The HRI Provider Enrollment Process

Please note that the enrollment process is fast and simple and only requires that you perform the following six items and return them to the HRI Claim’s Team:

✓ Complete and sign the Application for Participation (each dentist in the practice must complete a separate application)

✓ Sign the Dentist Provider Agreement (every dentist in the practice must sign)

✓ Fee Schedule as specified in Section 3(A)(1) of the Dentist Provider Agreement

✓ Complete and sign the provided Form W-9

✓ Provide a copy of the face page of your malpractice insurance policy (for each dentist in the practice)

✓ Complete and sign the provided EFT Election Form (electronic funds transfer form)

Upon receipt of your complete package (6 required items listed above), the HRI Credentialing Committee will review your application. Upon approval, you will receive an acceptance notice and a copy of your signed Provider agreement.
Affirmation of Submitted Information
All information submitted in this application is true to the best of my knowledge and belief. I fully understand that any significant misstatement in the application may constitute cause for denial of my application or termination of a resulting participation agreement.

By applying for network participation in the Dental Health Options plans designed and marketed by Health Resources, Inc., (HRI), I signify my willingness to appear for interviews in regard to my application. I authorize HRI to communicate with associates and with bearing on my professional competence, character, and ethical qualifications. I further consent to the inspection by representatives of HRI of all documents that may be material to an evaluation of my professional qualifications and competence.

1. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

2. I release from liability all representatives of HRI for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations who provide information to HRI in good faith and without malice concerning my professional competence, ethics, character and other qualifications; and I hereby consent to the release and exchange of information relating to any legal or disciplinary action, suspension, or curtailment of professional privileges to HRI.

3. I am a practicing dentist licensed in all states in which I practice.

4. I hereby authorize the State Board of Dental Examiners in every state in which I am licensed to turn over to the Credentials Committee of HRI a copy of any and all documents related to my licensure.

5. I confirm with this application that I am personally responsible for all information issued from my office.

Each dentist in practice needs to complete an application

Signature

Full Name (print)

Date

A photocopy of this document shall be as effective as the original.
This is an application only—submitting this application does not automatically result in acceptance by HRI.
Office Information and Address

(If you maintain more than one office location, provide all practice information on this page, including Form W-9 on a second application, or attachment.)

All fields are required to be completed.

<table>
<thead>
<tr>
<th>Dentist Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Dentist NPI</td>
<td></td>
</tr>
<tr>
<td>Dentist Specialty</td>
<td>General</td>
</tr>
<tr>
<td></td>
<td>Pediatrics</td>
</tr>
<tr>
<td>Practice/Office Name</td>
<td></td>
</tr>
<tr>
<td>Practice Address</td>
<td></td>
</tr>
<tr>
<td>Practice City, State, Zip Code</td>
<td></td>
</tr>
<tr>
<td>Practice County (ie IN-Vanderburgh)</td>
<td></td>
</tr>
<tr>
<td>Practice Phone &amp; Fax Numbers</td>
<td>Phone:</td>
</tr>
<tr>
<td>Practice Email</td>
<td></td>
</tr>
<tr>
<td>Organization NPI</td>
<td></td>
</tr>
<tr>
<td>Are there other dentists in your group? If so, please list names.</td>
<td>Name(s):</td>
</tr>
<tr>
<td>Does your practice offer evening or weekend appointments?</td>
<td>Weekend</td>
</tr>
</tbody>
</table>

Form 1099 Reporting Information:

Tax ID / Form 1099 recipient SUBMIT enclosed Federal Form W-9

Claims Payee Information and Dentist’s EOB Receipt Information:

PAYEE SUBMIT enclosed Electronic Funds (EFT) Election Form

Note: Explanation of Benefits (EOB’s) are available at www.InsuringSmiles.com, via Dentist’s secure login. An email will be sent to the email address given to notify of each claims/EOB processing cycle.
Health Resources, Inc.
Application for Network Participation

**Malpractice Liability Insurance Information (Documentation required)**
Supply a copy of the face page of your malpractice liability insurance policy indicating:
- Amount and Period of Coverage

<table>
<thead>
<tr>
<th>Question</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If practicing in Indiana, do you participate in the medical malpractice patients’ compensation fund?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Education and Licensure**

<table>
<thead>
<tr>
<th>Dental Institution</th>
<th>Degree</th>
<th>Dates Attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post Graduate Specialty Education</td>
<td>Degree</td>
<td>Dates Attended</td>
</tr>
<tr>
<td>Are you Board certified in your specialty?</td>
<td>☐Yes</td>
<td>☐No</td>
</tr>
</tbody>
</table>

**Licensure** (List all states licensed to practice dentistry.)

<table>
<thead>
<tr>
<th>State</th>
<th>License Number</th>
<th>BNDD (DEA) Registration (narcotic license)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

**Confidential Questionnaire**
(If answered yes to any of the questions below, please provide details on a separate sheet.)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you currently have or have you had any medical or psychiatric problems, including drug, alcohol or narcotic use that might adversely affect your ability to practice dentistry?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your license to practice dentistry in any jurisdiction ever been limited, suspended, or revoked?</td>
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</tr>
<tr>
<td>Have you been named as a party in a dental malpractice suit within the previous five (5) years?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you presently under investigation in any jurisdiction for a claim of dental malpractice?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your BNDD (DEA) number (narcotics license) ever been suspended or revoked?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been subject to disciplinary action during the previous 10 years by a state licensing board?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you any pending action by a state licensing board?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever been convicted of a felony in any jurisdiction?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have any pending insurance issues with other insurance companies, including Medicare or Medicaid?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever previously been a dental provider with HRI?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
HEALTH RESOURCES, INC.
DENTIST PROVIDER AGREEMENT

This Agreement is made and entered into as of the _____ day of __________, 20__ by and between the undersigned, a Dentist duly licensed to practice in the State(s) of _______________________________ (the “Dentist”), and Health Resources, Inc. ("HRI"), an Indiana corporation.

WHEREAS, HRI offers and administers dental plans (the “Dental Benefit Plans”) to eligible members (the “Enrollees”) by means of written contracts with employers, individuals, associations, third party payors, insurers, health maintenance organizations, and other bona-fide entities (the “Payor”).

WHEREAS, HRI wishes to contract with the Dentist for the provision of dental services included under its Dental Benefit Plans and the Dentist wishes to undertake to provide services under the Dental Benefit Plans to Enrollees on the terms and conditions hereinafter set forth.

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

SECTION 1. APPLICATION

A. **Required Items.** Dentist hereby submits to HRI and represents and warrants to HRI the truth, accuracy and completeness of the following items, each of which shall be deemed incorporated herein by reference:

1. The Dentist’s Application for Participation;
2. The Dentist’s initial Fee Schedule in accordance with Section 3(A)(1), below;
3. Copy of the Dentist’s certificate of malpractice insurance, in the amount required under Section 2(B)(3) for each State identified in the opening paragraph of this Agreement;
4. If the Dentist is practicing in the State of Indiana, attestation of participation in the Indiana Patients’ Compensation Fund;
5. Internal Revenue Service Form W-9, Request for Taxpayer Identification Number and Certification;
6. Electronic Funds Transfer (EFT) Election Form, authorization to deposit funds electronically;
7. The Dentist’s check for the appropriate reinstatement fee, if any; and
8. A signed copy of this Agreement.

B. **Application Process.** Dentist acknowledges that this Agreement shall not be deemed accepted by HRI until written notice of acceptance is provided to the Dentist by HRI. After review and approval of the application by HRI’s Credentials Committee, HRI will provide written notice to the Dentist of the acceptance or rejection of the application.

If the application is rejected, HRI will return the Dentist’s reinstatement fee, if any, within thirty (30) business days of the rejection. If the application is accepted, unless otherwise notified by HRI, the effective date (“Effective Date”) of this Agreement shall be the later of (i) date first set forth above or (ii) the date HRI receives all required items in Section 1(A) from the Dentist. If the Dentist accepts Enrollees for treatment under a Dental Benefit Plan prior to the acceptance by HRI of the application, Dentist acknowledges that Dentist is assuming the risk that the application may not be accepted, in which case the Dentist may not receive any payments from HRI with respect to those Enrollees. Dentist acknowledges that HRI makes no guarantee as to the number or volume of Enrollees that will become patients of Dentist pursuant to Dentist’s participation as a Provider under Dental Benefit Plans.

C. **Group Practice Requirements.** If the Dentist practices as a member of a professional association, partnership or other dental group (“Group Practice”), each practicing Dentist therein must execute a Provider Agreement, comply with the application requirements described in Section 1(A) and be accepted by HRI as an authorized Provider under its Dental Benefit Plans in order for any member of the Group Practice to become and remain an authorized Provider. The existence of a Group Practice shall be
SECTION 2. RESPONSIBILITIES OF THE PARTIES

A. **HRI.** HRI represents and warrants to and covenants with Dentist that:

1. HRI will comply with:

   (a) all federal, state and local laws, statutes, regulations, orders, directives and other binding pronouncements of any federal, state or local authority applicable to the business of HRI;

   (b) HRI’s Policies for Providers, attached hereto as Exhibit A and incorporated herein by reference, as amended from time to time by HRI.

B. **Dentist.** Dentist represents and warrants to and covenants with HRI that:

   1. Dentist will comply with:

      (a) all federal, state and local laws, statutes, regulations, orders, directives and other binding pronouncements of any federal, state or local authority applicable to the practice of dentistry, operation of a business, employment of employees, maintenance of public facilities, participation in health maintenance or preferred provider organizations or other aspects of the Dentist’s practice;

      (b) the ethical principles contained in the *Ethics Handbook for Dentists* of the American College of Dentists, as amended from time to time;

      (c) HRI’s Policies for Providers (Exhibit A), as amended from time to time by HRI (but subject to Provider’s right to terminate under Section 6(D)); and

      (d) the Standard of Care applicable to the Dentist.

   2. Dentist currently maintains and will at all times maintain dental malpractice insurance coverage in an amount not less than $250,000 per occurrence and $750,000 aggregate in Indiana (if the Dentist practices in Indiana), and $200,000 per occurrence and $600,000 aggregate in any other State in which Dentist practices. If Dentist practices in Indiana, Dentist will maintain participation in the Indiana Patients’ Compensation Fund at all times, regardless if the limits are increased or decreased.

SECTION 3. DENTAL FEES AND CLAIMS

A. **Dental Fees of Dentist.**

   1. **Initial Fee Schedule.** At the time of application, Dentist shall provide HRI with a current schedule of fees customarily charged by Dentist (a “Fee Schedule”) for the ADA Procedure Codes covered under the Dental Benefit Plans. ADA Procedure Codes covered under the Dental Benefit Plans are available to the Dentist via various tools, including website, printed medium, call-center support, etc. The Dentist’s fee for any given ADA Procedure Code shall include all components that are necessary to accomplish the prescribed treatment for that Procedure Code. Each fee identified in the Fee Schedule must be no greater than the fees charged by the Dentist for the same service to at least 75% of the Dentist’s patients who are not Enrollnees and also not covered by a contractual relationship between the Dentist and another dental plan or an employer. If the Dentist is a member of a Group Practice, the Fee Schedule submitted by the Dentist must be identical to the schedule submitted by all other Providers practicing within the Group Practice.
2. **Subsequent Fee Schedules.** HRI will provide the opportunity for the Dentist to annually submit a revised Fee Schedule that will be applicable for the next calendar year. Each Fee Schedule must comply with all of the requirements described in Section 3(A)(1), except it shall be based upon fees to be charged by the Dentist for the period identified. Dentist acknowledges that if Dentist does not submit a revised Fee Schedule prior to the deadline established by HRI (which shall be not less than forty-five (45) days after HRI’s request), the most recent Fee Schedule submitted by the Dentist shall continue to apply for the next calendar year.

3. **Use of Fee Schedules.** Dentist understands that HRI may use this listing along with the listings from all other HRI providers for actuarial data to properly price its dental plans. This listing is also utilized by HRI to calculate maximum fee allowances for covered services, which allowances cannot be disclosed as a list. HRI agrees to keep confidential all Fee Schedules submitted by the Dentist and not to use them for any purpose other than administering its Dental Benefit Plans. The Dentist agrees not to share his Fee Schedules or any other fee information with other Providers outside of his/her Provider Group or any other person. Dentist agrees to keep confidential all financial, proprietary, confidential and other information about HRI that is not generally known to the public and not use any such information to the detriment of HRI.

**B. Claims.**

1. Dentist agrees to submit claims only upon completion of dental services actually rendered by the Dentist to Enrollees. Dentist agrees to not submit claims for services rendered by another Dentist not within the Dentist’s Provider Group. Dentist agrees to submit all claims in accordance with the established fee schedule of the office rather than the contacted fee reimbursement determined by HRI. Dentist agrees to submit all claims and supporting documentation for services rendered to Enrollees to HRI within one year of the date of service. Any claims submitted after one (1) year will not be paid by HRI. The Payor is not obligated to pay any claims submitted after the one (1) year deadline. All claims submitted by the Dentist shall be submitted in accordance with HRI’s Policies for Providers and the other terms provided in this Agreement. Unless otherwise directed by HRI, all claims shall be submitted on a standard ADA claim form or electronically in a manner approved by HRI. All claims shall use the ADA Procedure Codes in effect at the date of service for each dental procedure performed.

2. Dentist acknowledges that requirements for supporting documentation may vary among Dentists based upon data available to HRI, including but not limited to data resulting from confidential surveys, evaluations, and historical analysis. Dentist agrees to comply with all submission requirements, including documentation requirements, at no additional charge to the Payor or patient.

**C. Payments.**

1. **Allowed Claims.** The fee allowed by the Payor is the lesser of (a) the amount submitted by the Dentist, (b) the fee submitted by the Dentist in the Fee Schedule applicable to the date of service, (c) the Payor’s maximum allowable fee for such service, or (d) the maximum allowable in accordance with coordination of benefit insurance laws and regulations. The Payor may adopt interim modifications to the Maximum Allowable Fee Schedule as may be necessary to comply with the established Fee Schedule of the Payor. HRI, in its sole discretion, may modify the Maximum Allowable Fee Schedule(s) based upon data available to HRI, including but not limited to data resulting from confidential fee surveys, evaluations, and historical analysis. If a claim is accepted as filed, HRI shall use its reasonable best efforts to pay the Payor’s portion of the claim within ten (10) business days of receipt; provided, however, a claim will not be allowed if the date of service occurs in a month for which the premium for the Enrollee has not been paid. Dentist acknowledges that pre-authorization is conditioned upon payment of the premium for the month of date of service and Enrollee not having used up the maximum allowable benefit in the interim. Dentist agrees to accept, as full payment for covered services rendered to Enrollees, the amounts paid to Dentist by the Payor and the amounts payable as co-payments by the Enrollee. Dentist or agent, trustee, representative, or assignee of the Dentist shall never bring a legal or equitable action to attempt to collect from Enrollees except for co-payments and/or Plan deductibles. The preceding sentence shall survive the termination of this Agreement, regarding services rendered during the term of this Agreement, regardless of the reason for the termination.

2. **Covered Services.** Dental care services for which a reimbursement is available under an enrollee’s plan contract, or for which a reimbursement would be available but for the application of contractual limitation such as deductibles, copayments, co-insurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit programs, or any other limitation.
3. Co-Payments, Co-insurance and Deductibles. Dentist recognizes that the Payor is not liable for co-payments, co-insurance, or deductibles due from patients, the collection of which is the sole responsibility of the Dentist. Dentist agrees not to waive any co-payment, co-insurance, or deductible under any circumstance, without the express written consent of the CEO of HRI.

4. Offsets. Dentist authorizes HRI to deduct and/or offset from any payments owed Dentist by HRI any debts or charges for which Dentist is obligated to HRI or any of its subsidiaries.

5. Retention Discount. Dentist authorizes HRI to withhold 10% of the amount otherwise payable by the Payor with respect to a claim submitted by the Dentist. HRI may, in its sole discretion, waive all or a portion of the 10% retention discount for one or more Products, geographic areas, Plans, Lines of Business, Covered Services, or due to Dentist’s participation within Dental Networks. The waiver by HRI of all or a portion of the retention discount as specified above shall not affect HRI’s ability to apply the retention discount to similarly situated scenarios, as the retention discount is of independent discretion of HRI. A waiver by HRI, if any, does not apply or continue to apply to future waivers. Each waiver must be in writing and signed by the CEO of HRI to be effective.

SECTION 4. REVIEW AND SANCTIONS

Dentist acknowledges that a Dental Review Team ("DRT"), composed entirely of Dentists, has been established to administer and adjudicate quality assurance and utilization standards, as well as hear disputes between HRI, the Payor, Providers, employers, and Enrollees. In conjunction with any such review or program, Dentist will make available, at no charge to HRI and/or the Payor, whatever relevant information is requested in writing by HRI and/or the Payor. To the extent not prohibited by law, Dentist agrees to the right of members of the DRT to inspect and evaluate the diagnosis and treatment performed for Dentist’s patients who are Enrollees. Dentist acknowledges that Dentist’s failure to abide by decisions of the DRT, or make information available to HRI and/or the DRT shall constitute grounds for immediate termination of this Agreement.

Requests to inspect and evaluate the diagnosis and treatment performed by the Dentist’s will be held to the following Standard of Care. The Standard for Care for dental treatment performed by a Provider shall be: 1) what is accepted within the Dentist’s community and by the Dentist’s peers, 2) treatment and/or practices that is acceptable by the regional testing boards in the areas that the Dentist practices and. 3) treatment and/or practices that is acceptable by Council on Dental Accreditation (CODA) accredited dental schools. The Dental Review Team must be unanimous in their agreement of treatment delivered below these parameters. Communication will be sent to the Dentist requesting treatment clarification and the Dentist will be allowed to remedy such treatment and/or practices to meet the Standard of Care.

Dentist acknowledges that:

(i) HRI and the Dental Review Team reserve all rights to employ various sanctions appropriate given the circumstances of each case, including, without limitation, an assessment of fee, refund of the claim payment to HRI, and/or refund of the patient’s payment. Such sanctions are not to be construed as binding on HRI, but merely exemplary. HRI retains sole and absolute discretion whether to apply a sanction, which sanction to apply and whether to terminate this Agreement pursuant to a right to terminate provided herein rather than applying any sanction whatsoever;

(ii) Because such sanctions are entirely discretionary and may be modified from time to time, any such modification shall not be deemed to be an amendment of this Agreement; and

(iii) Findings by the Dental Review Team adverse to the Dentist may be reported to the appropriate State licensing or disciplinary agency or other entities as required by applicable state or federal laws.

SECTION 5. INDEMNITY

A. HRI. HRI agrees to indemnify, defend and hold Dentist and his/her representatives, employees, assigns, successors and affiliates (each an “Indemnified Party”) harmless from and against any and all actions, suits, proceedings, hearings, investigations, charges, complaints, claims, demands, injunctions, judgments, orders, decrees, rulings, damages, dues, penalties, fines, costs, amounts paid in settlement, liabilities, obligations, taxes, liens, losses, expenses, and fees, including court costs and attorneys’ fees and expenses (“Losses”), asserted against or suffered by an Indemnified Party as a result of any inaccuracy of the representations and
warranties of HRI contained in this Agreement or any breach by HRI of any covenant, agreement or other obligation contained in this Agreement.

B. **Dentist.** Dentist agrees that all risk regarding the quality, extent and nature of dental care that Dentist delivers to Enrollees shall be borne by Dentist. Dentist agrees to indemnify, defend and hold HRI and its representatives, officers, directors, employees, shareholders, assigns, successors and affiliates (each an "Indemnified Party") harmless from and against any and all Losses, asserted against or suffered by an Indemnified Party as a result of any inaccuracy of the representations and warranties of the Dentist contained in this Agreement, any breach by Dentist of any covenant, agreement or other obligation contained in this Agreement, or as a result of the Dentist’s operation of the Dentist’s dental practice.

SECTION 6. TERMINATION

This Agreement shall continue until terminated as provided herein.

A. **Without Cause.**

1. For Dentists who practice dentistry in Kentucky, the following without cause termination provisions apply:

   (i) This Agreement may be terminated, without cause, by Dentist one-hundred twenty (120) days after written notice, delivered by certified mail. This Agreement may be terminated, without cause, by HRI if HRI no longer serves the geographic coverage area in which the Dentist resides and after HRI has provided the Dentist sixty (60) days written notice, delivered by certified mail.

2. For Dentists who practice dentistry in any state other than those identified in Section 6(A)(1) above, the following without cause termination provisions apply:

   (i) This Agreement may be terminated, with or without cause, by either party sixty (60) days after written notice, delivered by certified mail. If, however, the Dentist or Group Practice supplies thirty percent (30%) or more of HRI’s services within the county of the Dentist’s practice, then advance notice of at least one hundred twenty (120) days must be given before the date termination of this Agreement can be effected.

B. **For Cause; Right to Cure.** Without limiting Section 6(C), either party may terminate this Agreement if the terminating party has given written notice to the other party of a breach by the other party of this Agreement or being put on probation and the other party fails to cure such breach within thirty (30) days after such notice. Notwithstanding the foregoing, a party may immediately terminate this Agreement without any opportunity to cure upon any subsequent breach by the other party of the same provision of this Agreement, whether or not it involves the same or another Enrollee, and the other party has previously been provided notice of the prior breach. HRI may also terminate this Agreement upon thirty (30) days advance written notice if the Dentist is put on probationary licensure status by any licensing authority.

C. **Immediate Termination.** Unless waived by HRI, this Agreement shall automatically terminate, without any notice or opportunity to cure, upon the occurrence of any of the following events:

1. If a dentist practices for a period of more than sixty (60) days as a member of the Dentist’s Group Practice without having in effect a Provider Agreement with HRI;

2. Noncompliance by the Dentist with the findings of the Dental Review Team or failure to make information available to the Dental Review Team;

3. Conviction of Dentist of a felony or conviction of a misdemeanor that may adversely reflect upon the Dentist’s dental practice, integrity or professional competence;

4. Commission of fraud by the Dentist in the submission of a claim or receipt of payment therefore, whether or not involving HRI’s Dental Benefit Plans;

5. Professional license suspension or revocation or failure to timely renew the Dentist’s license;
6. Material misstatement of the information provided by the Dentist on his or her Application, and
7. Failure of a Dentist to have immediate and continuous coverage under the Indiana Patients’ Compensation Fund, if
   the Dentist practices at all in Indiana.

D. Termination by Dentist upon Amendment. If HRI proposes an amendment to this Agreement, including an amendment to
   the Policies for Providers (Exhibit A), as provided in Section 7(J), the Provider shall have the right to terminate this Agreement by
   providing HRI written notice, within fifteen (15) days after the Provider’s receipt of notice of the amendment, informing HRI that the
   Provider chooses not to approve the amendment. If HRI does not receive written notification from the Provider indicating that the
   proposed amendment to this Agreement is not approved within fifteen (15) days, the proposed amendments are deemed approved,
   valid, and enforced. If the Provider exercises this right of termination, the amendment will not be effective with respect to the
   Dentist, and the effective date of the termination shall be the earlier of (i) 90 days after HRI receives the Dentist’s notice of
   termination, and (ii) any date prior thereto to which the parties may agree.

E. Effect of Termination. Except for Sections 3(A)(1), (B) and (C), 5, 6 and 7, which provisions shall survive any termination of
   this Agreement, and except as otherwise provided herein (such as Section 3(C)(1)), upon any termination of this Agreement, all rights
   and obligations of the parties hereunder shall terminate without any liability of either party to the other party (except for any liability
   of a party then in breach and the Payor continue to pay claims under the terms hereof for any services in progress on the date of
   termination). Upon any termination of this Agreement, Dentist agrees to inform all interested parties, including Enrollees cared for by
   Dentist, of such termination and must disclose his/her non-Provider status prior to treatment to all new patients who are Enrollees.
   Notification by the Dentist of his/her non-Provider status must be provided to and approved by HRI’s Credentials Committee prior to
   dispersal to all interested parties. Dentist agrees that HRI may also inform all interested parties of such termination without
   notification to the Dentist. Upon request, HRI will provide documentation of the patient notification letter to the dental office. HRI
   and the Dentist agree to communicate his/her non-Provider status in a professional, generic manner without inclusion of disparaging
   remarks (whether verbally, in writing, electronically, through social media, or through any other means of communication) regarding
   either party.

F. Determination of Events Causing Termination. The parties acknowledge that the other party may in good faith determine
   that a violation of a representation, warranty or covenant of the party or an event giving rise to a right of termination has occurred,
   and such other party may act upon such determination without first establishing by arbitration, judicial proceeding, ruling request of
   any licensing authority, or any other independent determination that such breach or event has in fact occurred. The party making
   such determination does so, however, at its own risk of being proven incorrect by the other party in any subsequent proceeding
   brought by the other party.

SECTION 7. MISCELLANEOUS

A. Governing Law. This Agreement shall be governed by and enforced in accordance with the laws of the State in which the
   dental service of the Enrollee was performed.

B. Costs. Except as otherwise provided herein, each party shall bear the cost of its own legal, accounting and other professional
   services associated with this Agreement. Either party may recover from the other its costs, including reasonable attorney’s fees
   sustained by such party by reason of default hereunder or enforcement of its rights hereunder.

C. Rights Cumulative, No Waiver. No right or remedy conferred upon or reserved to either of the parties is intended to be
   exclusive and every right shall be cumulative and in addition to any other right or remedy, now or later existing. The failure of either
   party to insist upon a strict observation or performance of any provision of this Agreement to the parties may be exercised from time
   to time and as often as appropriate.

D. Impossibility of Performance. Neither the Dentist nor HRI shall be deemed to be in default of this Agreement if prevented
   from performing for reasons beyond the party’s control, including without limitation, governmental laws and regulations, acts of God,
   war and strikes. In such case, the parties shall negotiate in good faith with the goal and intent of preserving this Agreement and the
   respective rights and obligations of the parties.

E. Partial Invalidity. If any provision of this Agreement or the application thereof to any person or circumstance shall, to any
   extent, be held void or invalid then the remainder of this Agreement or the application of such provision to persons or circumstances
   other than those to which it is held void or invalid shall not be affected thereby and each provision of this Agreement shall be valid
   and enforced to the full extent permitted by law.
F. **Notices.** HRI may from time to time issue written operational policies for the purpose of implementing or clarifying this Agreement, which may supplement or withdraw such policies as it deems warranted. All notices under this Agreement shall be in writing and made available upon request. Unless otherwise stated herein, all notices shall be effective upon mailing; postage prepaid, registered or certified mail with return receipt requested. The parties’ addresses for the receipt of notices are as provided hereunder or to such other address or to such other person as may be designated by written notice by one party to the other.

G. **Acceptance.** This Agreement shall be effective only upon execution by HRI.

H. **Audits.** HRI may audit Dentists’ books and records as may reasonably be necessary to verify the information submitted on fee schedules and/or claims.

I. **Relationship of Parties.** This Agreement establishes a contractual relationship between independent contractors. The Dentist is neither an agent nor an employee of HRI and nothing contained herein shall create the status of agent or employee. Dentist understands that Dentist is free to enter into similar contracts with other groups and organizations, including preferred provider organizations, prepaid dental plans, and health maintenance organizations.

J. **Amendment.** This Agreement may be amended by HRI upon notification to the Dentist of any changes at least forty-five (45) days prior to the effective date of change. Unless the Dentist terminates this Agreement pursuant to Section 6(D), the amendment shall become effective upon the date specified in HRI’s notice, but not sooner than forty-five (45) days after such notice.

K. **Assignment.** HRI shall have the absolute right, in its sole discretion, to assign all or any of its rights and responsibilities hereunder to any entity that is a parent, subsidiary or an affiliate of HRI or to any purchaser of substantially all of the assets of HRI or to the successor by merger to HRI. This Agreement and the obligations hereunder may not be assigned by the Dentist.

**SECTION 8. DEFINITIONS**

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

A. “ADA Procedure Codes” means the procedure codes specified from time to time by the American Dental Association.

B. “Allowable Amount/Expense” means the lowest allowable expense for a Covered Service as it relates to Network participation, coordination of benefits laws and regulations.

C. “Clean Claim” means a complete and accurate statement of services submitted on a standard ADA claim form or electronically in a manner approved by HRI which includes all provider and member information, as well as records and/or additional information needed to substantiate the medical necessity and appropriateness of service provided.

D. “Covered Services” means those dental care services for which a reimbursement is available under an enrollee’s plan contract, or for which a reimbursement would be available but for the application of contractual limitation such as deductibles, copayments, co-insurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit programs, or any other limitation.

E. “Dentist” means a person licensed to practice dentistry in the state in which dental services are performed.

F. “Effective Date” means the date this Agreement enforced with respect to the Dentist and his/her participation within the HRI Dental Network.

G. “Enrollee” means any individual who is enrolled in a Plan and through such participation is entitled to receive Covered Services.

H. “Filing Time Limit” means the 12 month period following the date in which services were rendered. The claim form must be considered “clean” with all required information present and accurate. Submitted claim forms with omitted, inaccurate, or incomplete information will not be considered.

I. “Maximum Allowable Fee” means the fees for Covered Services established by HRI and/or Payor, as amended from time to time.

J. “Network Access” means an agreement under which HRI agrees to provide a Payor with access to a Dental Network and the associated Maximum Allowable Fees as payment in full for Covered Services.

K. “Payor” includes, but is not limited to employers, individuals, associations, third party payors, insurers, health maintenance organizations, and other bond-fide entities

L. “Plan” means a defined set of Covered Services established by the Payor, for which the Payor is responsible for the application of benefits.
M. “Plan Requirements” means the rules and procedures established by the Plan, as amended by time to time, that establish the conditions to be followed by the Provider and Enrollee during the course of treatment.

N. “Provider” means any licensed Dentist which has contracted with HRI to provide Services to Enrollees and agree to accept the Plan’s maximum allowable fee as payment in full for Covered Services.

O. “Provider Group” means a Group Practice in which all Dentists practicing therein are Providers.

P. “Service Agreement” means any agreement, whether fully-insured or self-insured, in which a Payor has a written contract with HRI to provide access to a Dental Network, Services to, or payment of Services administered to an Enrollee.
EXHIBIT A
HEALTH RESOURCES, INC.
POLICIES FOR PROVIDERS

All capitalized terms used herein and not otherwise defined herein shall have the meanings assigned to them in the Provider Agreement.

A. HRI RESPONSIBILITIES:

1. Act on request from Dentist for Provider status within 4 weeks of application.
2. Permit Providers to join other organizations.
5. Will not dictate referrals.
6. Will not change Dentist’s procedure codes from that submitted in writing to HRI.
7. Provide the opportunity to revise fees at least annually.
8. Review maximum allowable fees at least annually.
9. Notify Providers of:
   a. A material change in financial condition of HRI.
   b. Change of HRI address.
   c. A material change in HRI management.
10. Provide an opportunity to nominate a duly qualified representative to the Dental Review Team.
11. Accept claims submitted on standard claim forms approved by the ADA or electronic claims, which contain complete information.
12. Recognize ADA’s definition for date of service/payment.
13. Develop and make available tools for verification of Enrollee eligibility, descriptions of Plan Covered Services and associated limitations.
14. Recognize Enrollees’ right to choose their Dentist, although coverage may require the services of a Provider.
15. Recognize Enrollees’ right for access to dental specialists without gatekeeper restrictions.
16. Permit Providers the right to designate and make public reference to their status as a Provider under HRI’s Dental Benefit Plans during the term of their Provider Agreements.

B. PROVIDER’S RESPONSIBILITIES:

1. Accept Enrollees as patients consistent with the manner in which other patients are accepted by Dentist and provide necessary dental services within the Provider’s field of practice, including emergency care, to Enrollees in conformity with the level of care provided to other patients.
2. Perform usual and customary dental services to Enrollees.

3. Not refuse service to Enrollees unless based upon just cause and consistent with the Provider’s refusal to provide service to non-HRI-enrolled patients.

4. Refer patients to other Dentists when needs for services exceed the Provider’s level of expertise.

5. Inform Enrollees that fees for services performed by non-Providers may not be payable as Covered Services, upon referral by the Provider to a non-Provider Dentist.

6. Submit Clean claims within the Filing Time Limit of twelve (12) months from the date of service.

7. Agree to accept claim payment as final after forty-five (45) days of receipt of Explanation of Benefits (E.O.B.).

8. Cooperate with requests from HRI and/or the Dental Review Team for information involving claims, payment resolution, quality of care issues.

9. Provide written notice to HRI within fourteen (14) days of the occurrence of any of the following:
   (a) any Dentist joining or leaving the Group Practice; written notice will include an reason as to the Dentist’s departure from the Practice;
   (b) any event requiring notice by the Provider to any malpractice insurance carrier, or any written or oral claim, suit or investigation brought against the Provider for dental malpractice, negligence or otherwise arising out of the Provider’s practice of dentistry or if Provider is arrested on account of a charge which may reflect upon Provider’s integrity or professional competency;
   (c) any lapse of a policy of insurance required under this Agreement;
   (d) any event, disability or physical, emotional or addiction condition which may render the Provider incapacitated for the purpose of the delivery of dental care and which may, in any manner, endanger the health of the Provider’s patients or compromise the quality of care;
   (e) any notice of disciplinary action, peer review hearing or any investigation of any sort that might have a material adverse effect on the Provider’s practice, commenced against the Provider by any federal, state or local authority, including any investigation by a dental licensing board or the U.S. Drug Enforcement Agency.
   (f) Any knowledge by Provider of any claim or potential claim alleged or threatened, whether oral or written, against HRI.
   (g) Change of Provider’s address.
   (h) Establishment or closure of any satellite office of Provider or the Provider Group.
   (i) Provider’s retirement from practice.
   (j) Sanctions, suspension, revocation, probation or lapse (including failure to renew) of Provider’s license to practice dentistry.
   (k) Conviction of Provider of a felony.
   (l) Bankruptcy, or the attachment of a judgment lien or other non-consensual lien against any property of the Provider or anyone in the Provider Group or garnishment enforced by court order against the Provider or anyone in the Provider Group.
10. Upon any incapacity described in Section B(9)(d) of this Exhibit A, expeditiously take all necessary steps under such incapacity or endangerment to protect the health of Provider’s patients, including, but not limited to, patient notification, immunization, and cessation of practice. Provider agrees to release to HRI all information regarding said incapacity, disability or endangerment, including all reports and materials occasioned by any program to which Provider is subject for the purpose of remediation or cure.

11. Permit HRI the right to designate and make public reference to the Provider, by name, symbol and service mark, as a Provider under HRI’s Dental Benefit Plans.

12. Except as permitted by Section A(16) of this Exhibit A, not use the name, symbols or service marks of HRI or any of its plans or proprietary programs, including its trade secrets, without the express written consent of the CEO of HRI.

13. Accept HRI’s right to notify Enrollees of any event, including termination of the Provider’s Provider status, if reasonably deemed necessary by HRI.
Signature Page

Each Dentist in practice must sign contract; please copy this page, as applicable

Dentist’s signature       Date

Dentist’s name (please print)

Dentist’s signature       Date

Dentist’s name (please print)

Dentist’s signature       Date

Dentist’s name (please print)

Accepted and agreed upon the terms set forth above:

HEALTH RESOURCES, INC.

President’s signature

President’s name (please print)

Effective Date ______________, 20___
Request for Taxpayer Identification Number and Certification

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; check only one of the following seven boxes:
   - Individual/sole proprietor ✔️
   - C Corporation
   - S Corporation
   - Partnership
   - Trust/estate
   - Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership).

   Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

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)

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

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 Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 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 on page 3.

Signature of U.S. person

Date

General Instructions

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

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at www.irs.gov/fw9.

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)
- Form 1098-E (student loan interest)
- Form 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? on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners’ share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See What is FATCA reporting? on page 2 for further information.
PART 1: Transaction Type

Effective Date: ______________________

☐ New Set Up
☐ Change Current Election
☐ Cancel EFT (complete Part 4 only)

PART 2: Payee/Payor Identification

☐ Advisor ☐ Dentist ☐ Employer Group ☐ Vendor

1. Name
2. HRI Number (if known)
3. Primary Contact Email Address
4. TIN Number
5. Address
6. Business Phone
7. City
8. State
9. Zip
10. Fax Number

PART 3: Financial Institution

11. Financial Institution Name
12. City
13. State
14. Zip
15. Routing Number (9 digits)
16. Bank Account Number
17. Type of Account ☐ Checking ☐ Savings

Following is an illustration to help you determine the routing transit number and account number from the bottom of a check. This is for illustration only - contact your bank if you are unable to determine these numbers. You must enter all 9 digits for the routing number. Account number digits will vary.

U.S. Check Sample

FOR

Routing Number       Account Number

PART 4: Authorization for Setup, Changes, or Cancellation

I hereby request and authorize Health Resources Inc.’s financial institution (bank) to deposit transactions to the above account electronically. Health Resources may only withdraw from the above account with my express consent. I recognize that if I fail to provide complete and accurate information on this authorization form, the processing of the form may be delayed or my deposits/withdrawals may be erroneously transferred electronically.

This authorization will remain in effect until written notice to terminate is given. The undersigned must allow 2 weeks for initiating or terminating Electronic Funds Transfer (EFT) and is responsible for notification to financial institution if required due to account restrictions.

18. Authorized Signature
19. Printed Name
20. Date

PART 5: Form Instructions

1. Fill in all fields (1-20) legibly and completely – KEEP A COPY FOR YOUR RECORDS
2. Send the form by mail or fax to:

   Address
   Health Resources Inc
   ATTN.: ACCOUNTING
   PO Box 659
   Evansville IN 47704-0659

   Fax
   812-401-4558

   Or upload to the HRI website (questions – contact Member Services 800-727-1444)
3. Once the setup has been activated, your transactions, reporting, and correspondence will be transmitted electronically permanently, unless written notification is received requesting otherwise.