (15%) discount off of Usual and Customary or Reasonable and Customary fees. Participating Dental Specialist on the CarePPO, CarePOS, or 500 Series plans will not use a fee schedule but agree to provide dental services at a twenty percent (20%) discount off of Usual and Customary or Reasonable and Customary fees. Specialist agrees to submit a copy of their Usual and Customary fees to Careington upon request. Each Dental Benefit Plan design will designate a maximum UCF for each area in which any charge over the set maximum will be subject to adjustment prior to reimbursement.

Participating General Dentist on the Careington-Humana, and HIP VIP plans agrees to accept as payment in full for Dental Services the amount shown in the attached assigned fee schedule (the "Reimbursement Amount"). Participating Dental Specialist on the Careington-Humana, and HIP VIP plans will not use a fee schedule but agree to provide dental services at a twenty percent (20%) discount off of Usual and Customary fees. Specialist agrees to submit a copy of their Usual and Customary fees to Careington upon request. Non covered procedures not listed on the Careington-Humana, and HIP VIP fee schedule is a cost to the member at a twenty percent (20%) discount off of Participating General Dentists Usual and Customary fee for that procedure.

When the Dental Benefit Plan under which a Covered Person is covered is secondary under coordination of benefit rules, Participating Dentist will receive as payment an amount no greater than the difference between the amount payable to the Participating Dentist by the primary payor and the Reimbursement Amount, if any. In any event, Careington shall have no obligation to Participating Dentist for any claims for Reimbursement Amounts not paid by or on behalf of a self-funded group plan sponsor for which Careington administers a Dental Benefit Plan. Careington reserves the right to change Reimbursement Amounts at any time upon notice to a Participating Dentist.

Any procedure not listed on the CarePOS or 500 Series fee schedule is a cost to the member at a twenty percent (20%) discount and any procedure not listed on the Care Platinum POS fee schedule is a cost to the member at a fifteen percent (15%) discount off of Participating General Dentists normal fee for that procedure. Any procedure not listed on the CarePPO fee schedule is a twenty percent (20%) discount off the Reasonable and Customary fees in your zip code which is defined by the carrier. Any procedure not listed on the Care Platinum PPO fee schedule is a fifteen percent (15%) discount off the Reasonable and Customary fees in your zip code which is defined by the carrier.

All lab fees incurred on any procedure are the responsibility of the patient, with the exception of the Care Platinum PPO, Care Platinum POS, and HIP VIP, and Humana plans. Participating Dentist shall bill payor(s) in the most current standard American Dental Association claim format.

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Participating Dentist acknowledges that the Participating Dentist has the option, in the Participating Dentist's sole discretion, to participate or not to participate in Careington Discount Plans (including Care Platinum POS, Care POS, or 500 Series) that provide discounts for services that are not covered by insurance or other 3rd party reimbursement. Participating Dentist acknowledges that Careington has not restricted in any manner the choice of the Participating Dentist to participate or not to participate in a Careington Discount Plan. If Participating Dentist chooses to participate in a Careington Discount Plan, Participating Dentist may cancel such participation at any time by providing written notice to Careington. Careington will not take any action against the Participating Dentist based on the Participating Dentist's decision to not participate, or to cancel participation, in a Careington Discount Plan.

J. Under no circumstances shall Participating Dentist bill Covered Persons for the balance, if any, between Participating Dentist's usual charges and the Reimbursement Amount, as described in Paragraph H above.

K. Covered Persons are responsible for all Dental Services that are not covered under their Dental Benefit Plan; Covered Persons are also responsible for all deductibles, co-payments and coinsurance amounts required under the Dental Benefit Plan. Participating Dentist agrees to charge and collect any applicable co-payments, coinsurance and/or deductible amounts required under the Dental Benefit Plan. Participating Dentist further agrees that any deductibles, coinsurance and/or co-payments shall be calculated based on the Reimbursement Amount.

L. Participating Dentist shall submit bills to Health Plans within ninety (90) days or as set forth in applicable law, whichever is less, of the date of service. Participating Dentist shall not separately bill Covered Persons for purposes of additional payments with respect to Dental Services other than for copayments, coinsurance, or deductibles in accordance with the Covered Person's contract. Participating Dentist agrees that failure to submit claims in accordance with the requirements herein may result in the denial of such claims. Participating Dentist has until the later of (i) one (1) year from the date that the Dental Service was rendered, or (ii) such other period as set forth in applicable state or federal law, to appeal a payment made by Health Plan. After such period, no further adjustments to payments shall be made.

M. Health Plans will process and pay or deny claims for Dental Services within thirty (30) calendar days of receipt of such claims in accordance with the Agreement. Participating Dentist agrees to prompt submission of information for claims payment.

N. Participating Dentist agrees to obtain and maintain in full force and effect professional liability insurance for itself and each Dentist providing Dental Services hereunder, at its sole cost and expense, in coverage amounts of not less than $200,000 per occurrence and $600,000 annual aggregate, or such higher amounts as may be required under applicable law. Participating Dentist shall maintain general and premises liability insurance, insuring against personal injury and death, workers' compensation, fire and casualty insurance and all other policies of insurance required by federal, state and local law or ordinance. Upon request, Participating Dentist shall provide to Careington or Health Plan, a "Certificate of Insurance" evidencing such coverage and all renewals thereof and shall notify Careington within ten (10) days of receipt of notice of the revocation, cancellation, amendment or modification of any such policies. Participating Dentist shall notify Careington and Health Plan in writing within forty-eight (48) hours of the receipt of verbal or written notice of a threatened or asserted claim, demand, action or complaint alleging medical malpractice, or the initiation of an investigation or inquiry with respect to a violation of any law, regulation, rule or administrative guideline pertaining to Participating Dentist.

O. Participating Dentist shall permit inspection, evaluation and audit directly by Careington, Health Plans, OIR, the Department of Health and Human Services (DHHS), the Comptroller General, and/or their designees any pertinent information for any particular contract period including books, contracts (including any agreements between Participating Dentist and its employees, contractors and/or subcontractors providing services related to the Agreement), documents, papers, medical records, patient care documentation, computer or other electronic systems, and other records and information involving or relating to the provision of services under the Agreement, and any additional relevant information that CMS or Careington may require (collectively, "Books and Records"). All Books and Records shall be maintained in an accurate and timely manner and shall be made available for such inspection, evaluation or audit for a time period of not less than ten (10) years, or such longer period of time as may be required by law, from the end of the calendar year in which expiration or termination of this Agreement occurs or from completion of any audit or investigation, whichever is greater, unless CMS, an authorized federal agency, or such agency's designee, determines there is a special need to retain records for a longer period of time, which may include but not be limited to: (i) up to an additional six (6) years from the date of final resolution of a dispute, allegation of fraud or similar fault; or (ii) completion of any audit should that date be later than the time frame(s) indicated above; (iii) if CMS determines that there is a reasonable possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit Books and Records at any time; or (iv) such greater period of time as provided for by law.

Participating Dentist shall cooperate and assist with and provide such Books and Records to Careington, Health Plan and/or CMS or its designee for purposes of the above inspections, evaluations, and/or audits, as requested by CMS or its designee and shall also ensure timely access for Covered Persons to their medical, health and enrollment information and records. Where CMS requests direct access to books and records, except in exceptional circumstances, CMS will provide notification to Health Plan that a direct request for information has been initiated. Participating Dentist agrees and shall require its employees, contractors and/or subcontractors and those individuals or entities performing administrative services for or on behalf of Participating Dentist and/or any of the above referenced individuals or

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entities: (i) to provide Careington, Health Plan and/or CMS with timely access to records, information and data necessary for: (1) Health Plan(s) to meets its obligations under its Medicare Contract(s); and/or (2) CMS to administer and evaluate the MA program; and (ii) to submit all reports and clinical information required by the Health Plan(s) under the Medicare Contract. Participating Dentists agrees to permit any federal or state agency having jurisdiction over Careington's and/or Participating Dentist's provision of services and/or any accrediting organization to conduct periodic site evaluations of Participating Dentist's facilities, offices and records. Upon a Health Plan's written request, Participating Dentist shall provide such Health Plan with a copy of the written response to any questions or comments posed by the agencies listed in the preceding sentence.

P. Notwithstanding anything to the contrary in the Agreement, Participating Dentist agrees that Health Plans may audit Participating Dentist's records for payment and claims review purposes. Careington, Health Plans and Covered Persons shall not be required to reimburse Participating Dentist for expenses related to providing copies of patient records or documents to any local, State or Federal agency or Health Plan (i) pursuant to a request from any local, State or Federal agency (including, without limitation, the Centers for Medicare and Medicaid ("CMS") or such agencies' subcontractors; (ii) pursuant to administration of Health Plans' quality improvement, utilization review, and risk management programs; (iii) in order to assist Health Plans in making a determination regarding whether a service is a covered service for which payment is due under a Dental Benefit Plan; or (iv) as otherwise may be required for Health Plans to meet their obligations. To the extent permissible under applicable federal or state law, a Participating Dentist may require a Covered Person reimburse the Participating Dentist for expenses related to providing copies of patient records to a Covered Person for transfer to another provider. The carrier's obligations to provide data and information to the provider, such as (i) performance feedback reports or information to the provider, if compensation is related to efficiency criteria; (ii) information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies. Notification of changes in these requirements shall also be provided by the carrier, allowing provider's time to comply with such changes.

Q. Except as provided herein, neither Participating Dentist nor Careington may use the other party's symbols, trademarks or service marks in advertising or promotional materials or otherwise without the prior written consent of that party. The Participating Dentist agrees to have his or her name, specialty, office address, office telephone number and office hours listed in the Careington dental directory of contracted dentists.

R. Participating Dentist agrees that when Careington contracts with Health Plans for use of Participating Dentist's services under this Agreement, Participating Dentist will provide services to Covered Persons of such Health Plans in accordance with the terms of this Agreement. In all events, however, Participating Dentist shall look for payment only to the particular Health Plan that covers the particular services for which Participating Dentist seeks to be compensated (except for applicable deductibles, co-payments or other obligations of Covered Persons).

S. Participating Dentist shall comply with Careington's credentialing and re-credentialing procedures and Health Plans' quality improvement, utilization review, peer review, grievance and appeal, and coordination of benefit procedures, and any other reasonable policies that Health Plans may implement.

T. The parties agree to keep the confidential and proprietary information or trade secrets of each other in trust and confidence and agree that such information shall be used for the purposes contemplated in this Agreement. Without limiting the generality of the foregoing, it is agreed that all compensation arrangements between the parties and the identities of Covered Persons shall specifically be considered proprietary and confidential.

U. For group plans for which Careington is providing administrative services, in the event of a failure to fund submitted claims by a self-funded group plan sponsor, Careington shall notify Participating Dentist of such failure to fund in writing in a timely manner and shall have no further responsibility therefore.

V. Participating Dentist agrees to cooperate with Careington and/or Covered Persons in resolving billing or grievance disputes. Participating Dentists will contact the Dental Benefit Plan directly for eligibility verification and benefit breakdown prior to treatment.

W. Participating Dentist agrees that any services provided by Participating Dentist to a Covered Person enrolled in a Health Plan with a Medicare Contract will be consistent with and will comply with the Health Plan's obligations under that contract.

II. **Term and Termination**

A. The term of this Agreement shall begin on the Effective Date listed on the signature page of this Agreement and shall continue in effect until terminated by either party pursuant to the terms of this Agreement.

B. This Agreement may be terminated (i) without cause by either party by giving the other party (30) thirty days' prior

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written notice (or sixty (60) days prior written notice in the case of a Health Plan with a Medicare Contract) delivered by certified mail, fax, or email using latest version of Careington provider cancelation form. In addition, this agreement will be terminated (ii) immediately by Careington if Participating Dentist's license(s) is/are revoked, suspended or restricted or if his or her professional liability insurance is terminated or restricted, or (iii) immediately by Careington upon the death or disability of participating dentists.

C. Notwithstanding the foregoing, this Agreement, as it applies to the provision of services to Covered Persons enrolled in a Health Plan with a Medicare contract, may also be terminated immediately if Participating Dentist is excluded from participation under a Federal Health Care Program as defined under Section 1128B(f) of the Social Security Act.

D. Nonpayment for goods or services shall not affect Participating Dentist's obligation to provide thirty (30) day notice of intent to terminate this Agreement or Participating Dentist's obligation to render Dental Services until the termination date, and to complete all work in progress.

E. If this Agreement is terminated, each party shall remain liable for any obligations or liabilities arising from activities carried on by it hereunder prior to termination. Participating Dentist agrees that except in instances of immediate termination by Careington or Health Plan for reasons related to professional competency or conduct and upon expiration or termination of the Agreement, Participating Dentist will continue to provide Dental Services to Covered Persons as indicated below and to cooperate with Careington or Health Plan to transition Covered Persons to other Participating Dentists in a manner that ensures medically appropriate continuity of care. In accordance with the requirements of any applicable Medicare Contract, Careington's or Health Plan's accrediting bodies and applicable law and regulation, Participating Dentist will continue to provide Dental Services to Covered Persons after the expiration or termination of the Agreement, whether by virtue of insolvency or cessation of operations of Careington or Health Plan, or otherwise: (i) for those Covered Persons who are confined in an inpatient facility on the date of termination until discharge; (ii) for all Covered Persons through the date of the applicable Medicare Contract for which payments have been made by CMS to Health Plans; (iii) for those Covered Persons undergoing active treatment of chronic or acute medical conditions as of the date of expiration or termination through their current course of active treatment not to exceed ninety (90) days unless otherwise required by item (ii) above; and (iv) for all other courses of treatment of Covered Persons that began prior to expiration or termination of this Agreement until such treatment is completed.

III. **Dispute Resolution**

A. Careington and Participating Dentist agree to meet and confer in good faith to resolve any problems or disputes that may arise.

B. In the event that any problem or dispute arising under this Agreement and/or concerning the terms of this Agreement is not satisfactorily resolved pursuant to Section A above, Careington and Participating Dentist will arbitrate such problem or dispute. Such arbitration shall be initiated by either party making a written demand for arbitration to the other party. The arbitration will be conducted by the American Arbitration Association under the Commercial Rules of the American Arbitration Association, unless otherwise mutually agreed in writing by Careington and Participating Dentist. Participating Dentist and Careington agree that the arbitration results shall be binding on both parties in any subsequent litigation or dispute.

IV. **Miscellaneous**

A. Participating Dentist shall be solely responsible to Covered Persons for the method or means by which Participating Dentist renders dental treatment or service to Covered Persons. Participating Dentist shall be solely responsible for any acts or omissions relating to the diagnosis and treatment of Covered Persons. Nothing herein shall be construed as granting Careington the right to engage in the practice of dentistry.

B. The parties are independent contractors, and nothing in this Agreement is intended to create nor shall it be construed to create any employment, agency, joint venture or partnership relationship between the parties. Careington shall have no dominion or control over Participating Dentist, the dentist-patient relationship, Participating Dentist's personnel or facilities, or Participating Dentist's services.

C. Careington and Participating Dentist hereby acknowledge and agree that Health Plans shall oversee and monitor the performance of Participating Dentist on an ongoing basis.and shall be accountable under any applicable Medicare Contract for Dental Services provided to Covered Persons under the Agreement regardless of the provisions of the Agreement or any delegation of administrative activities or functions to Participating Dentist under the Agreement.

D. The parties agree: (i) that nothing contained in the Agreement nor any payment made by Careington or Health Plan to Participating Dentist is a financial incentive or inducement to reduce, limit or withhold Medically Necessary services to Covered Persons; and (ii) that any incentive plans between Careington or Health Plan and Participating Dentist and/or between Participating Dentist and its employed or contracted physicians and other health care practitioners and/or Participating Dentists shall be in compliance with applicable state and federal laws, rules and regulations and in accordance with the Medicare Contract. Upon request, Participating Dentist agrees to disclose to Careington or Health Plan the terms and conditions of any "physician incentive plan" as defined by CMS and/or any state or federal law, rule or regulation.

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E. If Participating Dentist is not an individual but rather is a professional association, limited liability company, corporation or other entity whose staff of dental health care professionals consists wholly or partially of employees or independent contractors, Participating Dentist represents, warrants and covenants that it has the unqualified authority to bind all such employees or contractors to the terms of this Agreement. Careington and/or Health Plans reserve the right to limit practice of one or more individuals in the Participating Dentist's group that are found to be in breach of the terms of this Agreement.

F. The provisions of this Agreement shall be binding upon and inure to the benefit or successors and assigns of the parties. Careington may assign, convey or transfer this Agreement to any of its subsidiaries or affiliates without the approval of Participating Dentist

G. If any portion of this Agreement is found to be void or illegal, the validity or enforceability of any other portion shall not be affected. This Agreement shall be governed by the laws of the State of Texas.

H. No waiver or any breach, privilege or provision hereunder shall be construed as a waiver of any other breach hereunder.

I. Any notice, with the exception of a provider termination notification, shall be in writing and sent by mail or fax to the first address listed on the Participating Dentist's agreement.

J. This Agreement constitutes the entire agreement between the parties as to the subject matter hereof. This Agreement may be amended at any time during its term upon thirty- (30) days' prior written notice to Participating Dentist from Careington.

K. Participating Dentist shall arrange for emergency call coverage on his office phone via voice mail, answering service/machine after hours or arrange for on call coverage during after hours to accommodate emergency patients; (b) shall check this service periodically when office is closed to ensure emergencies are handled or directed in a timely manner.

V. **Hold Harmless**

A. Participating Dentist hereby agrees: (i) that in no event, including, but not limited to, nonpayment by a Health Plan, or a Health Plan insolvency, shall Participating Dentist bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or persons other than Health Plan for Dental Services covered under a Dental Benefit Plan.

This Section does not prohibit Participating Dentist from collecting copayments, coinsurance, or deductibles in accordance with the Covered Persons' contract or evidence of coverage. This Section shall survive termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Covered Person. This Section supersedes any oral or written contrary agreement now existing or hereafter entered into between Participating Dentist and a Covered Person or a person acting on Covered Person's behalf. If the carrier provides or arranges for the delivery of health care services on a prepaid basis, the provider shall not bill any network plan member for covered services, except for specified coinsurance, copayments, and applicable deductibles. This provision shall not prohibit a provider and member from agreeing to continue non-covered services at the member's own expense, as long as the provider has notified the member in advance that the carrier may not cover or continue to cover specific services and the member chooses to receive the service.

For all Covered Persons eligible for both Medicare and Medicaid and enrolled in a Health Plan with a Medicare Contract, Participating Dentist shall not hold the Covered Persons liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Participating Dentist will be informed of Medicare and Medicaid benefits and rules for Covered Persons eligible for Medicare and Medicaid. Participating Dentist may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in a Health Plan with a Medicare Contract. Participating Dentist will: (1) accept the Health Plan payment as payment in full, or (2) bill the appropriate State source.

Participating Dentist shall indemnify and hold harmless Careington, its director, officers, employees, subsidiaries, affiliates and Groups, Covered Persons enrolled in Health Plans and the Governmental Agencies from and against any and all liabilities, demands, claims, suits, losses, damages, fines, judgments, costs, expenses and causes of action, including costs and reasonable attorneys' fees at all levels, arising out of or by reason of any damage or injury to persons or property suffered, or claimed to have been suffered, by any negligent act or omissions of Participating Dentist, its directors, officers, agents and employees.

C. Careington shall indemnify and hold Participating Dentist, its directors, officers, and employees, Governmental Agencies and Covered Persons harmless from and against any and all liabilities, claims, suits, losses, damages, fines judgments, costs, expenses, and causes of action, including costs and reasonable attorney's fees at all levels, arising out of or by reason of any damage or injury to persons or property suffered, or claimed to have been suffered, by any grossly negligent act or omission of Careington, its directors, officers and employees. Participating Dentist shall make all reasonable efforts, consistent with advice of counsel and requirements of applicable

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insurance policies and carriers, to coordinate the defense of all claims in which Careington or Health Plan are either named as a defendant or may be named. The obligations, duties and responsibilities of this Paragraph shall survive the termination or expiration of this Agreement.

VI. **Group Practices**

A. If a group practice ("Group Practice") is a party to this Agreement:
1. The Group Practice assumes all the duties, obligations and responsibilities of Participating Dentist as described above.
2. The Group Practice shall require each Participating Dentist to comply with all duties, obligations and responsibilities of a Participating Dentist under this Agreement.
3. All payments for Dental Services provided to Covered Persons treated at the Group Practice shall be paid to the Group Practice. Careington shall have no responsibility to any person associated with the Group Practice beyond paying the Group Practice the compensation provided by this Agreement.

Signature

Please sign and date below that you have read and agree to the terms & conditions provided on pages 6-12 of and any Addendum, Amendment or Appendix to the Participating Dentist Agreement.

X Jarrod Lee
Participating Dentist (type or print name)

X _____
Dentist's Signature

X _____
Date

Careington
SOLUTIONS SIMPLIFIED

7400 Gaylord Parkway
Frisco, TX 75034