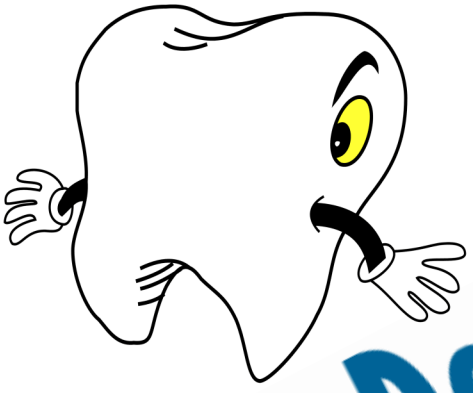


Savon Dental Plan®

America's Dental Plan

Nationwide Network Flex-Fee ® Provider Enrollment Guide

Covers All Zones For General Dentists— Uses The Flex® Fee Schedule

(602)841-3494 • Text Only (623)309-7247

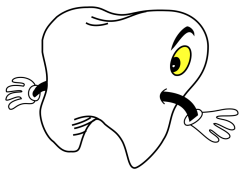
Corporate Office: Show Low, Arizona

Mailing Address: PO Box 63 • Show Low, AZ 85902

Website: www.SavonDentalPlan.com

Email: ProviderServices@SavonDentalPlan.com

Provider Participation Made Simple!



How to become a NETWORK FLEX FEE PROVIDER®

Agree to abide by the Savon Flex-Fee® Schedule

Complete and sign the Provider Agreement

Complete the Center Profile

Complete the Provider Profile

Mail all completed documents to Savon Dental Plan®

Once we receive the information we will provide you with the following:

A Flex Fee Provider® Window Sticker

Quarterly Rosters of your Savon patients (upon request)

Let's Get Started… Step 1

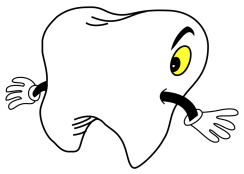
Agree to abide by the Flex-Fee® Schedule of Benefits as shown below.

***The Flex-Fee® Schedule is* based on preset discounts from your own Usual and Customary Fee.**

PROCEDURE	*CODE AREA*	*REDUCTION VALUE*
DIAGNOSTIC / RADIOGRAPHS	*D0100-D0999*	*40%*
PREVENTATIVE	*D1000-D1999*	*40 %*
RESTORATIVE	*D2000-D2999*	*35 %*
ENDODONTICS	*D3000- D3999*	*40 %*
PERIODONTICS	*D4000-D4999*	*40 %*
PROSTHODONTICS (Removable)	*D5000-D5899*	*40 %*
MAXILLOFACIAL PROSTHETICS	*D5900-D5999*	*35 %*
IMPLANT SERVICES	*D6000-D6199*	*20 %*
PROSTHODONTICS (Fixed)	*D6200-D6999*	*40 %*
ORAL SURGERY	*D7000-D7999*	*35 %*
ORTHODONTICS	*D8000-D8999*	*20 %*
ADJUNCTIVE GENERAL	*D9110-D9999*	*50 %*

Lab Fees Are Not Discounted

You May Charge For Precious Metals



Provider Participation Made Simple!

Step 2

Credentialing Check List for the Dental Center

Please make sure that you are submitting all of the following items.

For each dental center please submit:

[ ] COMPLETED, SIGNED and DATED PROVIDER AGREEMENT

[ ] The COMPLETED two (2) page CENTER PROFILE

[ ] A copy of your CURRENT practice FEE SCHEDULE

Please Note: ***If you have more than one (1) dental center, the two (2) page Center Profile is required for each center. Copies of these pages are permissible***

Step 3

Credentialing Check List for the Dentist

Please make sure that you are submitting all of the following items.

For each provider please submit:

[ ] The COMPLETED one (1) page PROVIDER PROFILE

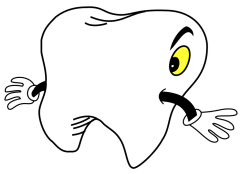
We only require numbers and expiration dates of the following items, we do not require copies of them.

[ ] PROFESSIONAL LIABILITY INSURANCE POLICY NUMBER AND EXPIRATION DATE

[ ] STATE DENTAL LICENSE NUMBER AND EXPIRATION DATE

[ ] DEA CERTIFICATE LICENSE NUMBER AND EXPIRATION DATE

Please Note: ***Please submit separate credentialing information for each provider at your facility. Copies of this page are permissible.***



Network Flex-Fee ® Provider Agreement

This Provider Agreement made and entered into this _____ day of _____, 20_____. by and between _____, hereinafter referred to as "Provider" and Savon Dental Plan, a membership dental provider organization, hereinafter referred to as "Plan".

Plan and Provider agree to the following:

Plan has a dental network to provide dental care to individuals, families, groups, businesses and eligible dependents of the aforementioned, (hereinafter referred to as "Members"). Provider agrees to provide care for the Members according to this agreement providing Member is able to provide proof of current membership in the plan.

RENDITION OF CARE: Provider agrees to render necessary dental services to each of the Members covered by Plan Agreement. Such rendition of services shall occur during his/her regular office hours, subject to prior appointments, provided, however, that Provider shall have the right within the framework of professional ethics to reject any patient seeking his/her professional services.

ELIGIBILITY: All determinations as to the eligibility of any person for benefits under a Plan Agreement, or the standing of any person with respect to membership in any group entitled to benefits under a Plan Agreement shall be determined by the Plan before the Provider renders any dental services. Provider shall make telephone contact with the Plan or verify eligibility via the internet, before delivering service to Members to confirm current membership and subscriber identification number.

DISCLOSURES AND REIMBURSEMENTS: This plan is NOT insurance. Savon Professional Services Inc., Savon Dental Plan is "discount medical plan organization," "DMPO" and is not an insurance company. We will not reimburse any member or doctor for any fees listed on the schedule of benefits, prescriptions or any fees that are not listed. No portion of any provider's fee will be reimbursed or otherwise paid by Savon.

FEES DUE DIRECTLY FROM MEMBER: Provider shall abide at all times by the Flex-Fee® Schedule. Lab Fees are not subject to any discount. Flex Fee Provider is not required to provide any services at no charge.

USE OF PROVIDER NAME: Provider consents to the inclusion of his/her name and facility information in Plan's Provider Directories, both print and electronic.

CHANGE IN SCHEDULE OF BENEFITS AND OTHER TERMS: It is specifically understood that the benefits, terms, and conditions of the Agreement between the Plan and Provider may be changed from time to time. Provider will be notified of changes to fee schedules (30) days prior to such changes and will have thirty (30) days to respond to the survey and request changes. Failure to respond to the survey and request changes within the allowed time will be considered acceptance of changes.

If a modification is augmented Provider has ten (10) days to accept or decline such modification. Unless, within ten (10) days after receipt of such notification, Provider notifies Plan in writing that he/she declines to provide dental services to the Members in accordance with the changed Plan Agreement; Provider agrees to continue to perform dental services under the modified Plan Agreement and this Provider Agreement shall be deemed amended accordingly.

STANDARD OF CARE: Provider agrees that he/she shall perform his/her obligations under this Provider Agreement in accordance with high standards of competence, care and concern for the welfare and needs of the Members in accordance with the "principles of ethics" of the American Dental Association and the Dental Practice Act of the State in which Provider is licensed. It is understood that the inclusion of Provider on the panel of the Plan is not a recommendation of Provider by the Plan.

NON – EXCLUSIVE: This Provider Agreement is not exclusive in any respect. Plan is entitled to enter into similar agreements with other parties, or with other dentists. Provider is free to enter into similar agreements with other parties, or with other groups not represented by Plan.

PROVIDER PATIENT RELATIONSHIP: Provider shall maintain the dentist-patient relationship with Members and shall be solely responsible to the patient for dental advice and treatment. It is expressly agreed between the parties that the Provider is an independent contractor and quality control issues notwithstanding, the Plan shall not have any dominion or control over the Provider's practice, the dentist patient relationship, his/her personnel or facilities.

MALPRACTICE: Provider agrees to carry malpractice insurance in at least an adequate amount which is usual and customary in their state.

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

COMPENSATION TO DENTIST/PROVIDER: Provider understands that there is no capitation involved in the Plan's dental program. Provider further agrees and understands that the total Member's financial obligation shall not exceed the fees listed on the Schedule of Fees and Benefits attached in this packet and made part of this Agreement.

DURATION OF AGREEMENT: Provider participation in this Provider Agreement shall be an on-going continual agreement with Plan that may be terminated by either party with a Thirty (30) day written notice mailed by registered or prepaid certified mail to the last known address of the other party. Provider agrees that upon termination of this agreement, he/she will continue to accept patients of record and their families for a period of one (1) year and/or complete any on-going treatments at Plan fees. Such termination shall have no effect upon the rights and obligations of the parties arising out of any transaction occurring prior to the effective date of such termination and any continuing obligations after the termination as set forth herein. Suspension or termination of Provider's Dental license, or failure to adhere to Plan's utilization and quality control process may result in immediate termination for cause of this Provider Agreement at any time.

If this Provider Agreement is terminated, Provider will complete all treatment in progress and forward copies of the covered person's records and duplicate x-rays and study models to a new Provider, designated by Member or Plan, within thirty (30) days after the completion of the treatment in progress.

NOTICE TO MEMBERS OF TERMINATION OF AGREEMENT: In the event that this Provider Agreement is terminated by either party, in accordance with the procedures set forth herein, Plan will, to the best of its ability, notify all Members assigned to Provider that the Agreement between Plan and Provider has been terminated and will, to the best of its ability, transfer all Members to a new Provider.

Provider agrees that at the time the patient seeks an appointment, he/she will notify Member prior to providing any dental service that the Agreement is no longer in effect. In the event such notice is not given to the patient, Provider agrees to accept payment for his/her services at a rate no more than set forth in the aforementioned schedule of benefits.

RULES OF ADJUDICATION:

Plan and Provider agree that if any part of this agreement is found to be in violation of any law of any State within the United States of America, only the section(s) that violate the law shall be voided. The rest of this agreement shall remain intact and enforceable at all times.

Plan and Provider agree that if any action by either party caused or may cause harm to the other party that forces the injured party to initiate litigation, such litigation shall be filed and adjudicated within the State of Arizona, Maricopa County. Plan and Provider agree that the aforementioned State and County shall at all times be the proper venue for any legal actions.

IF SIGNING AS AN INDIVIDUAL PRACTITIONER

By _____

(Dentist's/Provider's Signature) Authorized Signature)

_____

(Dentist's/Provider's Name – Please Print)

Date _____

_____

(Name of Individual Practice – Please Print)

_____

Email Address

IF SIGNING ON BEHALF OF A GROUP/CORPORATION

By _____

_____

(Name/Title of Above – Please Print)

Date _____

_____

(Name of Group or Corporation – Please Print)

_____

Email Address

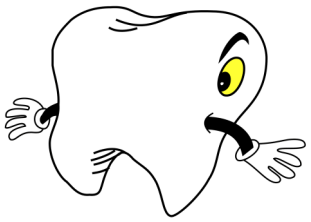
PLEASE DO NOT WRITE BELOW THIS LINE

Date Received:_____/____/20____ Credential Check Cleared [ ] Yes [ ] No Approved [ ] Denied [ ] Date:____/_____/20_____

_____

Corilee M. Parker Director of Provider Relations

Flex-Fee® Center Profile



Please Tell Us About Your Office

What is the name of your practice? _____

What is the physical address of the Office?_____

City:_____ State:_____ Zip Code:_____

What is the office phone number?(_____)_____-_____ Fax Number?(_____)_____-_____

What is the name of your office manager or appointment coordinator?_____

Office Manager's email address: _____

Do you have a Web Site? [ ] Yes [ ] No If yes please give us your web address: www._____

If you have a web site would you like a link from our dentist list to your web site? [ ] Yes [ ] No

Is your office in a Metropolitan Area (over 100,000 people) [ ] Yes [ ] No (If no) miles from a Metro Area? _____miles

Are languages other than English spoken in your office? [ ] Yes [ ] No (if yes, please specify) _____

Is the mailing address the same as the physical address? [ ] Yes [ ] No (If no, please give us the mailing address below).

Adress:_____City:_____State:_____Zip:_____

Please Tell Us About Your Operatories and Patient Capacity

How many operatories do you have?_____ How many assistants do you have?_____

Do you have a hygiene department? [ ] Yes [ ] No (if yes) How many hygienists do you have?_____

How many additional patients is your office willing to accommodate on a monthly basis? 10-20 21-50 51-70 71-90 91-100 over 100

(please circle the one that applies)

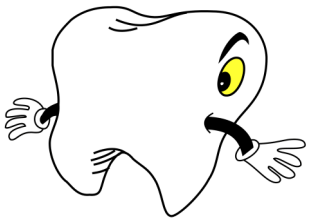
Please Tell Us About Options and Special Equipment that you have

(please check all that apply to your office)

[ ] Nitrous Oxide	[ ] Ultra Sonic Cleaning	[ ] Laser	[ ] Electro Surge
[ ] IV Sedation	[ ] Oral Sedation	[ ] Prophy Jet	[ ] Denta Cam
[ ] K.C.P. 2000	[ ] Brite Smile/Zoom (etc.)	[ ] High Speed Endo	[ ] Digital X-Ray
[ ] Cavitron	[ ] Children Sedation	[ ] On site denture Lab	[ ] On site Crown & Bridge Lab
[ ] Panoramic x-ray	[ ] Diode Laser	[ ] CAD/CAM (Cerec)	[ ] 3D Imaging

[ ] Other (please explain):_____

Flex-Fee® Center Profile



Page II

Please Tell Us What Days and Hours You are Open

Days Open: [ ] Sunday [ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday

Office Hours: ____-____ ____-____ ____-____ ____-____ ____-____ ____-____ ____-____

Please Tell Us About Your Payment Policy

Please check the credit cards that you accept: [ ] Mastercard [ ] Visa [ ] American Express [ ] Discover

Do you accept any other credit cards? [ ] Yes [ ] No (if yes, please specify)_____

Please check any of the following other forms of payments that you make available to patients

[ ] Personal Checks [ ] Care Credit [ ] "In house" financing [ ] Payment plans available through a finance company

[ ] Other (please explain):_____

Equipment Sterilization and Infection Control

Do you sterilize your instruments in office? [ ] Yes [ ] No (if yes) Type: [ ] Autoclave [ ] Chemclave [ ] Statem [ ] Steam [ ] Cold [ ] Other

Do you sterilize your handpieces in office? [ ] Yes [ ] No (if yes) Type: [ ] Autoclave [ ] Chemclave [ ] Statem [ ] Steam [ ] Cold [ ] Other

Do you spore test your sterilization unit? [ ] Yes [ ] No (If yes) how often? [ ] Daily [ ] Weekly [ ] Monthly [ ] Other

If other or no is checked for any of these questions please explain:_____

Personal Sterilization and Infection Control that is Used in this Office

In the Operatory, Do you wear: Mask [ ] Yes [ ] No Gloves [ ] Yes [ ] No

Eye Protection [ ] Yes [ ] No [ ] As Needed Protective Clothing [ ] Yes [ ] No [ ] As Needed

Emergency Control Procedures

Is your office equipped with Oxygen [ ] Yes [ ] No Is your office equipped with a Blood Pressure Device [ ] Yes [ ] No

Is your office equipped with a Defibrillator [ ] Yes [ ] No Does your office have at Least 1 C.P.R. Certified Person [ ] Yes [ ] No

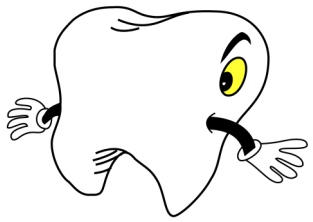
Compliance Procedures

Does your office Meet O.S.H.A. Standards [ ] Yes [ ] No Does your office Have a Written Infection Control Policy [ ] Yes [ ] No

Does your office Have a Written Hazard Control Policy [ ] Yes [ ] No Does your office have a written H.I.P.P.A. policy [ ] Yes [ ] No

Is your office able to accommodate patients with Disabilities (Special question for our disabled members) [ ] Yes [ ] No

Flex-Fee® Provider Profile



(A separate profile is required for each provider)

Please type or print clearly - All information is required unless noted otherwise

What is your name?_____ D.D.S. or D.M.D. Date of Birth_____/_____/_____

Emergency or Cell Phone Number: (_____)_____ What is your EMAIL address?_____

What Dental College did you graduate from?_____ In What Year?_____

What is your License Number?_____ State:_____ When does it expire?_____/_____/20_____

Who is your Professional Liability Insurance Carrier? _____

What is your Policy Number?_____ When does your policy expire?_____/_____/20_____

What is your D.E.A. Number?_____ When does it expire?_____/_____/20_____

What is the name of your practice? _____

Address:_____City:_____State:_____Zip:_____

Do you have any Dental Board problems that we should know about? [ ] Yes [ ] No (if yes; please use additional paper to explain)
NOTE: A yes answer to the above question DOES NOT automatically disqualify you from participation in our plan.

Skill comfort rating: On a scale of 0 -10

0- means that you DO NOT perform the procedure 10 - means that you DO perform the procedure including very difficult cases
With this in mind, please rate your comfort and skill level in the following fields:- (please circle one number for each field)

Orthodontics	0 1 2 3 4 5 6 7 8 9 10	Pedodontics	0 1 2 3 4 5 6 7 8 9 10
Endodontics	0 1 2 3 4 5 6 7 8 9 10	Prosthodontics	0 1 2 3 4 5 6 7 8 9 10
Oral Surgery	0 1 2 3 4 5 6 7 8 9 10	T.M.J.	0 1 2 3 4 5 6 7 8 9 10
Periodontics	0 1 2 3 4 5 6 7 8 9 10	Implants	0 1 2 3 4 5 6 7 8 9 10

Optional information: (for Savon Dental Plan's use in case of extreme emergency)

What is your Personal Mailing Address?_____

City:_____ State:_____ Zip Code:_____ Personal Phone Number? (_____)_____