ADDENDUM FOR THE STATE OF WASHINGTON
DENTAL

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

1. Payor shall establish a mechanism by which Network Provider can obtain timely information on Participant eligibility for Covered Services and health plan benefits, including any limitations or conditions on such services or benefits. Nothing contained in the Agreement may have the effect of modifying benefits, terms, or conditions contained in the Participant's health plan. In the event of any conflict between the Agreement and the Participant's health plan, the benefits, terms, and conditions of the health plan shall govern with respect to Covered Services provided to the Participant. Wash. Admin. Code [WAC] 284-170-421 (1)(2).

2. As required by the hold harmless and insolvency provisions of WAC 284-170-421(3)

a. Network Provider hereby agrees that in no event, including but not limited to nonpayment by Payor, Payor's insolvency, or breach of the Agreement, shall Network Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Participant or a person acting on a Participant's behalf, other than Payor, for services provided pursuant to the Agreement. This provision shall not prohibit collection of deductibles, copayments, coinsurance, and/or non-Covered Services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Participants in accordance with the terms of the Participant's health plan.

b. Network Provider agrees, in the event of Payor's insolvency, to continue to provide Covered Services to Participants of such Payor's plan for the duration of the period for which premiums on behalf of the Participant were paid to such Payor or until the Participant's discharge from inpatient facilities, whichever time is greater.

c. Notwithstanding any other provision of the Agreement, nothing in the Agreement shall be construed to modify the rights and benefits contained in the Participant's health plan.

d. Network Provider may not bill the Participant for Covered Services, except for deductibles, copayments, or coinsurance, where Payor denies payments because Network Provider has failed to comply with the terms or conditions of the Agreement.

e. Network Provider further agrees that: (i) the provisions of subsections (a), (b), (c), and (d) of this section shall survive termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Payor's Participants, and (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Network Provider and Participants or persons acting on their behalf.

f. If Network Provider contracts with other providers or facilities who agree to provide Covered Services to Participants of Payor with the expectation of receiving payment directly or indirectly from Payor, such providers or facilities must agree to abide by the provisions of subsections (a), (b), (c), (d), and (e) of this section.

3. Network Provider is hereby informed that willfully collecting or attempting to collect an amount from a Participant knowing that collection to be in violation of the Agreement constitutes a class C felony under Wash. Rev. Code [RCW] 48.80.030(5). WAC 284-170-421(4).

4. Payor or Zelis, as applicable, shall notify Network Provider of Network Provider's responsibilities with respect to Payor's or Zelis' applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements, and any applicable federal or State requirements, which may be provided electronically. WAC 284-170-421(6).

The following Section 5 shall supersede and replace Section 11.2 Amendment and Material Changes in Network Provider's Agreement.

5. To the extent required by law, Network Provider must be given reasonable notice of not less than sixty (60) days of changes that affect Network Provider's compensation and that affect health care service delivery, unless changes to federal or state law or regulations make such advance notice impossible, in which case notice shall be provided as soon as possible. Subject to any termination and continuity of care provisions of the Agreement, Network Provider may terminate the Agreement without penalty if Network Provider does not agree with such changes. No change to the Agreement may be made retroactive without the express consent of Network Provider. WAC 284-170-421(6).

6. Payor or Zelis may not in any way preclude or discourage Network Provider from informing Participants of the care they require, including various treatment options, and whether in Network Provider's view such care is consistent with medical necessity, medical appropriateness, or otherwise covered by the Participant's plan. Payor or Zelis may not prohibit, discourage, or penalize Network Provider otherwise practicing in compliance with the law from advocating on behalf of a Participant with Payor or Zelis. Nothing in this section shall be construed to authorize Network Provider to bind Payor or Zelis in any way to pay for any service. Payor may not preclude or discourage Participants or those paying for Participants' coverage from discussing the comparative merits of different health carriers with Network Provider. This prohibition specifically includes prohibiting or limiting Network Provider from participating in those discussions even if critical of Payor or Zelis. RCW 48.43.510(6)-(7); WAC 284-170-421(7).

7. Network Provider shall make health records available to appropriate State and federal authorities involved in assessing the quality of care or investigating the grievances or complaints

of Participants subject to applicable State and federal laws related to the confidentiality of medical or health records. WAC 284-170-421(8).

8. Network Provider and Zelis shall provide at least sixty (60) days' written notice to each other before terminating the Agreement without cause. If the Agreement provides for a longer notice period for termination without cause, such longer notice period shall govern. WAC 284-170-421(9). Section 10.2 Termination Without Cause in the Agreement provides for a longer notice period of ninety (90) days' prior written notice.

9. Network Provider shall furnish Covered Services to Participants without regard to the Participant's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when Network Provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions. WAC 284-170-421(11).

10. Network Provider shall not be penalized because Network Provider, in good faith, reports to State or federal authorities any act or practice by Payor or Zelis that jeopardizes patient health or welfare or that may violate State or federal law. WAC 284-170-421(12).

11. Notwithstanding any other provision of law, Payor may not prohibit directly or indirectly its Participants from freely contracting at any time to obtain any health care services outside the Participants' health care plan on any terms or conditions the Participants choose; provided, however, that nothing in this section shall be construed to bind Payor in any way for any services delivered outside the Participant's health plan. RCW 48.43.085.

The following shall be added to Article IV of the Agreement for applicable Payors:

12. To the extent required by WAC 284-170-431, the standards set forth in this section shall apply to the prompt payment of amounts owed by Payor to Network Provider for Covered Services provided to Participants under the Agreement, to the extent applicable and not otherwise preempted by federal law:

a. For purposes of this section, "clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim under this section.

b. For Covered Services provided to Participants, Payor shall pay Network Provider in accordance with the following standards:

i. Ninety-five percent (95%) of the monthly volume of clean claims shall be paid within thirty (30) days of receipt by Payor or agent of Payor; and

ii. Ninety-five percent (95%) of the monthly volume of all claims shall be paid or denied within sixty (60) days of receipt by Payor or agent of Payor, except as agreed to in writing by the parties on a claim-by-claim basis.

c. The receipt date of a claim is the date that Payor or Payor's agent receives either written or electronic notice of the claim.

d. Payor shall establish a reasonable method for confirming receipt of claims and responding to Network Provider's inquiries about claims.

e. If Payor fails to pay claims within the standards established under subsection (b) of this section, Payor shall pay interest on undenied and unpaid clean claims more than sixty-one (61)

days old until Payor meets the standards under subsection (b) of this section. Interest shall be assessed at the rate of one percent (1%) per month, and shall be calculated monthly as simple interest prorated for any portion of a month. Payor shall add the interest payable to the amount of the unpaid claim without the necessity of Network Provider submitting an additional claim. Any interest paid under this section shall not be applied by Payor to a Participant's deductible, copayment, coinsurance, or any similar obligation of the Participant.

f. When Payor issues payment in Network Provider's and the Participant's names, Payor shall make claim checks payable in the name of Network Provider first and the Participant second.

g. Denial of a claim must be communicated to Network Provider and must include the specific reason why the claim was denied. If the denial is based upon medical necessity or similar grounds, then Payor upon request of Network Provider must also promptly disclose the supporting basis for the decision.

h. Payor shall be responsible for ensuring that any person acting on behalf of or at the direction of Payor, or acting pursuant to Payor standards or requirements, complies with the billing and claim payment standards set forth in this section.

i. The standards set forth in this section do not apply to claims about which there is substantial evidence of fraud or misrepresentation by Network Provider, other providers, facilities, or Participants, or instances where Payor, Payor's agent, or Zelis has not been granted reasonable access to information under Network Provider's control.

j. Network Provider, Payor, and Zelis are not required to comply with the provisions of this section if the failure to comply is occasioned by any act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency, or the result of a strike, lockout, or other labor dispute.

13. To the extent applicable and not otherwise preempted by federal law, Payor may not unreasonably delay payment of a claim through the application of a coordination of benefits provision, as further specified in the time limits set forth in WAC 284-51-215.

The following Section 14 shall be in addition to those obligations detailed in Article VI Records:

14. To the extent required by WAC 284-170-460, the following audit guidelines shall apply to the Agreement, to the extent applicable and not otherwise preempted by federal law: (i) Payor and Zelis may not access health information and other similar records unrelated to Participants, provided that, this provision shall not limit Payor's or Zelis's right to ask for and receive information relating to the ability of Network Provider to deliver health care services that meet the accepted standards of medical care prevalent in the community; (ii) to the extent that Payor or Zelis accesses medical records for audit purposes, such access shall be limited to only those records that are necessary to perform the audit; and (iii) any billing audit standards set forth in the Agreement shall apply mutually to the parties.

15. If Network Provider subcontracts with other providers or facilities to deliver Covered Services to Participants under the Agreement, Network Provider shall require each such subcontracted provider or facility to satisfy the requirements of Section 2 of WAC 284-170-401, and to comply with the terms and conditions of the Agreement and this Addendum. WAC 284-170-401.Notwithstanding the foregoing, nothing in this section shall authorize Network Provider to subcontract, delegate, or assign any of Network Provider's services or obligations under the

Agreement to another provider or facility without the prior written consent of Zelis, which consent shall not be unreasonably withheld or delayed.

16. To the extent required by law, retrospective reviews conducted pursuant to the utilization management program under the Agreement shall comply with the following requirements, to the extent applicable and not otherwise preempted by federal law: (i) retrospective review determinations must be based solely on the medical information available to the attending physician or order provider at the time the health service was provided; (ii) coverage shall not be retrospectively denied for emergency and nonemergency care that had prior authorization under the plan's written policies at the time the care was rendered, unless the prior authorization was based upon a material misrepresentation by Network Provider; and (iii) a review conducted pursuant to a "postservice review request" must be completed within thirty (30) calendar days of receipt of all necessary information. RCW 48.43.525; WAC 284-43-2000.

17. a. To the extent required by RCW 48.43.600, if applicable and not otherwise preempted by federal law, Payor may not, except in the case of fraud:

i. Request a refund from Network Provider of a payment previously made to satisfy a claim unless Payor does so in writing to Network Provider within twenty-four (24) months after the date that the payment was made; or

ii. If doing so for reasons related to coordination of benefits (COB) with another carrier or entity responsible for payment of a claim, request a refund from Network Provider of a payment previously made to satisfy a claim unless Payor does so in writing to Network Provider within thirty (30) months after the date that the payment was made; or

iii. Request that a contested refund be paid any sooner than six (6) months after receipt of the request.

b. Any request pursuant to subsection (a) of this section must specify why Payor believes that Network Provider owes the refund. If made for reasons related to COB, such request must include the name and mailing address of the entity that has primary responsibility for payment of the claim.

c. If Network Provider fails to contest the request in writing to Payor within thirty (30) days of receipt of such request, the request is deemed accepted and the refund must be paid. This section is not applicable to subrogation claims.

d. Payor may at any time request a refund from Network Provider of a payment previously made to satisfy a claim if: (1) a third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law, such as tort liability; and (2) Payor is unable to recover directly from the third party because the third party has either already paid or will pay Network Provider for the health services covered by the claim.

18. a. To the extent required by RCW 48.43.605, if applicable and not otherwise preempted by federal law, Network Provider may not, except in the case of fraud:

i. Request additional payment from Payor to satisfy a claim unless Network Provider does so in writing to Payor within twenty-four (24) months after the date that the claim was denied or payment intended to satisfy the claim was made; or

ii. If doing so for reasons related to coordination of benefits (COB) with another carrier or entity responsible for payment of a claim, request additional payment from Payor to satisfy a claim unless Network Provider does so in writing to Payor within thirty

(30) months after the date the claim was denied or payment intended to satisfy the claim was made; or

iii. Request that the additional payment be made any sooner than six (6) months after receipt of the request.

b. Any request pursuant to subsection (a) of this section must specify why Network Provider believes that Payor owes the additional payment. If made for reasons related to COB, such request must also include the name and mailing address of any entity that has disclaimed responsibility for payment of the claim. This section is not applicable to subrogation claims.

Where applicable to the Payor, Section 11.10 Dispute Resolution in the Agreement shall be replaced with the following Section 19 - 23:

19. To the extent required by law, the "Arbitration" section of the Agreement is hereby deleted in its entirety and is replaced by the dispute resolution provisions set forth in this Addendum for the fair resolution of disputes between the parties arising out of the Agreement. Notwithstanding any provision to the contrary in the Agreement, the Network Provider disputes between the parties arising out of the Agreement shall not be subject to binding arbitration. Unless otherwise required by a specific federal or State statute or regulation governing dispute resolution, or otherwise preempted by federal law, such disputes shall be subject to the applicable provisions set forth in Sections 19 through 23 of this Addendum. WAC 284-170-421(13), WAC 284-170-440.

20. In accordance with Section 19 of this Addendum, the dispute resolution procedures in this section shall apply to disputes arising out of the Agreement with respect to Payor's claims payment issues:

a. Request for Reconsideration. In the event that Network Provider wishes to request reconsideration of a claim payment under the Agreement, Network Provider must either notify the Zelis Network Provider Resolution Team verbally by calling the toll-free telephone number or submit a request for reconsideration in writing to the contact information in your onboarding package). The completed Claim Reconsideration Form must be submitted to

Zelis at the following address:

Zelis Healthcare, LLC
Network Provider Payment Dispute
2 Concourse Parkway
Suite 300
Atlanta, Georgia 30328

Network Provider's request for reconsideration must be received by Zelis within forty-five (45) days after the date of Payor's explanation of payment (EOP), or within the period of time required by applicable law if longer. After receipt of Network Provider's completed request for reconsideration, Zelis will research Network Provider's concern and respond to Network Provider as soon as possible. If the request for reconsideration is resolved in Network Provider's favor, Zelis shall request Payor to reprocess the claim, and reissue a corrected EOP.. If the request for reconsideration is not resolved in Network Provider's favor, Network Provider will be advised to submit an appeal to the Payor or to Zelis in writing according to the procedures set forth in subsection (b) of this section.

b. Appeal. In the event that the request for reconsideration under subsection (a) of this section is not resolved in Network Provider's favor, Network Provider must submit an appeal in writing as instructed in your onboarding package. The appeal must also include, a copy of of the claim, and must be submitted to the Zelis Provider Contracting Team at the following address:

Zelis Healthcare, LLC
Network Provider Contract Appeal
2 Concourse Parkway NE
Suite 300
Atlanta, Georgia

Network Provider's appeal must be received by Zelis within thirty (30) calendar days from the date that Zelis orally advised Network Provider or, for written requests for reconsideration, the date of Zelis' or Payor's written notice (EOP, letter, etc.) advising Network Provider that Network Provider's request for reconsideration was not resolved in Network Provider's favor, or within the period of time required by law if longer. Zelis's Provider Contracting Team will endeavor to complete the review of Network Provider's appeal within thirty (30) calendar days of the date that Zelis receives all information necessary to review Network Provider's appeal. Zelis will communicate the results of its review of Network Provider's appeal in writing, which may include, when payment is issued, a check along with an explanation of payment.

c. Dispute Resolution. In the event that Network Provider is not satisfied with the decision rendered on appeal under subsection (b) of this section, Network Provider may request in writing, within sixty (60) days of the date of the appeal decision letter, that the parties attempt in good faith to resolve the dispute promptly by negotiation between representatives of the parties who have authority to settle the dispute. If the matter is not resolved within sixty (60) days of the date of Network Provider's written request for such negotiation, Network Provider and/or Zelis may proceed in accordance with subsection (d) of this section.

d. Judicial Remedies. The dispute resolution procedures specified in subsections (a), (b), and (c) of this section do not exclude judicial remedies, but such procedures are required prior to judicial remedies. WAC 284-170-440(4).

e. Survival. The provisions of this section shall survive any termination of the Agreement.

21. In accordance with Section 19 of this Addendum, the dispute resolution procedures in this section shall apply to disputes arising out of the Agreement with respect to termination of the Agreement:

a. Appeal. In the event that Network Provider wishes to appeal the termination of the Agreement, Network Provider must submit a written request to appeal such termination, along with supporting documentation, to Network Provider's designated Zelis Network Manager. Network Provider's written request must be received by Zelis within thirty (30) days from the date of Zelis' termination notice, or the period of time required by law if longer. Network Provider's appeal will be handled in accordance with any appeal processes required by applicable law. Zelis will endeavor to complete its review of Network Provider's appeal within thirty (30) calendar days after the date of receipt of Network Provider's written appeal. Zelis will communicate the results of its review of Network Provider's appeal in writing.

b. Dispute Resolution. In the event that Network Provider is not satisfied with the decision rendered on appeal under subsection (a) of this section, Network Provider may request in writing, within sixty (60) days of the date of the appeal decision letter, that the parties attempt

in good faith to resolve the dispute promptly by negotiation between representatives of the parties who have authority to settle the dispute. If the matter is not resolved within sixty (60) days of the date of Network Provider's written request for such negotiation, Network Provider and/or Zelis may proceed in accordance with subsection (c) of this section.

c. Judicial Remedies. The dispute resolution procedures specified in subsections (a) and (b) of this section do not exclude judicial remedies, but such procedures are required prior to judicial remedies. WAC 284-170-440(4).

d. Survival. The provisions of this section shall survive any termination of the Agreement.

22. In accordance with Section 19 of this Addendum, the dispute resolution procedures in this section shall apply to other disputes arising out of the Agreement which are not covered by Sections 20 or 21 of this Addendum:

a. Dispute Resolution. If, after exhausting the Zelis appeal process, Network Provider is not satisfied with the resolution of a dispute, or in the event of a dispute arising out of the Agreement which is not covered by such appeal process, a party wishes to submit the dispute for resolution, that party must first request in writing that the parties attempt in good faith to resolve the dispute promptly by negotiation between representatives of the parties who have authority to settle the dispute. If the matter is not resolved within sixty (60) days of such written request for negotiation, either party or both parties may proceed in accordance with subsection (b) of this section.

b. Judicial Remedies. The dispute resolution procedures specified in subsection (a) of this section do not exclude judicial remedies, but such procedures are required prior to judicial remedies. WAC 284-170-440(4).

c. Survival. The provisions of this section shall survive any termination of the Agreement.

23. To the extent required by RCW 48.43.055 and applicable to Network Provider, Zelis shall provide reasonable means allowing Network Provider to be heard after submitting a written request for review of a complaint arising under the Agreement. If Zelis fails to grant or reject a request for review of such complaint by Network Provider within thirty (30) days after it is made, Network Provider may proceed as if the complaint had been rejected. A complaint that has been rejected by Zelis may be submitted to nonbinding mediation. Mediation shall be conducted under the Uniform Mediation Act, as set forth in Title 7, Chapter 7.07, of the Revised Code of Washington, or any other rules of mediation agreed to by the parties. This section applies solely to the resolution of complaints by Network Provider. Complaints by, or on behalf of, a Participant are subject to the grievance processes in RCW 48.43.530, which shall be administered by the Payor or the Payor's designee for the Participant's plan.

24. To the extent required by RCW 284-170-433 and applicable to Network Provider, Payor shall reimburse Network Provider for a healthcare service provided to Participant through telemedicine or store and forward technology if; (i) The plan provides coverage of the health care service when provided in person by the provider; (ii) The health care service is medically necessary; (iii) The health care service is a service recognized as an essential health benefit under section 1302(b) of the federal Patient Protection and Affordable Care Act in effect on January 1, 2015, RCW 48.43.005 and 48.43.715; (iv) The health care service is determined to be safely and effectively provided through telemedicine or store and forward technology according to generally accepted health care practices and standards, and the technology used

to provide the health care service meets the standards required by state and federal laws governing the privacy and security of protected health information; and

(b) Beginning January 1, 2023, for audio-only telemedicine, the Participant has an established relationship with the provider

25. To the extent required by RCW 284-170-433 and applicable to Network Provider, except as provided in 24(b), Payor will reimburse Network Provider for a health care service provided to a Participant through telemedicine as provided in RCW 48.43.735(1) or subsection (1) of this section the same amount of compensation the Payor would pay the provider if the health care service was provided in person by the provider. (b) Hospitals, hospital systems, telemedicine companies, and provider groups consisting of 11 or more providers may elect to negotiate an amount of compensation for telemedicine services that differs from the amount of compensation for in-person services. For purposes of (b) of this subsection, the number of providers in a provider group refers to all providers within the group, regardless of a provider's location. (c) For purposes of this section, reimbursement of store and forward technology is available only for those covered services specified in the negotiated agreement between the health Payor and the health care provider.

26. To the extent required by RCW 284-170-433 and applicable to Network Provider, an originating site for a telemedicine health care service subject to subsection 1 of this section includes: (i) Hospital; (ii) Rural health clinic; (iii) Federally qualified health center; (iv) Physician's or other provider's office; (v) Licensed or certified behavioral health agency; (vi) Skilled nursing facility; (vii) Home or any location determined by the individual receiving the service including, but not limited to, a pharmacy licensed under chapter 18.64 RCW or a school-based health center as defined in RCW 43.70.825. If the site chosen by the individual receiving service is in a state other than the state of Washington, a provider's ability to conduct a telemedicine encounter in that state is determined by the licensure status of the provider and the provider licensure laws of the other state; or (viii) Renal dialysis center, except an independent renal dialysis center.

b) Except for (a)(vii) of this subsection and a hospital that is an originating site for an audio-only telemedicine encounter, any originating site under this subsection may charge a facility fee for infrastructure and preparation of the patient. Reimbursement for a facility fee must be subject to a negotiated agreement between the originating site and the Payor. A distant site, a hospital that is an originating site for an audio-only telemedicine encounter, or any other site not identified in this subsection may not charge a facility fee.

27. To the extent required by RCW 284-170-433 and applicable to Network Provider, Network Provider must obtain patient consent from the Participant for the billing in advance of the service being delivered, consistent with the requirements of this subsection and state and federal laws applicable to obtaining patient consent. A Participant's consent must be obtained prior to initiation of the first audio-only encounter with a provider and may constitute consent to such encounters for a period of up to 12 months. If audio-only encounters continue beyond an initial 12-month period, consent must be obtained from the Participant for each prospective 12-month period.

(ii) Consent to be billed for audio-only telemedicine services must be obtained by the provider or auxiliary personnel under the general supervision of the provider.

(iii) A Participant may consent to a provider billing them or their health plan in writing or verbally. Consent to billing for an audio-only telemedicine encounter may be obtained and documented by the provider or auxiliary personnel under the general supervision of the provider as part of the process of making an appointment for an audio-only telemedicine encounter, recorded verbally as part of the audio-only telemedicine encounter record or otherwise documented in the patient record. Consent must be documented and retained by the provider for a minimum of five years. As needed, a Payor also may request documentation of the Participant's consent as a condition of claim payment.

(iv) A patient may revoke consent granted under this subsection. Revocation of the patient's consent must be communicated by the patient or their authorized representative to the provider or auxiliary personnel under the general supervision of the provider verbally or in writing and must be documented and retained by the provider for a minimum of five years. Once consent is revoked, the revocation must operate prospectively.

28. Network Provider shall ensure that access to telemedicine services is inclusive for those who may have disabilities or limited English proficiency and for whom the use of telemedicine technology may be more challenging consistent with Payor's obligations under WAC 284-43-5940 through 284-43-5965 with respect to design and implementation of plan benefits.

The following Section 29 shall supersede and replace Credentialing Section 5.2 in Network Provider's Agreement.

29. Network shall complete a credential and recredentialing check of Dentist and accept or deny Dentist within Ninety (90) days following the submission of Dentist's completed application. Network shall make available to Dentist a list of all information required to be included in the application. RCW 48.43.750.

The following Section 30 shall supersede and replace Section 11.8 Entire Agreement, Waiver in Network Provider's Agreement.

30. This Agreement and any Attachments and/or Amendments, which is hereby incorporated by reference, shall constitute the entire agreement between the parties with respect to the subject matter hereof, and as of the Effective Date, shall supersede any previous agreements or understandings, written or oral, between the parties. The failure of either party to insist upon strict compliance with any provision hereof shall not constitute a waiver of such provision.

The following Section 31 shall supersede and replace Section 11.9 Governing Law, Invalidity, Venue in Network Provider's Agreement.

31. This Agreement, its terms and adjudication of all claims or controversies arising hereunder, shall be governed in all respects in accordance with the laws of the state of Washington. The invalidity of any terms or conditions hereof shall in no way affect the validity or enforceability of any term or provision.

32. As a Network, Zelis enters into agreements with its Clients to lease the Zelis Dental Network per Article VIII of the Participating Dentist Agreement. Zelis maintains a listing of the third parties with access to the Zelis Dental Network in Washington and makes the list available to the Provider upon (a) contract execution and credentialing approval and (b) upon Provider request

via Dentalppo@zelis.com and 1-888-266-3053. The third parties with access to the Zelis Dental Network in Washington are specifically listed in Exhibit A of this Addendum which may be updated from time to time. Notwithstanding, the entities listed in Exhibit A may be contracted directly with Zelis or with Zelis' Client.

Exhibit A

- DenteMax
    - Kaiser Foundation Health Plan of the Northwest
        - Classic+Dental Choice
        - Added Choice+Dental Choice
        - PPO Plus+Dental Choice
        - Dental Choice
    - Unum (aka AlwaysCare)
    - Beam Dental
    - Mutual of Omaha
    - Renaissance
    - Dental Care Plus Group
- Principal Life Insurance Company
    - Principal Plan Dental in WA
        - Outside Market Small Group/Group Dental Expense Insurance
        - Large Group Std Master Group Dental Expense Insurance
- Ameritas
    - Ameritas PPO Network
- Cigna Dental Insurance
    - Cigna Dental Preferred Provider Insurance
    - Cigna Dental Exclusive Provider Insurance