ADDENDUM FOR THE STATE OF NEW JERSEY

The provisions set forth in this Addendum are being added to the Agreement to comply with the legislative and regulatory requirements of the State of New Jersey regarding provider contracts with providers rendering health care services in the State of New Jersey. To the extent that Network Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the Zelis provider website at https://www.zelis.com/provider-solutions/provider-networks/state-federal-law-coordinating-provisions/ shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, including ERISA, the provisions set forth in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. References to Zelis in this Addendum shall mean Zelis Network Solutions, LLC, on behalf of itself and its proprietary PPO networks, for services in the State of New Jersey where the Payor reimburses on a fee-for-service basis, and where the Payor reimburses on a capitated or risk basis.

1. With respect to health care services rendered in the State of New Jersey, the section regarding Compensation and Payment by Customers shall not apply and the following shall apply instead:

New Jersey Payment Terms

(a) Except as provided in (b) below or otherwise herein, Network Provider will be paid the undisputed amount payable under this Agreement for authorized Covered Services within 45 days after Zelis's receipt of a properly completed, accurate, non-duplicated invoice containing all required data elements as specified in the onboarding material ("Clean Claim") from Network Provider or the period of time required by applicable law. Clean claims for Covered Services subject to the New Jersey prompt pay law are required to be paid within 30 days of receipt if submitted electronically and within 40 days of receipt for paper claim submissions, and, if paid late, are subject to simple interest at the rate of 10% per annum. N.J.S.A. 17:48H-33.1(d).

(b) If applicable, the Payor be the representative of Network Provider solely for purposes of accepting Network Provider's claims submissions and billing and receiving payment from such Payor for the Covered Services rendered by Network Provider. When Payor receives a Clean Claim for Covered Services from Network Provider as to such Payor, Payor will bill the applicable plan on behalf of Network Provider in accordance with the rate and other terms agreed upon by Zelis with such Payor. Clean Claims for Covered Services subject to the New Jersey prompt pay law are required to be paid within 30 days of receipt if submitted electronically and within 40 days of receipt for paper claim submissions, and, if paid late, are subject to simple interest at the rate of 10% per annum. N.J.S.A. 17:48H-33.1(d). All other Clean Claims for Covered Services will be paid within 10 days of the date Network Provider receives both payment in full and a complete explanation of payment from the Payor for such Clean Claim for Covered Services. Network Provider will be reimbursed for such claims in accordance with the rate specified in this Agreement and applicable plan design. Network Provider understands and agrees that, as to Payors subject to this subsection (b), Zelis is not the delegate of the Payor for purposes of claims processing.

2. Any sections of the Agreement that conflict with applicable state or federal law are effectively amended to conform to the requirements of the state or federal law. N.J.A.C. 11:24B-5.2(a)1.

3. The compensation methodology is specified in the Compensation section of the Agreement, the fee schedule attached to the Agreement, the onboarding material, and/or the Zelis Network Provider website.

To the extent that a different compensation methodology and terms apply to different products, such methodology, terms, and complete fee schedule shall be specified in the Agreement, the onboarding material, and/or the Zelis Network Provider website. In the event that fees for Covered Services under the Agreement are not individually negotiated, Zelis shall make available to Network Provider and prospective network providers complete fee schedule(s) that are or are to be included in the Agreement. Fee schedules shall be supplied in writing unless Zelis makes the fees for included CPT or HCPCS codes available on the Zelis Network Provider website or otherwise makes them available electronically to providers. To the extent that Network Provider is reimbursed for covered services on a basis other than fee-for-service (for example, capitation, per diem, or percent of charges), the Agreement shall specify the dollar amount or methodology used by Zelis to determine reimbursement, and shall identify the services included in and excluded from the alternate reimbursement methodology. The compensation methodology shall not provide financial incentives to Network Provider for the withholding of covered health care services that are medically necessary. This does not prohibit or limit the use of capitated payment arrangements between Zelis and Network Provider except that capitation shall not be the sole method of reimbursement if Network Provider primarily provides supplies rather than services. To the extent that some portion of the compensation is tied to the occurrence of a pre-determined event or the non-occurrence of a pre-determined event, the event must be clearly specified, and Network Provider has a right to receive a periodic accounting of the funds held which shall be no less frequently than annually. Network Provider may appeal a decision denying compensation to which Network Provider believes it is entitled under the terms of the Agreement in accordance with the appeal process described in the onboarding material as modified by this Addendum. N.J.A.C. 11:24B-5.2(a)2; 11:24C-4.3(c)1.i. and ii.; N.J.A.C. 11:24C-4.4; N.J.A.C. 11:24C-4.3(b)1; N.J.A.C. 11:24C-4.3(b).

4. Network Provider's activities and records relevant to the provision of health care services may be monitored from time to time either by Zelis, the Payor, or another contractor acting on behalf of Zelis or the Payor in order for Zelis or the Payor to perform quality assurance and continuous quality improvement functions. N.J.A.C. 11:24B-5.2(a)3.

5. Network Provider shall comply with Payor's quality assurance program. Payor is responsible for the day-to-day administration of such program. Network Provider may lodge complaints regarding such program and otherwise provide feedback regarding Payor's operations by contacting Zelis and provide feedback regarding Payor operations or by contacting the applicable Payor identified on the patient identification card. N.J.A.C. 11:24B-5.2(a)4; N.J.A.C. 11:24-15.2(b).

6. Network Provider must comply with the applicable Payor's utilization management program as adopted by Payor. Depending on the arrangement with the applicable plan, Payor may be responsible for making authorization approval decisions with the applicable plan making any denial determinations or Payor may be responsible for making both authorization approval and denial decisions. The utilization management program requirements are specified in the onboarding material, including the method for obtaining a utilization management decision and appealing a utilization management decision. Network Provider has the right to obtain the name and phone number of the physician denying or limiting a service or procedure. The onboarding material and/or patient identification card include information and/or a telephone number through which Network Provider may receive information regarding utilization management protocols, any parameters that may be placed on the use of one or more protocols, and how Network Provider can review and provide comment on the applicable protocols for Network Provider's practice area. To the extent required by New Jersey law, Network Provider has the right to rely upon the written or oral authorization of a service if made by the applicable Payor or the entity identified as being responsible for the day-to-day operations of the utilization management program and such services will not be retroactively denied as not medically necessary except in cases where there was material

misrepresentation of the facts to the Payor or the entity responsible for the day-to-day operations of the utilization management program, or fraud. N.J.A.C. 11:24B-5.2(a)5; N.J.A.C. 11:24C-4.3(c)1.v.

7. Information regarding the rights and obligations of Network Provider when appealing a utilization management decision on behalf of a covered person may be obtained from the Payor, the applicable denial letter and/or by calling the phone number on the patient identification card, including whether Network Provider must obtain the consent of the covered person in order for the appeal to be reviewed in accordance with the Stage 1 and Stage 2 process as set forth at N.J.A.C. 11:24-8 and 11:24A-3.5 or whether failure to obtain consent of the covered person results in review of the appeal using a separate complaint or provider grievance process. In the event that an appeal to a Payor instituted by Network Provider on behalf of a covered person will be entertained as a member utilization management appeal without the covered person's consent, such appeals will not be eligible for the Independent Health Care Appeals Program, established pursuant to N.J.S.A. 26:2S-11, until the covered person's specific consent to the appeal is obtained. Network Provider is not limited to submitting an appeal on behalf of the covered person in situations in which the covered person may be financially liable for the costs of the health care services. N.J.A.C. 11:24B-5.2(a)6; N.J.A.C. 11:24-15.2(b).

8. This Agreement is governed by New Jersey law. N.J.A.C. 11:24B-5.2(a)7.

9. The term of this Agreement and renewal and termination rights and obligations are specified in the provision of this Agreement entitled Term and Termination. The Agreement may automatically renew, provided, however, that no adverse change may be made to the terms of the Agreement upon its automatic renewal. Any such adverse change may be made to the Agreement as set forth in section 22 below, either before or after renewal of the Agreement. To the extent required by law, Zelis will give Network Provider 90 days advance notice of a termination of this Agreement and Network Provider has a right to request a hearing regarding such termination except when the termination is based on nonrenewal of the contract, a determination of fraud, breach of contract by Network Provider or in the opinion of the Zelis medical director Network Provider represents an imminent danger to a patient or the public health, safety and welfare. Such termination notice will include the reason for termination and process for requesting a hearing. Any such hearing will not be deemed an abrogation of Network Provider's legal rights. In the event of a termination, Network Provider will continue to provide services at the contract rate in accordance with N.J.A.C. 11:24-3.5. N.J.A.C. 11:24B-5.2(a)8 and 9; 11:24C-4.3(c)1.iii.; N.J.A.C. 11:24C-4.3(e); N.J.A.C. 11:24-15.2(b).

10. In no event, including but not limited to nonpayment by Payor, shall Network Provider bill or otherwise pursue payment from a covered person for the costs of services or supplies rendered in-network that are covered or for which benefits are payable under the covered person's plan regardless of whether the provider agrees with the amount paid or to be paid for the services or supplies rendered. Further, in the event of insolvency of Payor, Network Provider agrees to continue to provide covered services to covered persons through the date payments were made by Payor for such services. N.J.A.C. 11:24B-5.2(a)10; N.J.A.C. 11:24-15.2(b).

11. Network Provider must be licensed as required by law, credentialed and otherwise eligible to participate in various programs as appropriate. The time periods for credentialing and recredentialing are specified in the onboarding material. Network Provider must comply with Zelis's credentialing process. Network Provider shall maintain malpractice insurance in the amount of not less than $1,000,000 per occurrence and $3,000,000 annual aggregate. N.J.A.C. 11:24B-5.2(a)11 and 12; N.J.A.C. 11:24-15.2(b).

12. The services to be provided by Network Provider are specified in the Agreement, as amended, including but not limited to Schedule A. N.J.A.C. 11:24B-5.2(a)13; N.J.A.C. 11:24-15.2(b).

13. Network Provider has the right and obligation to communicate openly with all covered persons regarding diagnostic tests and treatment options. N.J.A.C. 11:24B-5.2(a)14; N.J.A.C. 11:24-15.2(b).

14. Network Provider shall not be terminated or otherwise penalized because of complaints or appeals that Network Provider files on its own behalf, or on behalf of a covered person, or for otherwise acting as an advocate for covered persons in seeking appropriate, medically necessary health care services covered under the covered person's health benefits plan. N.J.A.C. 11:24B-5.2(a)15; 11:24-15.2.(b) 2 and 3.

15. Network Provider shall not discriminate in its treatment of a Payor's covered persons. N.J.A.C. 11:24B-5.2(a)16; N.J.A.C. 11:24-15.2(b).

16. The procedures for submitting and handling claims, including any penalties that may result in the event that claims are not submitted timely, the standards for determining whether submission of a claim has been timely, how any interest on late claims will be paid to Network Provider, and the process for Network Provider to dispute the handling or payment of claims is specified in the Agreement and remittance advice provided. Claims should be submitted to the address referenced on the Participant's identification card or by contacting the Zelis Network Provider Resolution Team at the toll free number specified in the onboarding material. N.J.A.C. 11:24B-5.2(a)17. Monthly invoices are not required, but claims must be submitted to Zelis within 60 days of the date of service or within the timeframe required by applicable law if later. To the extent applicable, N.J.S.A. 45:1-10.1 allows licensed health care professionals to submit claims in which the patient has assigned benefits within 180 days of the last date of service for a course of treatment.

17. Network Provider may submit and seek resolution of complaints and grievances, separate and apart from submitting complaints and grievances on behalf of a covered person, and complaints addressing compensation and claim issues may be submitted in accordance with the procedures specified in the onboarding material and Agreement, as modified by the applicable terms in this Addendum. Such procedures shall comply with N.J.S.A. 17B:27-44.2e and 26:2J-8.1e to the extent applicable (for example, to the extent Zelis is delegated by the Payor to handle such complaints and grievances and to the extent required by New Jersey law, the time frame for submitting any such complaints and grievances shall not be less than 90 days following Network Provider's receipt of the claims determination, only one level of appeal will apply, and the timeframe for resolving such complaints and grievances shall not exceed 30 days following receipt of the complaint or grievance. To the extent provided under New Jersey law, Network Provider may submit complaints and grievances to the Department if not satisfied with the resolution of the complaint or grievance through the internal provider complaint mechanism, and any such matters submitted for arbitration must be submitted within 90 days of receipt of the appeal determination, and the amount in dispute must be $1,000 or more (Network Provider may aggregate disputed claim amounts to meet the $1,000 threshold). N.J.A.C. 11:24B-5.2(a)18; N.J.A.C. 11:24C-4.3(c)1.vii.

18. To the extent required by New Jersey law, recoveries of overpayments to Network Provider shall conform to N.J.S.A. 17B:27-44.2d (10), (11), and -44.2e, and 26:2J-8.1d (10), (11), and -8.1e (for example, except in situations involving fraud, 45 days' notice of the overpayment, stay of recovery efforts pending internal payment appeal and state sponsored arbitration if applicable, 18 month limitation on recoveries from the date of payment, recoupment permitted means of recovery if provided sufficient detail so provider can reconcile each covered person's bill).

19. The standards for confidentiality regarding health care information and exchange of information between the parties are specified in the Miscellaneous Terms of the Agreement. N.J.A.C. 11:24B-5.2(a)19; N.J.A.C. 11:24-15.2(b).

20. The Payor is a third party beneficiary of the Agreement, with privity of contract, and a right to enforce the provisions of the Agreement in the event that Zelis fails to do so. N.J.A.C. 11:24B-5.7(a); N.J.A.C. 11:24-15.2(b).

21. The provision in the Agreement entitled Independent Contractor shall be deleted and replaced with the following: Network Provider and Zelis are independent contractors as permitted by statute, regulation, and/or common law. Network Provider and Zelis have no employment, partnership, or joint venture relationship. N.J.A.C. 11:24B-5.2(b)1.

22. The methods by which the Agreement may be amended, renewed, and terminated are specified in the Amendment and Waiver section, and the Term and Termination section, of the Agreement. Any provision in the Agreement that establishes a unilateral right of a party to amend the Agreement and requires a party to abide by the amended terms of the Agreement during a notice of termination period in the event that one party elects to terminate the Agreement rather than accept the amendment shall not apply unless such amendment is required by state or federal law. To the extent that the terms of the Agreement have been the subject of negotiation between the parties, no changes shall be made unilaterally to the administration of the Agreement materially impacting those terms. For example, if rates have been negotiated, carriers may not unilaterally introduce Multiple Procedure Logic or changes to billing requirements that would result in a material reduction in reimbursement for services affected by the change. Any adverse change or amendment to the Agreement may be made in accordance with the terms of the Agreement only upon ninety (90) days' notice prior to the effective date of the change or amendment. If Network Provider declines to accept the amendment, Network Provider may terminate the Agreement as set forth in N.J.A.C. 11:24C-4.3(c)3. N.J.A.C. 11:24B-5.2(c)2; N.J.A.C. 11:24C-4.3(c)1.iv.; N.J.A.C. 11:24C-4.3(c)3; N.J.A.C. 11:24C-4.3(c)4; N.J.A.C. 11:24C-4.3(d).

23. To the extent required by New Jersey law, (a) the term "Medical necessity" or "medically necessary" shall mean or describe a health care service that a health care provider, exercising his prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is: in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the covered person's illness, injury or disease; not primarily for the convenience of the covered person or the health care provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered person's illness, injury or disease; and (b) with respect to services or supplies that are medically necessary under the terms of the applicable plan but that were not pre-certified or pre-authorized and for which payment is denied solely on that basis, upon substantiation of such medical necessity, payment will be made at 50% of what would otherwise have been paid had pre-certification or pre-authorization been obtained for the medically necessary service. N.J.S.A. 17B:30-50; N.J.A.C. 11:24B-5.2(c)6.

24. Network Provider's obligation to maintain liability insurance is specified in the Insurance section of the Agreement. N.J.A.C. 11:24C-4.3(c)1.vi.

25. The Agreement shall not contain a most favored nation clause, or clauses having a similar effect. N.J.A.C. 11:24C-4.3(c)2.

26. Pursuant to the applicable requirements of N.J.A.C. 11:24C-4.3(c)5, the Agreement specifically provides that Zelis may enter into agreements with third parties allowing the third parties to obtain Zelis' rights and responsibilities under the Agreement as if the third party were Zelis. Such third parties may include, but are not limited to, preferred provider organizations (PPOs), organized delivery systems (ODSs), and such other entities to which Zelis may lease its provider network, in accordance with the terms set forth below:

a. Every third party accessing the Agreement is contractually obligated to comply with all of its terms;

b. Zelis shall identify all such third parties in existence as of the date the Agreement is entered into;

c. Zelis shall include on its website a listing, updated no less frequently than every ninety (90) days, identifying all such third parties;

d. The source of the discount shall be identified on all remittance advices and/or explanations of payment under which a discount is taken;

e. Zelis shall notify the third party of the termination of the Agreement upon issuance of the notice of termination by Zelis or upon receipt of the notice of termination from Network Provider;

f. The third party ceases its right to Network Provider's discounted rate upon termination of the Agreement. For purposes of this subsection f., "third party" does not include any employer or other group for which Zelis provides administrative services, including at least the payment of claims; and

g. Zelis shall deliver to Network Provider a copy of any agreement relied on in the adjudication of a claim within thirty (30) days after the date of a request from Network Provider subject to the terms of such agreement.

27. Zelis shall deliver to Network Provider a copy of the fully executed initial Agreement and any amendments thereto within thirty (30) days after the effective date of the initial or amended Agreement, and within thirty (30) days after the date of a request from Network Provider for a copy of the Agreement and/or amendments thereto. N.J.A.C. 11:24C-4.3(f).

28. Payor shall make available online the name of any commercially available software used by Payor for editing claims, together with a description of Payor-specific edits in a manner detailed enough to provide an understanding of such specific edits. N.J.A.C. 11:24C-4.3(b)2.

29. Defined terms, including but not limited to, "Adverse change," "adverse amendment," "Health care provider" or "provider, "most favored nation clause," and "Multiple Procedure Logic" set forth in those provisions above required by N.J.A.C. 11:24C-4 are set forth at N.J.A.C. 11:24C-4.2