ADDENDUM FOR THE STATE OF NEW YORK

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of New York regarding provider contracts with providers rendering health care services in the State of New York. 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 but not limited to ERISA, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Participant" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, an insurance company licensed to offer accident and health insurance subject to Article 32 of New York Insurance Law, a corporation licensed pursuant to Article 43 of New York Insurance Law, or an entity possessing a certificate of authority under Article 44 of the New York Public Health Law, except to the extent that any of the foregoing is excluded under applicable law. References to Network Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. Nothing in the Agreement shall be construed to prohibit or restrict Network Provider from:

a. Disclosing to a Participant or a Participant's designated representative, any information that Network Provider deems appropriate regarding:
(i) a condition or course of treatment, including the availability of other therapies, consultations, or tests; or (ii) the provisions, terms, or requirements of Payor's or Zelis's products to the extent that they relate to the Participant. N.Y. Ins. Law § 3217-b(a).

b. Filing a complaint, making a report, or commenting to an appropriate governmental body regarding the policies or practices of Payor or Zelis, which Network Provider believes may have a negative impact upon the quality of, or access to, patient care. N.Y. Ins. Law § 3217-b(b).

c. Advocating to Payor or Zelis on behalf of a Participant for approval of coverage of a particular course of treatment or for the provision of Covered Services. N.Y. Ins. Law § 3217-b(c).

2. Nothing in the Agreement shall be construed to transfer to Network Provider, by indemnification or otherwise, liability for the activities, actions, or omissions of Payor or Zelis, as opposed to the activities, actions, or omissions of Network Provider. N.Y. Ins. Law § 3217-b(d).

3. To the extent required by New York law and not otherwise preempted by federal law, the method by which payments to Network Provider shall be calculated, and the other payment terms and conditions specified in N.Y. Ins. Law § 3217-b(e), are set forth in the Agreement, including applicable schedules thereto and the onboarding material. To the extent permitted by N.Y. Ins. Law § 3217-b(e)(5), either party may seek resolution of a dispute arising pursuant to the payment terms of the Agreement through a proceeding under article seventy-five of the civil practice law and rules (N.Y. Civ. Prac. Law, Art. 75, Arbitration).

4. To the extent required by New York law and not otherwise preempted by federal law, Network Provider shall initially submit a claim within one hundred and twenty (120) days after the date of service unless a longer time period is permitted under the Agreement or applicable law. Network Provider shall be permitted

to request reconsideration of a claim that is denied exclusively because it was submitted untimely; and Payor shall pay such claim in accordance with applicable law if Network Provider can demonstrate that non-compliance was a result of an unusual occurrence and that Network Provider has a pattern or practice of submitting claims in compliance with timely submission requirements. Payor may reduce the reimbursement due for an untimely claim by an amount not to exceed twenty-five percent (25%) of the amount that would have been paid had the claim been submitted in a timely manner; provided, however, that nothing herein shall preclude the parties from agreeing to a lesser reduction. Payor may deny the claim in full for a claim submitted three hundred and sixty-five (365) days or more after the date of service. N.Y. Ins. Law § 3224-a(g) and (h).

5. The following provisions shall be added to the Agreement if and to the extent that Payor and plan enter into a financial risk transfer agreement that is subject to N.Y. Comp. Code R. & Regs., Tit. 11, Chap. IV, Subchap. B, Part 101 (Regulation 164):

a. Network Provider shall not, in the event of default by Payor, demand payment from plan for any Covered Services rendered to Participants for which the in-network capitation payment was made by plan to Payor pursuant to a financial risk transfer agreement that includes a prepaid capitation arrangement and is subject to Regulation 164 of the New York State Department of Financial Services. 11 NYCRR § 101.4(a)(1).

b. Network Provider shall not collect or attempt to collect from a Participant any amounts owed to Network Provider for Covered Services, other than any amounts that the Participant is obligated to pay pursuant to the Participant's applicable health benefit plan. Network Provider acknowledges that this subsection (b) is in addition to the protections afforded to Participants under New York Insurance Law Section 4307(d). 11 NYCRR § 101.4(a)(2).

c. In the event that the financial risk transfer agreement between Payor and plan is terminated by the Superintendent of the New York State Department of Financial Services (the "Superintendent") pursuant to 11 N.Y.C.R.R. § 101.9(a)(7), the Agreement with Network Provider may be assigned on a prospective basis (without any obligation to pay any amounts owed to Network Provider by Payor) to each plan that entered into a financial risk transfer agreement with Payor, for a period of time that is determined by either: (i) the Commissioner of the New York State Department of Health with respect to payors [HMOs] certified pursuant to Article 44 of the New York Public Health Law, or (ii) the Superintendent with respect to all other payors. This assignment is necessary in order to provide the services that Payor is legally obligated to deliver to its Participants. However, no such assignment shall exceed twelve (12) months from the date that the financial risk transfer agreement between Payor and plan is terminated by the Superintendent. 11 NYCRR § 101.4(a)(3).