ADDENDUM
State-Specific Provisions:
ARIZONA

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Arizona regarding provider contracts with providers rendering health care services in the State of Arizona. 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, a health care insurer or health care services organization, as those terms are defined in applicable Arizona law. References to Network Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. To the extent that Covered Services are rendered to Participants enrolled in a health care services organization (HMO) plan, the following provisions shall be added to the Agreement to the extent required by law and applicable to Network Provider:

    a. Nothing in the Agreement shall be construed to restrict or prohibit Network Provider's good faith communication with a Participant concerning the Participant's health care or medical needs, treatment options, health care risks, or benefits. Ariz. Rev. Stat. § 20-1061(B)(1).
    b. Zelis shall not terminate or refuse to renew the Agreement solely because Network Provider in good faith (i) advocates in private or in public on behalf of a Participant, (ii) assists a Participant in seeking reconsideration of a decision to deny coverage for a health care service, or (iii) reports a violation of law to an appropriate authority. Ariz. Rev. Stat. § 20-1061(B)(2).
    c. The Agreement shall not contain a financial incentive plan that includes a specific payment made to or withheld from Network Provider as an inducement to deny, reduce, limit, or delay medically necessary care that is covered by a Participant's evidence of coverage for a specific disease or condition. This provision does not prohibit per diem or per case payments, diagnostic related grouping payments, or financial incentive plans, including capitation payments or shared risk arrangements, that are not connected to specific medical decisions relating to a Participant for a specific disease or condition. Ariz. Rev. Stat. § 20-1061(C).
    d. In the event that Payor is declared insolvent, Network Provider shall provide services to Participants at the same rates of reimbursement and subject to the same terms and conditions established in the Agreement for the duration of the period after Payor is declared insolvent, until the earliest of the following:
        i. A determination by the court that Payor cannot provide adequate assurance that it will be able to pay Network Provider's claims for Covered Services that were rendered after Payor is declared insolvent.
        ii. A determination by the court that the insolvent Payor is unable to pay Network Provider's claims for Covered Services that were rendered after Payor is declared insolvent.
        iii. A determination by the court that continuation of the Agreement would constitute undue hardship to Network Provider.
        iv. A determination by the court that Payor has satisfied its obligations to all Participants under its health care plans. Ariz. Rev. Stat. §§ 20-1074(B).
    e. In the event that Payor fails to pay for Covered Services as set forth in the Agreement, the Participant shall not be liable to Network Provider for any amounts owed by Payor, and Network Provider shall not bill or otherwise attempt to collect from the Participant any amount owed by Payor. Neither Network Provider nor any agent, trustee, or assignee of Network Provider shall maintain an action at law against a Participant to collect any amounts owed by Payor. Ariz. Rev. Stat. § 20-1072.

2. To the extent required by law, except in cases of fraud: (i) Payor or its designee shall not adjust the payment of a claim more than one (1) year after the date that Payor or its designee paid the claim; and (ii) Network Provider shall not request

adjustment of the denial of a claim more than one (1) year after the date that Payor or its designee denied the claim. If the Agreement provides for a longer period of time to adjust or request adjustment of the payment or denial of a claim, that period shall be the same length of time for Payor or its designee and Network Provider. Ariz. Rev. Stat. § 20-3102(I).