PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement ("Agreement") is made and entered into this _____day of _____, _____ ("Effective Date"), by and between _____ ("Dentist") and Dominion Dental Services, Inc., on behalf of itself and its applicable affiliates ("Plan"). Whenever mentioned herein, the term "Dentist" shall include all employees of Dentist, all partners, dental associates, and all staff personnel under Dentist's direct supervision and/or control. Dentist and Plan may hereinafter be referred to individually as a "Party" and collectively as the "Parties." The Regulatory Compliance Addendum attached to this Agreement as **Exhibit A** is expressly incorporated into this Agreement and is binding upon the Parties to this Agreement. In the event of any inconsistent or contrary language between the Regulatory Compliance Addendum and any other part of this Agreement, including but not limited to exhibits, attachments or amendments, the Parties agree that the provisions of the Regulatory Compliance Addendum shall prevail, but, if applicable, only with respect to a particular Program, line of business and/or product.

WHEREAS, Plan intends to provide individuals, health plans and groups with access to preferred provider organization ("PPO") and/or discounted fee-for-service or other program benefits. Plan, and entities designated by Plan to provide access to PPO programs and/or discounted fee-for-service or other program benefits, will hereinafter be referred to as "Applicable Payor"; and

WHEREAS, Subscribers (defined herein) and/or groups have entered into contracts with Applicable Payor to arrange for certain professional services including dental services. Plan is entering into this Agreement with Dentist who will provide dental services and who will bill Applicable Payor (or Subscriber under discounted fee-for-service programs) according to a fee schedule established by Plan.

NOW, THEREFORE, in consideration of the mutual covenants herein contained and for other good and valuable consideration, it is agreed as follows:

1. **DENTIST TO PARTICIPATE IN PLAN PROGRAMS.** Dentist agrees to participate in each Plan program described in **Exhibit B** to this Agreement (the "Program"), which is attached hereto and made a part of this Agreement hereof. If the Plan adds a Program, the Plan shall provide an amended **Exhibit B** to Dentist at least sixty (60) days prior to the effective date of such Program addition. The amended **Exhibit B** shall be deemed to be agreed to by the Parties unless Dentist provides written notice to Plan of its election not to participate in any new Program, which notice must be received at least thirty (30) days prior to the effective date of such Program addition.

2. **RENDITION OF CARE:** Dentist agrees to render all necessary dental services to each of the Subscribers covered by the Applicable Payor during Dentist's regular office hours, subject to prior appointments; provided, however, that Dentist shall have the right within the framework of professional ethics to reject any patient seeking Dentist's professional services. Dentist agrees (a) not to discriminate in the treatment of Dentist's patients or in the quality of services delivered to Subscribers on the basis of race, sex, sexual orientation, age, religion, place of residence, health status, membership in a Program, national origin, disability, or source of payment, and (b) to observe, protect, and promote the rights of Subscribers as patients.

   The term "Subscriber" refers to an individual who meets all applicable eligibility requirements of an individual or group contract for dental benefits and who enrolls in accordance with the requirements and for whom the payment required by such individual or group contract for dental benefits actually has been received by Plan or entities designated by Plan.

3. **COVERAGE DETERMINATIONS; ELIGIBILITY:** Plan, Applicable Payor or either party's designated representative shall have sole authority to determine: (a) what is a Covered Service; (b) who is a Subscriber; and (c) the amount and application of cost-sharing provisions. Dentist further acknowledges that such determinations of covered services, non-covered services, Subscribers and cost-sharing provisions may vary among group contracts. Except as otherwise provided in this Agreement, the obligation of Plan or Applicable Payor to pay Dentist pursuant to this Agreement is conditioned upon the determination that the person receiving services, supplies, products, or accommodations from Dentist is a Subscriber and that such services, supplies, products and/or accommodations are covered services. Dentist agrees to accept such determination of the foregoing, which shall be made in accordance with the Plan's policies and procedures. Evidence of Coverage shall be issued to each Subscriber.

4. **FEES:** Dentist agrees to charge Applicable Payor as payment in full for services rendered under the scope of this Agreement no more than the amounts set forth in the attached fee schedule, which is attached hereto as **Exhibit C** and made a part of this Agreement hereof. The fees set forth in **Exhibit C** will apply even if the applicable dental coverage is secondary for purposes of coordination of benefits.

5. **BILLING:** Billing shall include detailed and descriptive dental/patient data and identifying information. In the case of Indemnity/PPO claims, a standard ADA claim form shall be used. Dentist shall look solely to Applicable Payor (or Subscriber under discounted fee-for-service programs) for compensation and shall not seek compensation from Subscribers, except for applicable cost sharing amounts or services not covered under the applicable dental benefit.

   For covered services where a Subscriber has a cost-share obligation, in whole or in part, whether through a deductible, co-pay,

waiting period, annual or lifetime maximum, frequency limitation, alternative benefit or other cost share obligation, Dentist shall not bill Subscriber for the balance, if any, between Dentist's actual fees and the Plan's fee schedule. Dentist agrees to offer the Plan's fee schedule to Subscribers for those procedures that are not covered due to the Subscriber's plan contract limitations or exclusions, and Dentist agrees to not bill Subscriber for the balance, if any, between Dentist's actual fees and the Plan's fee schedule. Dentists who do not agree to offer the Plan's fee schedule to Subscribers for non-covered services shall initial at the end of this Agreement and it will be so noted in the Plan's directory of participating providers.

Dentist may bill a Subscriber for non-covered services rendered by Dentist to such Subscriber only (a) if such services are non-covered services and the Dentist satisfies any notification or other requirements established by the Plan prior to Dentist's provision of such services, or (b) if the patient was not eligible to receive covered services on the date such services were provided. Plan shall not be liable to pay Dentist for any service rendered by the Dentist to a Subscriber that is determined by Plan to be a non-covered service.

Dentist shall comply with the policies and procedures established by Plan regarding overpayments and adjustments.

6. **AMENDMENT OR MODIFICATION:** The terms of this Agreement may be amended in writing as agreed to by the Parties; provided, however, the Agreement may be amended automatically, without the consent of the Dentist, in order to comply with applicable state and federal statutory and regulatory requirements. The Plan shall provide Dentist with written notice of such amendments for statutory and regulatory compliance. In addition, Plan may amend this Agreement for any reason upon at least sixty (60) days' prior written notice to Dentist. If Dentist fails to object to any such amendment in writing at least thirty (30) days prior to the effective date of the amendment, Dentist will be deemed to have consented to the amendment of the Agreement and such amendment will become effective. Any such objection shall be deemed to be notice by Dentist of Dentist's election to terminate this Agreement without cause pursuant to Section 7 of this Agreement; provided, further, Dentist shall be bound by the amended terms during the ninety (90) day termination notification period under Section 7 or any greater period of time required by applicable law (e.g., continuation of care requirements).

7. **DURATION OF AGREEMENT:** This Agreement shall commence as of the Effective Date and shall continue in full force and effect for an initial term of one (1) year (the "Initial Term") and shall thereafter automatically renew for additional terms one (1) year each, unless and until terminated in accordance with this Section 7 of the Agreement. Following the Initial Term, this Agreement may be terminated by either Party at any time without cause upon at least ninety (90) days prior written notice to the other Party.

   Either Party shall have the right to terminate this Agreement on thirty (30) days' prior written notice to the other Party if the Party to whom such notice is given is in breach of any material provision of this Agreement. Such notice shall set forth the facts underlying the alleged breach. If such breach is cured within such thirty (30) day notice period, then the Agreement shall continue in effect for its remaining term, subject to any other provision of this Agreement.

   Plan may terminate this Agreement immediately and without possibility of reinstatement upon cure if it determines that one or more Subscribers' health may be impaired by the continuation of this Agreement or if the Plan determines that any of the following events have occurred with respect to Dentist, which determinations shall be made by the Plan acting in good faith: (a) the restriction, suspension or revocation of Dentist's licensure or, if applicable, the suspension or loss of Dentist's DEA number or other right to prescribe controlled substances; (b) Dentist's loss of or failure to maintain general and professional liability insurance as required under this Agreement; (c) Dentist's exclusion from participation in Medicare, Medicaid or any other third party, state or federal programs; (d) felony conviction of Dentist; (e) impairment of Dentist's ability to provide services; and/or (f) Dentist's failure or inability at any time to satisfy Plan's credentialing criteria as in effect from time to time.

8. **STANDARD OF CARE:** Dentist agrees that he/she shall perform his/her obligations under this Agreement in accordance with (a) high standards of competence, care and concern for the welfare and needs of the Subscribers, (b) applicable standards of care, (c) the principles of ethics of the American Dental Association and (d) applicable state and federal laws. Dentist shall meet and maintain all credentialing and other professional qualification requirements of Plan, including qualifications regarding licensure and eligibility to participate in state and federal health care programs. Dentist will cooperate with the Plan's credentialing, utilization review, patient management and quality assurance programs and, by way of example but not limitation, maintain full and complete credentialing and recredentialing files, dental histories, financial data, utilization records and all other data and records related to services provided to Subscribers by Dentist under the terms of this Agreement. It is understood that the records of Subscribers shall be treated as confidential so as to comply with all state and federal laws and regulations regarding the confidentiality of patient records.

9. **NON-EXCLUSIVE:** This Agreement is not exclusive in any respect, and Plan is entitled to enter into similar contracts with other Dentists. Dentist is entitled to enter into similar contracts with other Parties, or with other groups not represented by Plan, and to maintain his/her private practice.

10. **DENTIST-PATIENT RELATIONSHIP:** Dentist shall maintain the Dentist-Patient relationship with Subscribers of the Applicable Payor, and shall be solely responsible to the patient for dental advice and treatment. It is expressly agreed between the Parties that Dentist is an independent contractor and that neither Subscriber nor Applicable Payor shall have any dominion or

control over Dentist's practice, the Dentist-Patient relationship, Dentist's personnel or facilities.

11. COMPLIANCE WITH PLAN'S PROGRAMS AND PROCEDURES: Dentist shall comply with Plan's programs and policies and procedures, including, without limitation, Plan's credentialing criteria, privileging process, verification of eligibility, determination of coverage, quality of care standards, quality improvement, clinical management, peer review, Dentist and Subscriber complaint and grievance programs and processes and procedures, claims processing, administrative requirements, and other programs and policies and procedures established by the Plan, as may be provided for in Plan's **Provider Manual** or otherwise. No substantive changes to Plan's programs, policies and procedures will be made by Plan except upon at least sixty (60) days' prior written notice to Dentist of such amendment, unless a shorter period of time is required to comply with applicable law. If Dentist fails to object to any such amendment in writing at least thirty (30) days prior to the effective date of the amendment, Dentist will be deemed to have consented to the amendment of the Plan's policies and procedures and such amendment will become effective. Any such objection shall be deemed to be notice by Dentist of Dentist's election to terminate this Agreement pursuant to Section 6 of this Agreement. If Dentist chooses to terminate participation without cause in accordance with Section 6 hereof due to the amendment made by the Plan, Dentist shall be bound by the amended terms of Plan's policies and procedures during the ninety (90) day termination notification period.

12. SUBSCRIBER HOLD HARMLESS: Dentist agrees that in no event, including, but not limited to, non-payment, insolvency of the Plan or breach of this Agreement by the Plan shall Dentist bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against any Subscriber or persons other than the Plan acting on behalf of Subscriber for covered services provided pursuant to this Agreement. This provision shall not prohibit collection of payments permitted under a cost-sharing provision in accordance with the terms of the applicable Program and group contract.

13. MALPRACTICE: Dentist agrees to carry Malpractice Insurance in amounts required by Plan; and Dentist shall provide Plan with evidence of such coverage providing for 10 days notice of cancellation, as evidence of compliance with this section of the Agreement.

14. NOTICE TO SUBSCRIBER ON TERMINATION OF AGREEMENT: In the event that this Agreement is terminated by either Party, in accordance with the procedure set forth herein, Dentist agrees that at the time the Subscriber seeks an appointment Dentist will notify each Subscriber, prior to giving service, that the contract is no longer in effect.

15. ASSIGNABILITY OF AGREEMENT: This Agreement, being intended to secure the personal services of Dentist and dentists associated with Dentist, shall not be assigned or transferred without the prior written consent of Plan.

16. DENTAL RECORDS: Dentist agrees to ensure that dental records are maintained for each Subscriber for whom the Dentist has provided services. Dentist shall allow the Plan or its designee, any state and/or federal regulatory agency, and any external review organization access to copies of dental records of Subscribers for quality assurance, investigation of complaints or grievances, enforcement of regulated activities or any other purpose related to compliance with state and federal laws and Plan's **Provider Manual** and policies and procedures, subject to applicable laws related to confidentiality. Where applicable, Dentist agrees to obtain all proper releases from Subscribers needed under applicable state and federal law to comply with this request. Such records shall be retained and kept confidential by the Dentist for the greater of (a) the timer period required by applicable state and federal laws, and (b) ten (10) years. The obligations of Dentist under this section of the Agreement shall survive the termination of this Agreement. Notwithstanding the foregoing, Dentist shall retain all financial, accounting, administrative and claim records related to services provided to Subscribers for at least ten (10) years.

17. INDEMNIFICATION: Plan and Applicable Payor shall not be liable for any act or omission by Dentist. Dentist agrees to defend, indemnify and hold Plan and Applicable Payor harmless against and in respect of any loss, liability, damage, cost and expense (including any reasonable attorneys' fees) suffered or incurred by Plan and/or Applicable Payor in connection with any action, suit, proceeding, demand, assessment or judgment of any kind arising out of or incident to or related in any manner to Dentist's negligent acts or omissions, including any breach of Dentist's duties and obligations under the terms of this Agreement.

18. SERVICES TO AFFILIATES: Dentist agrees to provide services to any affiliate of Plan. The term "affiliate" shall mean an entity that controls, is controlled by, or is under common control with Plan. When Plan notifies Dentist that services shall be provided to an affiliate, Dentist will be deemed to have a contract directly and exclusively with such affiliate for the benefits offered and/or administered by the affiliate. The affiliate will be solely and exclusively responsible for all of its products, services and other obligations under the new contract. Any such new contract will be deemed to have the same terms as those in the current agreement with Plan, except for differences identified to Dentist by the affiliate. Dentist consents and agrees that Plan may lease its dental network.

19. NOTICE: Any notice required to be given pursuant to this Agreement shall be sent by certified mail, return receipt requested or overnight mail delivery with proof of confirmation of delivery to the addresses listed on the signature page to this Agreement. Notice shall be deemed to be effective as of the date mailed. Either Party may, at any time, change or amend its address by mailing a notice, as required above. Any notice provided by Plan to Dentist shall be deemed to have been given to any associated dentist(s).

20. Governing Law: This Agreement shall be governed in all respects by the laws of the state where Dentist is located. Each Party shall comply with all relevant state and federal laws, rules, statutes, ordinances, orders and regulatory guidance relevant to the terms and conditions of this Agreement.

21. Medicare Program: Dentist shall comply with CMS requirements in the provision of services to Medicare Advantage (MA) Subscribers, including those CMS requirements attached hereto as **Exhibit D** and made a part of this Agreement hereof. The CMS required terms apply only to services rendered to subscribers who are MA Subscribers and will, to the extent inconsistent with any other terms of the Agreement, supersede such inconsistent terms solely as they relate to services rendered to MA Subscribers.

22. Incorporation of Recitals: The Parties incorporate the recitals into this Agreement as representations of fact to each other.

23. Severability: Any determination that any provision of this Agreement or any application of it is invalid, illegal or unenforceable in any respect in any instance shall not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement.

IN WITNESS WHEREOF, the undersigned Parties have executed this Agreement by their duly authorized officers, intending to be legally bound hereby.

Dentist Name: **X**_____

Signature:_____

Address: _____

City/State/Zip_____

Date: _____

Phone: (_____)_____ - _____

DOMINION DENTAL SERVICES, INC.

Signature:_____

Date: _____

251 18th St. South, Suite 900
Arlington, VA 22202
(855) 224-3016

Dentist does not agree to offer the Plan's fee schedule to Subscribers for non-covered services: _____
Dentist's Initials

EXHIBIT A

Regulatory Addendum

MASSACHUSETTS

For purposes of this Regulatory Addendum, the terms "Health Care Provider," "Provider" and "Health Care Professional" as used herein refers to "Dentist." The term "Claimant" refers to the Subscriber. The terms "Carrier," "Health Benefit Plan" and "Insurer" refers to Plan and Applicable Payor. The term "contract" refers to this "Agreement."

As required by 211 CMR 52.11 (titled "Provider Contracts"), the parties agree as follows:

Carrier shall not refuse to contract with or compensate for covered services an otherwise eligible Health Care Provider solely because such Provider has in good faith: communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the Carrier's Health Benefit Plans as they relate to the needs of such Provider's patients; or, communicated with one or more of his or her prospective, current or former patients with respect to the method by which such Provider is compensated by the Carrier for services provided to the patient. (See, also, M.G.L.A. 1760 § 4)

The Provider is not required to indemnify the Carrier for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the Carrier based on the Carrier's management decisions, Utilization Review provisions or other policies, guidelines or actions. (See, also, M.G.L.A. 1760 § 5)

No terms of this Agreement may be construed as an Incentive Plan that includes a specific payment made to a Health Care Professional as an inducement to reduce, delay or limit specific, Medically Necessary services covered by the health care contract; provided, however, there is no prohibition against contracts that contain Incentive Plans that involve general payments such as Capitation payments or shared risk agreements between Carriers and Providers, so long as such contracts, which impose risk on such Providers for the costs of care, services and equipment provided or authorized by another Health Care Provider, comply with 211 CMR 52.11 (4) and 155.00.

In the event that Provider makes any decisions about coverage of requested care, then the Carrier remains responsible to ensure compliance with all applicable utilization review processes, including but not limited to adverse determination notices that describe rights to appeal medical necessity denials.

No Carrier may enter into a new contract, revise the risk arrangements in an existing contract, or revise the fee schedule in an existing contract with a Health Care Provider which imposes financial risk on such Provider for the costs of care, services or equipment provided or authorized by another Provider unless such contract includes specific provisions with respect to the following: stop loss protection; minimum patient population size for the Provider group; and identification of the Health Care Services for which the Provider is at risk.

Health Care Professionals shall not profit from provision of covered services that are not Medically Necessary or medically appropriate.

Carrier shall not profit from denial or withholding of covered services that are Medically Necessary or medically appropriate.

Neither the Carrier nor the Provider has the right to terminate the contract without cause.

Carrier shall provide a written statement to a Provider of the reason or reasons for such Provider's involuntary disenrollment.

The Carrier shall notify Providers, either by mail or electronically, of modifications in payments, modifications in covered services or modifications in a Carrier's procedures, documents or requirements, including those associated with Utilization Review, quality management and improvement, credentialing and Preventive Health Services, that have a substantial impact on the rights or responsibilities of the Providers, and the effective date of the modifications. The notice shall be provided 60 Days before the effective date of such modification unless such other date for notice is mutually agreed upon between the Carrier and the Provider.

Providers shall not bill patients for charges for covered services other than for deductibles, copayments, or coinsurance.

Health Care Providers are prohibited from billing patients for nonpayment by the Carrier of amounts owed under the contract due to the insolvency of the Carrier. This requirement shall survive the termination of the contract for services rendered prior to the termination of the contract, regardless of the cause of the termination.

Provider must comply with the Carrier's requirements for Utilization Review, quality management and improvement, credentialing and the delivery of Preventive Health Services.

Health Care Provider is required to maintain the confidentiality of compensation terms under this contract as permitted under M.G.L.A. 1760 § 4.

No term of this contract shall be construed to restrict or limit the rights of Health Benefit Plans to include as Providers Religious Non-medical Providers or to utilize medically based eligibility standards or criteria in deciding Provider status for Religious Non-medical Providers.

As required by M.G.L.A. 176O § 9A, no term of this contract shall be construed to:

(a) limit the ability of the carrier to introduce or modify a select network plan or tiered network plan by granting the health care provider a guaranteed right of participation; (ii) requires the carrier to place all members of a provider group, whether local practice groups or facilities, in the same tier of a tiered network plan; (iii) requires the carrier to include all members of a provider group, whether local practice groups or facilities, in a select network plan on an all-or-nothing basis; or (iv) requires a provider to participate in a new select network or tiered network plan that the carrier introduces without granting the provider the right to opt-out of the new plan at least 60 days before the new plan is submitted to the commissioner for approval; or

(b) require or permit the carrier or the health care provider to alter or terminate a contract or agreement, in whole or in part, to affect parity with an agreement or contract with other carriers or health care providers or based on a decision to introduce or modify a select network plan or tiered network plan; or

(c) require or permit the carrier to make any form of supplemental payment unless each supplemental payment is publicly disclosed to the commissioner as a condition of accreditation, including the amount and purpose of each payment and whether or not each payment is included within the provider's reported relative prices and health status adjusted total medical expenses under M.G.L.A. 12C § 10 (titled "Reporting Requirements for Private and Public Health Care Payers and Third-Party Administrators"); and

(d) limit the ability of either the carrier or the health care provider from disclosing the allowed amount and fees of services to an insured or insured's treating health care provider.

(e) limit the ability of either the carrier or the health care provider from disclosing out-of-pocket costs to an insured.

As required by M.G.L.A. 175 § 108, the parties agree as follows:

Within fifteen days after an insurer's receipt of notice of claim by a claimant or provider under a policy of accident and sickness insurance which is delivered or issued for delivery in the commonwealth, and which provides hospital expense, medical expense, surgical expense or dental expense insurance, the insurer shall furnish such forms as are usually furnished by it for filing proofs of loss. Within forty-five days from said receipt of notice if payment is not made the insurer shall notify the claimant in writing specifying the reasons for the nonpayment or whatever further documentation is necessary for payment of said claim within the terms of the policy. If the insurer fails to comply with the provisions of this paragraph, said insurer shall pay, in addition to any benefits which inure to such claimant or provider, interest on such benefits, which shall accrue beginning forty-five days after the insurer's receipt of notice of claim at the rate of one and one-half percent per month, not to exceed eighteen percent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim which an insurer is investigating because of suspected fraud.

EXHIBIT B

Program Schedule

Medicare Advantage Program (PPO)

EXHIBIT C

Fee Schedule

[Placeholder for the Medicare Advantage fee schedule.]

EXHIBIT D

MEDICARE ADVANTAGE REQUIREMENTS

The following provisions shall only apply to services rendered to Subscribers who are Medicare Advantage members enrolled in the Medicare Advantage PPO Program and/or Medicare Advantage DHMO Program ("Medicare Advantage Program"), as applicable (hereinafter, the "MA Members"). In case of conflict between the Agreement and these terms, these terms shall control as to the Medicare Advantage Program only, provided that to the extent Dentist is required by law or by the Agreement to comply with other laws, regulations or requirements by accrediting agencies, the broadest obligation shall control. These provisions may be supplemented by Medicare Advantage Plan's (the "MA Plan") policies, procedures and provider manual provisions, as the same may be updated from time to time. To the extent that any greater rights or obligations between the parties are created in these provisions than are in the Agreement, such rights and obligations shall only apply to Covered Services provided under the Medicare Advantage Program. If there is any conflict between the Agreement and Medicare Advantage laws, regulations or guidelines, the Medicare Advantage laws, regulations and guidelines shall control to the extent applicable.

DEFINITIONS

For purposes of Dentist's participation in the Medicare Advantage Program, the following capitalized terms shall have the meanings set forth below. All other capitalized terms shall have the meaning set forth in the Agreement.

"Affiliated Parties" means Dentist's employees, affiliates, subsidiaries, members of its board of directors, key management, executive staff, or persons owning 5% or more of Dentist.

"Centers for Medicare and Medicaid Services" or "CMS" shall mean the federal agency within the Department of Health and Human Services responsible for administration of the Medicare Program.

"Clean Claim" will mean a claim that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare. "Required substantiating documentation" includes data required under § 1.13 below.

"Covered Services" shall mean Medically Necessary and Appropriate benefits, services, treatment and supplies which the MA Member is entitled to receive under MA Member's Plan Description.

"Downstream Entity" has the meaning set out in 42 C.F.R. § 422.500(b) and § 423.501. Downstream Entities include any of Dentist's subcontractors and their subcontractors down to the level of the ultimate provider of dental and administrative goods and services to MA Members.

"Dual Eligible" shall mean a MA Member who is eligible for both Medicare and Medicaid benefits.

"First Tier Entity" has the meaning set out in 42 C.F.R. § 422.500(b) and § 423.501. First Tier Entities consist of MA Plan's subcontractors, including Dentist, that provide administrative services or dental care services to MA Member.

"MA Contract" shall mean the Medicare Advantage contract between CMS and MA Plan.

"MA Plan" shall mean a qualified Medicare Advantage organization offering MA Programs through an MA Contract.

"Plan Description" shall mean the Evidence of Coverage and Summary of Benefits issued to MA Members by MA Plan that describes Covered Services, exclusions, and Cost Sharing Provisions.

"State" shall mean the state where the Dentist is located.

1. DENTIST RESPONSIBILITIES

1.1 Dentist Credentialing and Selection. To the extent that MA Plan has delegated the credentialing process to Dentist, Dentist shall expeditiously credential dental care practitioners providing services on behalf of Dentist, in compliance with applicable laws and with the standards and requirements of the MA Plan and appropriate licensing, regulatory and accrediting agencies, including NCQA (to the extent applicable to services rendered under this Agreement) and the applicable State regulatory agencies. MA Plan shall have the right upon reasonable notice to review and monitor Dentist's policies and procedures, including all documentation describing the credentials of dental care professionals providing

services in connection with this Agreement. Further, MA Plan retains the right to audit the credentialing process on an ongoing basis and to revoke such delegation. As part of the credentialing process, Dentist shall obtain certification from each dental care professional providing the services listed above that such individual or entity has not been excluded from participation under Medicare nor has opted out of Medicare. In the event that Dentist has the responsibility or authority under this Agreement to select providers, or subcontractors to provide Covered Services, directly or indirectly, to MA Members, MA Plan retains the right to approve, suspend or terminate any such responsibility or authority.

Dentist warrants that Dentist, and all dental care practitioners, including employees, contractors and agents of Dentist, who provide Covered Services to MA Members, shall be at all times during the term hereof, properly licensed by the state in which such services are rendered, certified, qualified and in good standing in accord with all applicable local, state and federal laws. Dentist and each of its sites shall be accredited, if applicable. Dentist, Dentist's sites and all providers furnishing services hereunder shall meet applicable requirements and be properly certified under the Medicare programs, as set forth in Title XVIII of the Social Security Act. Upon request, Dentist shall provide satisfactory documentary evidence of such licensure, certification, and qualifications of Dentist, Dentist's sites and physicians or other dental care providers furnishing services at Dentist's sites.

1.2 Licensure and Certification. Dentist warrants that Dentist, and all dental care practitioners, including employees, contractors and agents of Dentist, who provide Covered Services to MA Members, shall be at all times during the term hereof, properly licensed by the state in which such services are rendered, certified, qualified and in good standing in accord with all applicable local, state and federal laws. Dentist and each of its sites shall be accredited, if applicable. Dentist, Dentist's sites and all providers furnishing services hereunder shall meet applicable requirements and be properly certified under the Medicare programs, as set forth in Title XVIII of the Social Security Act. Upon request, Dentist shall provide satisfactory documentary evidence of such licensure, certification, and qualifications of Dentist, Dentist's sites and physicians or other dental care providers furnishing services at Dentist's sites.

1.3 Access.

Dentist shall make its services available to MA Members in the same manner as to its other patients. Dentist shall ensure that services are provided in a culturally competent manner to all MA Members including those with limited English proficiency or reading skills, and diverse cultural and ethnic background.

1.4 Non-Discrimination. Dentist shall not discriminate in the provision of dental services to MA Members on the basis of any protected status such as race, age, color, national origin, ancestry, religion, sex, marital status or any factor that is related to dental status. Factors related to dental status include, but are not limited to, the MA Member's medical condition, claims experience, medical history, evidence of insurability or genetic information. Dentist shall ensure that any employee and subcontractor of Dentist complies with all applicable federal and State laws and regulations and Medicare instructions. MA Plan reserves the right to require Dentist to demonstrate compliance with this provision.

1.5 Professional Standard of Care. Dentist shall comply with all applicable federal and State laws and regulations. Dentist shall provide services under this Agreement in a manner consistent with professionally recognized standards of dental care and consistent with the MA Plan's obligations under its MA Contract.

1.6 Compliance with MA Plan Policies and Procedures. Dentist shall comply and shall contractually obligate its Downstream Entities to comply with MA Plan's relevant written policies and procedures including but not limited to policies and procedures to ensure that MA Members are informed of specific dental care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own dental and policies and procedures for the control of fraud, waste and abuse under the Medicare Part C and Part D Programs.

1.7 Consistency with MA Contract. Dentist shall perform Covered Services and shall ensure that Downstream Entities perform Covered Services in a manner that complies and is consistent with MA Plan's obligations under its MA Contract.

1.8 Quality Review and Improvement.

1.8.1 Dentist acknowledges that CMS requires MA Plan to implement quality assessment and improvement programs to monitor the quality assessment and improvement activities of contracting providers. Dentist agrees to (i) participate in MA Plan's quality assessment and improvement programs, including review by MA Plan's quality assurance and improvement committees and staff; (ii) to abide by MA Plan's quality

assessment and improvement plans; and (iii) to cooperate with MA Plan to objectively monitor and evaluate the quality of services provided by Dentist at Dentist's site or otherwise, including, but not limited to, the availability, accessibility, acceptability and continuity of such care.

1.8.2 Dentist shall maintain at all times during the term hereof of a quality assessment and improvement program, which meets all State and federal licensure, accreditation and certification requirements, including, but not limited to, accreditation standards of NCQA or other organizations, as applicable. Upon request, Dentist shall provide MA Plan with Dentist's quality assessment and improvement plan and a copy of all updates and revisions thereto.

1.8.3 Dentist shall investigate and respond immediately to all quality issues and shall work with CMS and/or MA Plan to resolve accessibility and other quality issues related to Covered Services provided to MA Members. Dentist shall remedy, as soon as reasonably possible, any condition related to patient care that has been determined by CMS, MA Plan or any governmental or accrediting agency to be unsatisfactory. Such remedy may include timely compliance with a corrective action plan, which MA Plan shall monitor. Dentist shall work with CMS and/or MA Plan to continuously assess and improve the quality and accessibility of care provided to MA Members and to resolve problems related to the provision of Covered Services.

1.8.4 Dentist shall ensure that all information provided to CMS and/or MA Plan shall be reliable and complete and shall make such information available to CMS and other State and federal governmental agencies and accrediting organizations upon request. Dentist shall provide information, including, but not limited to, provider and patient specific information. MA Plan shall protect the confidentiality of such information and records (i) which MA Plan must review for accreditation by the NCQA and for credentialing activities that meet NCQA standards, and (ii) which is required by other accrediting organizations. Dentist shall provide information, including, but not limited to, provider and patient specific information, for MA Plan's quality assessment and improvement activities. MA Plan's quality assessment and improvement activities include, but are not limited to, (i) accreditation by and credentialing activities of the NCQA and (ii) similar activities of other accrediting organizations. MA Plan shall protect the confidentiality of such information. Dentist shall provide CMS and/or MA Plan access to all patient care protocols, policies and procedures, and any modifications thereto, upon request.

1.8.5 Dentist shall permit, at reasonable times with reasonable notice, inspection of its sites by NCQA and other accrediting organizations. Upon reasonable notice, Dentist shall permit CMS, MA Plan or its designee and government officials to conduct periodic site evaluations of Dentist's sites. Dentist shall participate in all utilization management, quality assessment and improvement, credentialing, peer review and any other activities required by MA Plan or its designee, and regulatory accrediting agencies.

1.8.6 Dentist shall cooperate with any independent review and improvement organization or other external review organization that CMS and/or MA Plan retains as part of its quality assessment and improvement program.

1.9 MA Plan Medical Policy, Quality Assurance Programs, and Medical Management Procedures. In providing Covered Services to MA Members hereunder, Dentist shall comply with and abide by MA Plan's medical policy, quality improvement programs and medical management requirements and procedures. Dentist shall consult with MA Plan, as MA Plan shall reasonably request, to assist in developing such policy, programs and procedures in accordance with applicable federal or State laws or regulations.

1.10 Hold Harmless.

1.10.1 Dentist agrees that in no event, including but not limited to non-payment by CMS and/or MA Plan, insolvency of MA Plan or breach of this Agreement, shall Dentist bill, charge, collect a deposit from, impose surcharges or have any recourse against a MA Member or a person acting on behalf of a MA Member for Covered Services provided pursuant to this Agreement. The Agreement does not prohibit Dentist from collecting Member Cost Sharing Provisions, as specifically provided in the Plan Description, or fees for non-covered services as long as MA Member has been informed in advance of what services are not covered and has agreed to be financially responsible. This provision shall survive termination of the Agreement, regardless of the reason for termination, including the insolvency of MA Plan and shall supersede any oral or

written agreement between Dentist and a MA Member.

1.10.2 Cost Sharing Responsibility of Dual Eligibles. Dentist agrees that in no event, including but not limited to non-payment by the State, shall Dentist bill, charge, collect a deposit from, impose surcharges or have any recourse against a Dual Eligible MA Member for Medicare Part A and Part B Cost Sharing that is the responsibility of the State Medicaid program. To ensure compliance, Dentist agrees to either (i) accept MA Plan's Medicare Advantage Program payments as payment in full, or (ii) bill the State Department of Public Welfare (DPW) for the amounts that are the responsibility of the State Medicaid program.

1.11 Payments from Federal Funds. Payments to Dentist under this Agreement are, in whole or in part, from federal funds, and as such Dentist is subject to all laws applicable to individuals or entities receiving federal funds.

1.12 Encounter Data. Dentist hereby acknowledges that MA Plan is required to provide CMS and other federal and State regulatory agencies and accrediting organizations with encounter data. Such data may include medical records and other data necessary to characterize each encounter between a MA Member and Dentist. Dentist agrees to cooperate with this obligation of MA Plan and to provide CMS and/or MA Plan with all encounter data in such form and manner as required.

1.13 Certification of Accuracy of Data. Dentist recognizes that MA Plan is required under applicable federal laws and regulations to certify the accuracy, completeness and truthfulness of data requested or provided to CMS. Such data includes encounter data, payment data, and any other information provided to MA Plan by Dentist or its Downstream Entities. Dentist hereby represents and warrants that any information Dentist submits to MA Plan shall be accurate, complete and truthful, and Dentist acknowledges that MA Plan may use the information for the purpose of obtaining federal funds. Upon request, Dentist shall make such certification in the form and in the manner specified by CMS and/or MA Plan. Dentist shall require any Downstream Entity from which Dentist obtains information for submission to MA Plan to represent and warrant that the information shall be accurate, complete and truthful, and to acknowledge that MA Plan may use the information for the purpose of obtaining federal funds.

1.14 Confidentiality. Dentist shall safeguard MA Members' privacy and confidentiality and assure accuracy of a Member's dental records and maintain records of MA Members in an accurate and timely manner. Dentist shall abide by all federal and State laws regarding the confidentiality and disclosure of medical records or other dental and enrollment information, including the Health Insurance Portability and Accountability Act of 1996, as amended. Dentist shall also ensure timely access by MA Members to records and information that pertain to them.

1.15 Maintenance and Provision of Certain Information. Dentist acknowledges that MA Plan is required under applicable federal law and regulations to submit to CMS certain information regarding the benefits provided by MA Plan and quality and performance indicators, including but not limited to, (i) disenrollment rates of MA Members enrolled in MA Plan for the previous two years; (ii) information regarding MA Member satisfaction with MA Plan and (iii) information on dental outcomes. Dentist acknowledges that MA Plan is also required under such laws and regulations to disclose certain information to MA Members in such form and manner requested by CMS. Dentist shall maintain all records and reports reasonably requested by CMS and/or MA Plan and shall provide such records and reports to CMS and/or MA Plan as reasonably requested, to enable MA Plan to meet its obligation to submit such information to CMS and to disclose certain information to MA Members as required by applicable law and regulations.

1.16 Continuation of Covered Services. Dentist shall continue to provide Covered Services to Members as required under applicable state and federal laws. This provision shall survive the termination of the Agreement, regardless of the reason for termination, including the insolvency of MA Plan, and shall supersede any oral or written agreement between the Dentist and a Member.

1.17 Contracts with Downstream Entities. If Dentist contracts with a Downstream Entity to fulfill Dentist's obligations hereunder, Dentist shall require the Downstream Entity by written agreement to comply with all provisions of these Medicare Advantage Requirements. Dentist shall include in its written agreement with a Downstream Entity any and all provisions required to be included by Medicare law and regulations. MA Plan retains the right to approve, suspend, or terminate any arrangement between Dentist and a selected Downstream Entity with respect to services provided under

these Medicare Advantage Requirements.

1.18 Grievance and Appeals. Dentist shall cooperate in a timely manner with grievance and appeal procedures established from time to time by MA Plan. Such cooperation shall include, but is not limited to, gathering and forwarding requested information to MA Plan within the timeframes reasonably established by MA Plan. Dentist shall comply with final determinations of MA Plan or its designee with respect to Dentist and MA Member grievances and appeals. The parties acknowledge that Dentist's right to appeal an administrative denial is in addition to any MA Member appeal rights established by applicable law or regulation.

1.19 Excluded Persons.

1.19.1 Certification. Dentist represents and certifies that neither it, nor its Affiliated Parties or Downstream Entities have been suspended or excluded from participation in the Medicare program or any other federal health care program (as defined in 42 U.S.C. § 1320a-7b(f)). Dentist shall require its Affiliated Parties and Downstream Entities to certify each year that they have not been suspended or excluded from participation in the Medicare program or any other federal health care program.

1.19.2 Federal Exclusion Screening. Dentist shall check appropriate databases at least monthly to determine whether any Affiliated Party or Downstream Entity has been suspended or excluded from participation in the Medicare program or any other federal health care program. Databases include the U.S. Department of Health and Human Services ("HHS") Office of Inspector General List of Excluded Individuals/Entities, the Healthcare Integrity and Protection Data Bank and the General Service Administration Lists of parties Excluded from Federal Procurement and Nonprocurement Programs .

1.19.3 State Exclusion Screening. Dentist shall also check appropriate databases at least monthly to determine whether any Affiliated Party or Downstream Entity has been suspended or excluded from participation in any state contracts or Medical Assistance Program by the applicable state agencies.

1.19.4 Notification of MA Plan. Dentist shall notify MA Plan immediately in writing if Dentist, an Affiliated Party, or any Downstream Entity is suspended or excluded from the Medicare program, or any other federal or state program monitored as described in Sections 1.19.2 or 1.19.3.

1.19.5 Prohibition of Excluded Persons. Dentist shall prohibit any Affiliated Party or Downstream Entity that appears on any of the above-listed databases or who has opted out of Medicare from doing any work directly or indirectly related to the Covered Services.

1.19.6 Annual Attestation. Dentist shall annually provide a written attestation to MA Plan certifying that Dentist has complied with Sections 1.19.1 – 1.19.5.

1.19.7 Penalties. Dentist agrees that it and its Affiliated Parties are subject to 2 C.F.R. Part 376 (relating to excluded persons). Dentist shall require its Downstream Entities to agree that they are subject to 2 C.F.R. Part 376.

1.20 Fraud, Waste and Abuse Prevention.

1.20.1 Code of Conduct. Dentist shall adopt and follow and Dentist shall require its Downstream Entities to adopt and follow a code of conduct that reflects a commitment to detecting, preventing, and correcting fraud, waste, and abuse in administration of both the Medicare Part C and Part D programs as applicable.

1.20.2 Freedom from Conflicts of Interest. Dentist shall collect from those of its managers, officers, and directors who are responsible for the administration or delivery of Medicare Part C and Part D benefits as applicable, a signed statement, attestation, or certification stating that the person is free of any conflict of interest in administering or delivering such benefits. Dentist shall collect these statements, attestations, or certifications (1) within a reasonable time after, as applicable, (a) the effective date of the Amendment or (b) an individual's first day of employment or board service and (2) annually thereafter. Dentist shall maintain such statements, attestations, or certifications in accordance with Section 1.21.2 and make them available to MA Plan upon request.

1.20.3 Training.

(i) Compliance Training. Dentist shall provide Medicare Part C and Part D compliance training for all persons involved in administration or delivery of Medicare Part C and Part D benefits, as applicable. Compliance training shall address matters related to the Dentist's compliance responsibilities, including, but not limited to the Dentist's code of conduct, applicable compliance policies and procedures,

disciplinary and legal penalties for non-compliance, and procedures for addressing compliance questions and issues.

(ii) Specialized Training. Dentist shall provide specialized training to appropriate personnel for issues posing compliance risks based on job function upon initial hire or contracting, and annually thereafter. Dentist shall also provide specialized training when job function or job requirements change and when an employee works in an area previously found to be non-compliant or implicated in past misconduct. As applicable, areas of specialized training include compliance program administration, prevention of fraud, waste and abuse (FWA), FWA laws and regulations, recognizing and reporting FWA, consequences and penalties of FWA, available FWA resources, and areas requiring specialized knowledge of applicable Medicare Part C and Part D procedures and requirements in order for Dentist to perform or provide services under this Agreement.

(iii) Training Records. Dentist shall maintain records of the date, time, attendance, topics, training materials and results of training. Dentist shall maintain such records in accordance with Section 1.21.2 and make the records available to MA Plan upon request.

1.20.4 Annual Attestation. Dentist shall annually provide a written attestation to MA Plan certifying that it has provided training in accordance with Sections 1.20.3(i) – (iii).

1.20.5 Reporting Compliance Concerns. Dentist shall promptly report and shall cause Affiliated Parties and Downstream Entities, to promptly report compliance concerns and suspected or actual misconduct to MA Plan. Dentist may not retaliate against any Affiliated Party or Downstream Entity for reporting in good faith compliance concerns and suspected or actual misconduct. Dentist acknowledges that such retaliation constitutes a material breach of the Agreement.

1.20.6 MA Plan Compliance Audits. In addition to any inspection and audit provisions set forth in the Agreement or elsewhere in these Medicare Advantage Requirements, Dentist shall permit MA Plan or its designees to routinely and randomly audit any of Dentist's contracts, books, documents, papers, or records pertaining to Dentist's performance of its obligations under these Medicare Advantage Requirements. MA Plan's audit may include documents and records pertaining to Medicare Parts C and D, as applicable, and include documentation, supporting data, and background information related to the Agreement such as invoices, licenses, claim transaction records, signature logs, purchase records, prescriptions, and rebate, discount, and all other relevant agreements. Dentist shall make appropriate personnel available for interviews related to MA Plan's audit.

1.20.7 Cooperation with Compliance Activities. Dentist shall cooperate with MA Plan's compliance program, including, but not limited to inquiries, preliminary and subsequent investigations, and implementation of corrective actions. Dentist shall cooperate with CMS' compliance activities, including investigations, audits, inquiries by CMS or its designees, and implementation of any corrective action. Upon completion of any audit that Dentist performs pursuant to the Agreement (including these Medicare Advantage Requirements), Dentist shall provide MA Plan a copy of audit results and shall make all audit materials available to MA Plan upon request.

1.20.8 Fraud and Abuse Statutes. Dentist shall comply with federal statutes and regulations designed to prevent fraud, waste, and abuse, including without limitation applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. § 3729 et seq.), the Anti-Kickback statute (42 U.S.C. § 1320a7b(b)), the Anti-Influencing statute (42 U.S.C. § 1320a-7a(a)(5)), and the Stark statute (42 U.S.C. § 1395nn).

1.21 Inspection, Evaluation, Audit and Document Retention.

1.21.1 Access to Records. Dentist shall permit MA Plan, the U.S. Department of Health and Human Services (HHS), and the U.S. Comptroller General, or their designees, to inspect, evaluate, and audit any books, contracts, records, including medical records, and documentation of the Dentist and Downstream Entities that pertain to any aspect of Services performed, reconciliation of benefits, and determination of amounts payable under the MA Contract, or that HHS may deem necessary to enforce the MA Contract (the "Records"). Dentist shall provide the Records to MA Plan for provision to HHS, the Comptroller General, or their designees, unless otherwise mutually agreed by the parties. Dentist may not make the access described in this paragraph contingent upon a confidentiality statement or agreement. The above-described rights to inspect, evaluate, and audit shall extend through the period during which Dentist is required to maintain the Records established in paragraph 1.21.2 below.

1.21.2 Retention Period. Dentist shall maintain the Records for ten (10) years from the longer of (a) the termination or

expiration of the Agreement or (b) completion of final audit by CMS, unless otherwise required by law.

1.22 Additional Contract Terms Required by CMS. These Medicare Advantage Requirements shall automatically amend to include terms and conditions necessary to implement additional contract terms required by CMS, unless Dentist notifies MA Plan that the additional contract terms required by CMS may have a material adverse effect upon Dentist. The parties shall attempt to reasonably adjust such terms in a mutually satisfactory manner to resolve the material adverse effect and maintain compliance with the MA Contract. If the parties are unable to so resolve the material adverse effect, either party may elect to terminate Dentist's participation in the Medicare Advantage Program by giving the other party written notice of such termination within forty-five (45) days after CMS' instruction to implement such additional required contract terms.

1.23 Offshore Operations. Dentist shall not disclose any of MA Plan's enrollees' dental or enrollment information, including any medical records or other protected health information (as defined in 45 C.F.R. § 160.103), to, or allow the creation, receipt or use of any of MA Plan's protected health information by any Downstream Entity for any function, activity or purpose to be performed outside of the United States, without MA Plan's prior written approval.

2. MA PLAN RESPONSIBILITIES

2.1 MA Plan Monitoring. MA Plan shall monitor the performance of Dentist on an ongoing basis. MA Plan's monitoring activities include assessing Dentist and Downstream Entities' compliance with applicable Medicare Part C and Part D provisions. MA Plan shall oversee and be accountable to CMS for any responsibilities described herein.

2.2 Prompt Payment. MA Plan shall pay Dentist for Covered Services rendered to MA Members within thirty (30) calendar days of MA Plan's receipt of a Clean Claim.

2.3 Confidentiality. MA Plan shall establish procedures to abide by all federal and State laws regarding confidentiality and disclosure of medical records and other dental and enrollment information. MA Plan shall safeguard MA Members' privacy and confidentiality.

2.4 Cease Payment Upon Exclusion. MA Plan shall immediately cease making all payments to Dentist for Covered Services provided to MA Members by Excluded Persons as described in Section 1.19 as of the date Dentist, or any Affiliated Party or Downstream Entity employed by Dentist has been excluded from participation under Medicare as determined by CMS.

3. JOINT DENTIST AND MA PLAN RESPONSIBILITIES

3.1 Termination Without Cause. In the event that the Agreement expressly permits either party to terminate without cause upon the giving of notice, then either Dentist or MA Plan may terminate this Agreement without cause by providing written notice to the other party upon the greater of (i) sixty (60) days or (ii) such other longer notice period as set forth in the Agreement. Nothing stated herein shall create a right in either Party to terminate without cause if the Agreement does not already provide for such right.

3.2 Termination for Material Breach. Notwithstanding any termination provision in the Agreement, in the event Dentist materially breaches this Amendment and fails to cure the breach within thirty (30) days after MA Plan gives Dentist written notice of the breach, MA Plan may terminate this Exhibit and the Agreement upon five (5) days' written notice to Dentist. For purposes of these Medicare Advantage Requirements, a material breach will have occurred upon the following events including, but not limited to (i) a material violation of MA Plan's policies and procedures under Section 1.6 above, or (ii) a determination by CMS that Dentist has not satisfactorily performed its obligations under the Agreement.

3.3 Effect of Termination of MA Contract. In the event the MA Contract is terminated or not renewed, MA Plan is required to send a prior written notice to MA Members at least ninety (90) days before the date that the non-renewal is effective, and at least sixty (60) days prior to termination of the Agreement, including a description of alternatives available for obtaining Medicare services and other options. In the event of such termination or non-renewal, Dentist will no longer be paid for dental services rendered to MA Members of MA Plan with the exception of services required by law to be provided post-termination including services provided in the event of MA Plan's insolvency or MA Member being hospitalized on the date of termination.

3.4 Accountability. MA Plan and Dentist understand and acknowledge that MA Plan oversees and is ultimately accountable to CMS for any functions or standards and that MA Plan may only delegate functions to Dentist or a contractor pursuant to a written agreement specifying the activities and responsibilities of each party, including provisions for revocation of delegation activities and reporting requirements. The performance of Dentist and a contractor will be monitored by MA Plan on an ongoing basis including MA Plan's review of, where applicable, Dentist's credentialing process. MA Plan may only delegate functions to Dentist or a Downstream Entity pursuant to a written agreement specifying the activities and responsibilities of each party, including provisions for revocation of delegation activities and reporting requirements. MA Plan shall monitor the performance of Dentist on an ongoing basis, including MA Plan's review of Dentist's compliance with credentialing criteria, where applicable. MA Plan retains the right to approve, suspend or terminate any delegation arrangement with Dentist.

3.5 Compliance. Dentist and MA Plan shall comply with all applicable Medicare laws, regulations and CMS instructions and shall ensure that any of their contractors, subcontractors, Downstream Entity or related entity complies with all applicable Medicare laws, regulations and CMS instructions. Dentist and MA Plan shall comply with the provisions of Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973 Americans with Disabilities Act and all other applicable laws and regulations pertaining to recipients of federal funds. Dentist and MA Plan shall not employ or contract with, directly or indirectly, any individual or entity who is excluded from participation under Medicare or who has opted out of Medicare and who provides dental services, utilization review, medical social work or administrative services with respect to MA Members. CMS instructions include additional terms required by CMS to be included in MA Plan's contract(s) with Dentist and Dentist's contracts with Downstream Entities. Dentist and MA Plan shall comply with the provisions of Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the Americans with Disabilities Act and all other applicable laws and regulations pertaining to recipients of federal funds.

3.6 Payments for Services to Medicare-Eligible Individuals with Other Medicare Coverage.

3.6.1 If a Medicare-eligible individual is ineligible as a MA Member on the date of service, MA Plan will not be liable for payments. Dentist may seek payment from the Medicare-eligible individual's primary payor.

3.6.2 If MA Plan erroneously identifies a Medicare-eligible individual as a MA Member, MA Plan will be liable for payments if Dentist cannot seek payment from the Medicare-eligible individual's primary payor.

3.6.3 MA Plan will be liable to Dentist for Covered Services rendered to a Member who erroneously represented to the Dentist that the MA Member had coverage under another private dental and/or health plan's Medicare program ("Other Medicare Coverage"), so long as the circumstances satisfy the following conditions: (a) Dentist can document that the MA Member was previously covered under Other Medicare Coverage; (b) Dentist provided Covered Services on the good faith belief that the MA Member was covered under such Other Medicare Coverage as of the date of service; (c) relying on conditions (a) and (b), Dentist was unaware of the application of MA Plan's Preauthorization requirements; (d) Dentist's services satisfy MA Plan's Medical Necessity and Appropriateness criteria; and (e) under the circumstances, MA Plan would have otherwise approved a Preauthorization request for the services provided to the MA Member.